Child Poverty in America Today

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Edited by Barbara A. Arrighi and David J. Maume

Introduction by Diana Pearce

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To our children
Eiler, Elena, and Megan
and
Meghan and Allison
Our concern for their welfare piqued our interest in the welfare of all children

Contents

Acknowledgments

First, we wish to thank all the contributors to the four volumes for the exceptional caliber of their research. Their dedication and commitment to understanding the causes of child and family poverty is remarkable. It has been a pleasure to work with such a fine group of scholars. It is noteworthy, too, that more than a few of the contributors endured family emergencies and/or experienced personal crises during the research and writing phase, yet remained committed to the project. For that, we are grateful.

We are honored that Diana Pearce is the author of the Introduction for Volume 1: Families and Children. Professor Pearce has written a thoughtful essay weaving common threads among diverse chapters. She is a tireless researcher who has been a pioneer in examining the causes and effects of poverty in the lives of women and children. Not only has Professor Pearce illuminated the way for other researchers in explaining the complex factors influencing women's poverty, she has been an ardent advocate for ending the feminization of poverty.

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Introduction

Diana Pearce

"A child in the United States is born into poverty every 40 seconds."[1]

Child poverty in the world's richest nation continues to be a confounding paradox. No one is "for" child poverty, yet it persists, and continues to increase: over the last five years, an additional approximately 1.5 million children in America became poor, with the total now over 13 million.[2] Comparative studies have found that it is worse to be a poor child in America than in any other developed country.[3]

While none would doubt that it is harmful, the numbers are still quite sobering:

- At birth, a poor child is 1.8 times as likely to be premature, 1.9 times to be low birth weight, and 2.8 times as likely to have had inadequate prenatal care as the nonpoor child.
- A poor child is 1.6 times more likely to die as an infant, and 8 times as likely to live in a family that has had too little food in the last four months.
- A poor child is twice as likely to repeat a grade, about 3.5 times as likely to be expelled or drop out of school, and only half as likely to finish college as a nonpoor child.[4]
- The impacts do not end with childhood, as various studies have documented that childhood poverty is associated with higher rates of teenage childbearing, juvenile delinquency, and adult poverty.[5]

Yet simply describing childhood poverty and its effects on children, does not advance our understanding of this phenomenon, and why it persists. So the task undertaken by this volume is to present new perspectives on why and how childhood poverty persists. We begin with the contexts of child poverty in early twenty-first century America, starting with the demographic and historical context.

THE CHANGING DEMOGRAPHIC CONTEXT OF CHILD POVERTY

The demographic context in which children experience poverty has been changing dramatically. At the same time that the number of poor children is increasing, children and their families are becoming more and more a minority of households, and those households are changing. Once the norm was that most households were headed by married couples, and most of them had children; for example, in 1940, three-fourths of households were headed by married couples, and even as late as 1980, over half of families had children.[6] However, as of 2004, only 32 percent of households have children in them, less than one-third.[7] At the same time, the living circumstances of children have become more diverse, with more children living in families with less economic security. As recently as 1960, seven out of eight children lived with two parents. However, by 2005 only two-thirds of children lived with two parents, while almost one in four lived with his/her mother, only one in 20 with father only and about the same number with other relatives (grandmother, aunts, uncles, etc.) or non-relatives.[8] Likewise, the proportion of households with children that are not white increased from 20 percent to 38 percent between 1975 and 2005, with Hispanics increasing their proportion the most over the last three decades, from 6 percent to 17 percent of families with children.[9]

Poverty trends are similar, but the even more dramatic demographic shifts have had a differential impact on children. Because children have become, with the decrease in birth rates and increased longevity, a smaller proportion of the population, children are a smaller proportion of the poor, falling from 44 percent of all poor persons in 1975 to 35 percent in 2005.[10] At the same time, poor *families* with children increased their proportion of all poor *families*, from about two-thirds of all poor families in 1960 to about three-fourths in 2005. This trend reflects the increased diversity of race-ethnicity and living arrangements described above, so that more of the burden of child poverty is now found among families who are either maintained by women alone, or are African American or Hispanic, or both. Thus in 1975, more than half of poor families with children were white (non-Hispanic) (53%) but by 2005, that proportion had fallen to less than two in five (38%). Conversely, the proportion who are non-Hispanic African American fell slightly over these three decades (from 31% to 28%) while the proportion who are Hispanic increased dramatically over this period from 13 percent to 29 percent. Likewise, the percentage of poor families with children who are maintained by women alone has increased dramatically, from 28 percent of all poor families in 1960 to 61 percent in 2005.[11]

Finally, it is worth noting the differential and disturbing trends in poverty rates. On the one hand, the poverty rates for all families, and for all persons fell dramatically between 1960 and 2005, from 18 percent to 10 percent for families, and from 22 percent to 13 percent for all persons. Poverty rates also fell for some of the most economically disadvantaged groups as well: for example, the poverty rate for black families fell from 39 percent in 1967 (the earliest year for which there is this data by race) to 28 percent in 2005, while the poverty rate for women-maintained families fell from 49 percent in 1960 to 31 percent in 2005. However, while the poverty rate for

children under 18 initially also fell—from 27 percent in 1960 to a low of 14 percent in 1969—it rose again, reaching 17 percent by1975, and has stayed at approximately this level, rising and falling by a few percentage points, for the next 30 years, and is now at 18 percent.[12] Thus, alone, among all demographic groups, children's poverty has remained stubbornly high for three decades.

In sum, then, the demographic trends are such that:

- Children and families with children are a smaller proportion of the population as a whole, and of the poverty population as well. There are fewer children per family, and fewer families with children.
- While other demographic groups (characterized by age, gender of head, and/or race-ethnicity) have experienced declining poverty rates, that has been much less true of children.
- Children in the United States, especially poor children, reflect greater diversity than in the past in terms of race-ethnicity and living arrangements.
- The continuing high poverty rates of children reflect the high numbers of children in single mother and/or African American, Hispanic, and Native American families.

This demographic context provides the serious challenge of disentangling and understanding the dynamics of children's poverty, even as it is becoming more complex and diversified. Children's poverty in the United States has become in a real sense, a series of different poverties, overlapping to some extent but also differing in essential and important ways. For this reason, these chapters can be seen as analogous to the proverbial blind men and the elephant, each describing a different aspect of children's poverty, with their differences not reflecting inconsistency, but a real diversity of the reality of American childhood poverty.

THE POLITICAL/POLICY, ECONOMIC, AND SOCIAL CONTEXT

This growing diversity exists in a societal context that shapes the choices and options for all entities, whether individual, institutional, or societal. There are three trends that should be mentioned in particular, but in brief:

1. *A Decreased "Safety Net"/Benefit Programs*. Welfare reform, enacted in 1996, ended the entitlement to cash assistance. Combined with time limits and an emphasis on "work first" (rather than addressing health problems or deficits in educational preparation or English language), this has greatly reduced the availability of a "safety net" for poor single mother families. In addition, beginning in the 1980s, there has been an erosion of a range of other transfer programs, in terms of both benefit levels and coverage, from unemployment insurance to food stamps, from disability benefits to health insurance.
2. *Increased Reliance on Market/Wage Income*. At the same time, a rapidly expanding economy in the late 1990s increased employment opportunities, resulting in an increased proportion of single mothers in the workforce. Even though the sluggish economy in the early years of the twenty-first century has resulted in some loss of these employment gains, the curve has shifted, so that a substantially larger proportion of poor families,

particularly single mother families, are reliant to a larger degree on earnings rather than transfers (both cash and noncash). This means, as will be seen in more detail, both higher living costs (with the addition of employment-related costs such as child care) and greater instability of income.

3. *Increased Economic Inequality*. Although beginning several decades ago, by the early 2000s, several economic trends have coalesced to create an income (and resources) distribution that is increasingly unequal, with particular consequences for those at the lower end. These trends include: the shift in employment from higher-paying manufacturing to lower-waged service sector jobs; the decline in unions—with the attendant decrease in the union-associated premium on wages; the shrinking of the public sector; the decrease in health insurance and other benefits through employers; the erosion of the federal minimum wage "floor" under the wage structure (only partially offset by recent state minimum wage increases).

NEW PERSPECTIVES ON CHILD POVERTY

Given the changing demographic, political, and economic context in American society, these chapters break important new ground by offering new perspectives on children's poverty. They do so through a number of themes that recur across these chapters that together provide the reader with new understandings on childhood poverty. These themes are:

1. An emphasis on structural factors in explaining children's poverty such as racial and ethnic residential segregation or gender-based occupational segregation, rather than individual characteristics such as age or educational level.
2. The necessity of addressing the fact that the measurement of poverty is problematic, and thus alternative definitions or approaches must be used to define poverty, and who is poor.
3. The need to more directly measure economic hardship, reflecting another weakness of the poverty measure, through examination of the "costs" side of the poverty "equation."
4. Poverty among children is concentrated in certain racial and ethnic groups, particularly African American and Hispanic families, as well as Native American, and thus childhood poverty analyses must take into account how race and ethnicity impact the experience and dynamics of children and their poverties in each of these groups.
5. Childhood poverty occurs within a neighborhood context, with race-ethnic and household composition characteristics that interact to create impacts on children that reflect neighborhoods levels of poverty concentration.
6. Poverty among children is today very strongly related to women's poverty, and thus understanding children's poverty must include a gender analysis

Theme #1: Emphasis on Structural Factors

While it is almost a truism, it bears repeating that because children are by definition dependent, understanding their poverty must involve analysis of the sources of poverty for the adults on which they are economically (as well as emotionally)

dependent. The reason for the need for this emphasis is that too often, children who are poor are characterized as "innocent victims." While one would hardly disagree with this particular characterization, it contains an implicit syllogism that if children are innocent victims, their parents must be "guilty" perpetrators. Thus, it is but one step from this characterization of children to one that blames the parents, the responsible and supporting adults, for the poverty experienced by their children. Such analysis then can easily become a classic "blame the victim" analysis, in which the characteristics of the adult parents who are poor are used to explain their individual poverty.[13] An example of this would be to blame parental poverty on the number of children in the family, or on being a single parent.

In contrast, all the chapters in this volume avoid this trap, looking instead at a range of structural factors to explain parental poverty. For example, several authors—Barnes and Bynum, Kelly, Firestone, and McDonough—explore the child-care issues faced by low-income parents, demonstrating how the lack of a system of affordable quality child care forces parents to make Hobbesian choices between taking care of their children themselves, or using problematic child care so that they can work for a minimally adequate income at best. Child-care difficulties are both cause and effect of poverty, and are part of the structure and context that must be understood to address children's poverty.

A second analytical bias that a "children as innocent victims" perspective may lead to is that of mistaking "correlation" for causation, sometimes even missing that the causal links go in the other direction. For example, alcohol abuse may be the result of poverty, rather than the cause; neighborhoods may have high levels of teen parenting because they are high poverty neighborhoods. Thus, even though at the individual level, teen parenting has a high probability of resulting in subsequent lifelong low income, understanding how the neighborhood context plays a role in this reveals an important dynamic of poverty.

At the same time, structural analysis does not mean that the responsible adults, parents, and guardians, are but passive victims themselves, but are agents in their own lives, both positive and negative. Indeed, it is clear from all the chapters here, as well as many other analyses, that poor parents struggle greatly to make ends meet, to meet the material needs but also the child care, health care, and other needs of their children, against very great odds. As Friedman points out, it is important to empower, rather than blame parents for their poverty/homelessness. To understand these efforts better, however, requires the kind of analysis presented here that disentangles the various structural factors that contribute to children's poverty.

Theme #2: A Flawed Measure of Poverty

Up to this point, the discussion has taken for granted that the readers and authors are in agreement as to what is meant by "poverty." While most would agree on a general conception that encompasses the idea of "not having enough resources to meet basic needs" (with perhaps some debate about how to define "enough"), U.S. researchers face a very basic measurement problem. That is, there is broad

agreement that the widely used official federal poverty measure no longer accurately measures what most people mean by poverty.[14] Indeed, this is one of those rare topics in social science where one can, with reasonable confidence, assert that there is a consensus. One indicator is that the calls for changes in the early nineteen-nineties resulted in a Congressionally mandated multiyear study with dozens of research projects, culminating in the National Academy of Sciences publishing a massive study, *Measuring Poverty*, in 1995, including findings and recommendations.[15] What is lacking, however, is a political consensus, for no political entity wants to pay the political cost of overhauling the poverty measure, for it would undoubtedly increase the count of the poor substantially. Thus more than a decade later, the measure remains unchanged (see below.)

Given this stalemate, the researcher is faced with a federal poverty measure that is seriously out of date, no longer reflecting the reality of the costs faced by the poor, nor their variation by place, family type, and work status. Developed over four decades ago by Molly Orshansky, the federal poverty measure was based on a food budget that provided enough for a minimally adequate diet nutritionally. On the basis of expenditure surveys that showed families spent about a third of their income on food, this food budget was multiplied by three to cover all necessities. This froze the relationship between food and other expenses, building in the assumption that all expenses would increase at the same rate, and allowed for no new costs, such as child care. As workforce participation patterns and family composition changed, and as some costs such as housing and health care rose much faster than food, this measure has become increasingly out of kilter with the actual expenses faced by families. Even the Census Bureau acknowledges this: "The poverty measure . . . use as a historical measure, not as a yardstick of what families and individuals need to meet their needs. . . .[16]

As a result of its outdated and "frozen" methodology, the federal poverty measure has a number of flaws, but first and foremost, it is too low, and therefore seriously underestimates the poverty population, which in turn means it does not "capture" the true nature and diversity of the poverty population, or of the poverty problem. For example, there is no variation in the federal poverty measure between places, even though major costs such as housing and child care vary as much as 5:1 from the most to least expensive place.[17] Finally, it should be noted that as the "count" of the poor in the United States is based on a household survey, it does not include the poorest of the poor, those who are homeless, including homeless families. Thus, analyses of the homeless, such as those of Friedman and Jasinski et al., and others elsewhere, are focused on a poverty population, a substantial number of whom are children, who are not even "counted" as poor in official statistics. This is not an insubstantial number: estimates of the number of homeless children range from 1.2 million[18] to 1.35 million among 600,000 families.[19]

Every analyst and every policy or program has had to address these issues, implicitly or explicitly, and the chapters in this volume are no exception. Indeed, they illustrate the two very different approaches taken to reconcile a flawed measure with the need for finding a way to analyze poverty. On the one hand, several chapters take a substantially qualitative approach, and use an ecological, or self-defined definition

of poverty. This is the approach taken by Jasinski et al., for example, in her study of homeless women. Alternatively, those who are undertaking more quantitative analyses often use multiples of the poverty line, such as 125 percent (Davidson) or 200 percent of the poverty line (Kelly), designating households that fall beneath this line as "low income," "working poor," or "near poor." A variation of this approach which is an equivalent of multiples of the poverty line, used by Timberlake in this volume to measure poverty at the neighborhood level, is to designate a neighborhood as "high poverty" when 40 percent or more of residents have incomes below the official federal poverty measure. Using such a measure—which is common and widely accepted[20]—is based on the assumption that one can designate a neighborhood as "high poverty" when only a minority of residents are officially poor, because many of those whose incomes are above the poverty threshold nevertheless lack enough resources to adequately meet their needs. That is, as with using 125 percent or 200 percent of the federal poverty measure, if we had a more adequate measure, they would be designated as poor. There is a third alternative, which is to more directly assess the ability of families to meet the costs of specific basic needs, such as housing, which we will discuss in the next section in more detail.

To sum up, a common theme across these chapters is that the analysis of poverty is complicated greatly by the lack of an accurate, credible measure of who is poor, requiring researchers to find alternative measures to define the population they are studying. Of course, whenever the measures being used are not "standardized," this makes comparison and generalization somewhat more difficult and hazardous, for it may be the measure, rather than the findings that differ between studies. Nevertheless, by addressing this issue, and more accurately drawing the line around who is poor in a real sense, the poverty analysis is much more accurate and comprehensive in all these chapters.

Theme #3: Making Ends Meet: The High Cost of Housing and Child Care

All too often, analyses of poverty emphasize the "income" side of the poverty "equation," and ignore the "cost" side. Yet it is the costs side, and the problems and distortions that are occurring in this area that often are key to understanding poverty dynamics today. This is in part the result of another inadequacy of the poverty measure, which is based on a single need, that of food, so that one cannot use this measure to explain, much less measure, poverty that is *cost*-related. If instead, the poverty measure was built up from the cost of *each* major basic need, then its analysis could begin with a discussion of how, for example, the substantial increase in poverty thresholds has been driven by rising housing prices, and therefore, this additional group of people, in these particular places, are experiencing increased poverty (including homelessness). Lacking such a measure, which would be a tool to analyze such issues, requires using another definition of poverty, explicitly or implicitly. For example, it seems obvious that those who become homeless lack sufficient income to meet this basic need, regardless of whether that income is above or below the official poverty threshold, and therefore are "poor." Thus, to understand the issues facing the poor, it is necessary to look in detail at these basic needs, and the

problems inherent in meeting these needs, both in terms of price and availability. In short, understanding poverty cannot be reduced to just a question of income, as not all problems or needs are "fungible" in a market.

The official poverty measure not only does not directly reflect what it costs to "make ends meet," it is built on implicit assumptions that are now long out of date—such as that "low income people do not pay taxes," or that "there is no need to allow for child-care costs because either one parent stays home or if a single parent, that single parent would not be in the workforce." This results in conclusions such as the frequent assertion that welfare reform has successfully reduced "poverty," for employment rates and incomes have risen for single mothers, taking some out of official poverty. If, however, analysis were to measure the increases in *costs* (such as taxes, child care, and transportation) associated with employment and not just the increases in *income*, one would undoubtedly get a very different, and more mixed view of the outcome of welfare reform.

Chapters in this volume address the costs side of poverty in two ways, by examining in detail how families in fact manage to meet the costs of their basic needs, and by developing alternative estimates of income adequacy to measure economic hardship.

Of these costs, the chapters in this volume particularly focus on two, housing and child care. As Friedman demonstrates, the cost of housing has risen so much, relative to incomes, particularly in some metropolitan areas, that many families end up losing their housing, and become homeless, resulting in a whole different set of issues beyond the poverty experienced by the housed. Thus, to see this just as a "market" problem, or just another one of the basic needs to be purchased, misunderstands the nature of poverty as it is now experienced. As is pointed out by Friedman, and in a different way by Jasiniski et al, the very existence of the family unit, as a functioning entity, is threatened by the inadequacies of the shelter system. What begins as an affordability/availability problem must be solved by much more global efforts to empower families to make their way in a frayed safety net of services as well as the housing market. Yet for poor families, particularly those maintained by women alone, the resources available such as welfare and child welfare, often "blame" them, rather than provide support to meet this need. This is particularly the case for women—and children as well—who are experiencing domestic violence. As pointed out by Brandwein, when the housing is "owned" by the abuser, or the woman must flee for her and her children's safety, meeting the need of housing is key to addressing poverty. Clearly, the issues of housing and children's poverty are not just ones that are market, or economic, but reflect larger welfare and other policies that reflect sexism, racism, and classism, as argued by Brandwein and others. And, as pointed out by Jasinski et al., the poverty that is highly correlated with abuse in one generation, becomes both cause and effect of poverty and abuse in the next generation.

Child care is another "cost" issue that is much more than cost. As Firestone, Scott, Barnes and Barnum, Kelly, and McDonough all point out, child care involves a complex of issues—not only cost/affordability, but availability of child care (particularly for Latina mothers), low child-care salaries that affect availability and cost, lack of child care for evening and weekend in an economy in which service jobs are rapidly

expanding, issues with relative care, lack of services for children with disabilities and special needs, the difficult logistics (especially for single mothers) of combining work and child care (without being tardy/absent), inconsistent/unstable child-care provision (especially in rural areas and for low-income parents), and the inadequate, highly rationed availability of public child-care subsidies to parents and providers. Clearly, child care is a poverty issue that is about cost—and much more.

Another way to highlight the costs issue is to assess the ability of a family's income, regardless of the poverty level, to meet the costs of a set of major basic needs. Davidson developed such a measure to assess income adequacy, or economic hardship (using four major basic needs). This is a version of the basic needs budgets and other measures developed by the critics of the poverty measure, including the Self-Sufficiency Standard. These measures use an empirical approach to build an income adequacy measure from the costs of all basic needs (not just food), and vary it by family composition (number of adults, and number and age of children), as well as by place (usually county.)[21]

Theme #4: The Neighborhood Context of Children's Poverty

An important theme in these chapters that advances our understanding of children's poverty is that of the neighborhood or community context of that poverty. Rather than the individualistic paradigm described above, several authors explore how poverty is experienced, as well as created/perpetuated within communities with high levels of poverty. This is a major focus of the Timberlake and Michael, and Wagmiller chapters that develop a detailed picture of the kind of communities in which poor children grow up, whether urban or nonmetropolitan. As pointed out by Timberlake and Michael, interest in this phenomenon was sparked by William Julius Wilson's work, but it has rarely been applied to analyses of children's poverty. Interestingly, Jasinski et al.'s chapter on childhood exposure to violence as a predictor of adult homelessness and poverty, although focused on this phenomenon as individual/intergenerational, also includes discussions of the community experience and exposure to violence. The community context clearly impacted on, and reinforced the impact of childhood victimization on their subsequent adult lives. Likewise, Firestone's discussion of child-care issues for Latina mothers in San Antonio, references the community context.

Theme #5: Poverty and Diversity: Race-Ethnicity and Disability

Not all poverties are experienced in the same way, nor do they have the same causes, or cures, yet too often analyses of poverty make, at best, a passing reference to race and/or ethnicity, or disability. Commonly, it is noted that children's poverty, as with people of all ages, is experienced at much higher levels among most nonwhite races and ethnic groups, except Asian Americans (with exceptions for certain subgroups of Asian Americans, such as Hmong.) The analysis here provides new insight into how these higher poverty rates affect children of color, and how these effects differ by group. Thus both Timberlake and Michael, and Wagmiller describe how racial

and ethnic segregation has reinforced the segregation of the poor, creating doubly disadvantaged communities, exposing children particularly in those communities to economic disadvantage at the community level, even if their own families are not poor. This combination of racial segregation and poverty segregation led Wagmiller to conclude that black children occupy a unique, and unfortunate, "ecological niche" of highly disadvantaged neighborhoods. At the same time, both authors note that while these segregation levels (both racial and economic) rose during the 1970s and 1980s, they have started to fall significantly in the 1990s, as they and other others have documented.[22]

Other chapters contribute greater understanding of how the strategies used to deal with poverty differ between various ethnic and racial groups. For example, Firestone documents how low income Latina mothers bridge the gap between their low incomes and their need for child care, through a higher rate of usage of relative care (less expensive, though often not free). Similarly, Davidson's analysis of the variety of living arrangements found in single mother households differentiates these, and their impact on poverty and economic hardship, by ethnicity and race, finding that because different living arrangements are associated with different race-ethnic groups, and thus with poverty levels, a focus on race-ethnicity rather than marriage may be a more effective antidote to poverty. Finally, Scott's chapter analyzes in depth how disability interacts with often quite rigid institutions of school and work, resulting in further impoverishing families with children with disabilities (particularly socio-emotional difficulties.) Altogether, across these chapters, there is a recurring theme that suggests that calls for renewed attention to how race and ethnic segregation and discrimination are contributing to child poverty.

Theme #6: Gender and Children's Poverty

While none of these articles takes an explicitly gendered approach, or uses a gender analysis exclusively (except it is one of the explicit frames used by Brandwein, with sexism, racism, and classism informing her analysis throughout), gender is the subtext virtually throughout this volume. That is, one cannot discuss children's poverty from almost any perspective, without acknowledging that children in women-maintained families, especially those maintained by African American and Latina mothers, experience substantially higher rates of poverty and related disadvantage and economic hardship.

Women's poverty is qualitatively different from that experienced by men, and in the context of children's poverty, single mother's poverty is distinctly different from that experienced by families maintained by married couples or men alone. There are three aspects of single mother's poverty that are particularly salient.

- First, women tend to bear the economic as well as emotional burden of childrearing, alone or mostly alone. This is so much accepted, almost as a truism, that it may seem odd to

mention it. But it is striking that across all of these chapters, child support is hardly mentioned (and then only as a less than dependable or substantial income source).

- Second, single mothers in the workforce, although often the primary or sole source of income for their families, nevertheless face all the disadvantages of all women in the workforce. As with all women, single mothers experience unequal pay (74 cents compared to the dollar earned by male workers), occupational segregation patterns in which predominantly female occupations are consistently and significantly lower in pay, jobs in the service sector with hours (evening, weekends, swing shift) that are difficult to combine with family responsibilities, and sexual and gender harassment (particularly if they seek higher paying jobs that are nontraditional for women) that result in lost wages, promotions, and jobs.
- Third, single mothers needing work supports (such as child care) or cash assistance when they cannot work, face a social welfare system that either does not acknowledge their particular circumstances as women, or the opposite, conditions services and benefits on sexist assumptions and requirements. Examples of programs that ignore the particular circumstances of women are unemployment compensation programs that do not recognize sexual harassment as a valid reason for leaving a job, or welfare programs that do not recognize the particular needs of women who have experienced domestic violence (Brandwein and Jasinski et al.) or childhood abuse (with impacts on the next generation as well, as pointed out by Jasinski et al. and McDonough). The opposite problem is that of social welfare programs which impose gender-based and gender-biased requirements as conditions for receiving assistance, such as those that encourage or even require marriage ("wedfare"), encourage or require the use of contraceptives, or require certain parental behavior such as guaranteeing school attendance by their children.

The distinctive character of women's poverty is a theme found in almost every chapter. Thus Kelly, Scott, Firestone, and Barnes and Bynum particularly focus on the interrelationship between the first and second aspects of women's poverty described above, that is, how single mothers seek to balance the competing demands of work and family. As shown in almost every chapter, it is the combination of the low wages that women receive, and the burden (borne almost uniformly by mothers alone) of trying to arrange child care against its high costs and limited availability—especially for children with special needs or children of color—plus the extremely limited and highly contingent support from the public sector (in the form of benefits such as child-care assistance, etc.) that make for such high levels of economic hardship for their children. Without these gendered aspects of their poverty, children's poverty would be more easily addressed. But certainly acknowledging and specifying these issues is a very important step to better understanding, and thus addressing children's poverty.

Altogether, these chapters provide insights that build a new perspective on children's poverty, one that acknowledges the many diversities of poverties experienced by children who differ by where they live (urban, suburban, or rural; high, moderate or low poverty neighborhoods, areas of high or low racial/ethnic segregation), and by their living arrangements (particularly, if they live in a single-mother household).

They finesse the problems of an inadequate poverty measure in imaginative ways. Finally, they provide new insights into two key issues that are major costs, but also shape the lives and futures for families with children, and those issues are housing (including homelessness) and child care. All these perspectives emphasize how the ecological, social, and welfare structures impact on the lives of poor children, and point the way to alternative futures, ones in which the poverty of children is addressed and reduced.

NOTES

1. "Children in the United States," Children's Defense Fund, n.d. Available at http://www.childrensdefense.org/site/DocServer/us-2.pdf?docID=958

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CHAPTER 1

THE EFFECT OF CHILD CARE ON EMPLOYMENT TARDINESS AND ABSENCES FOR MOTHERS: DOES MARITAL STATUS MATTER?*

Sandra L. Barnes and Mia Smith Bynum

Employment provides minority women with economic as well as personal satisfaction and is particularly important for women who are poor, single mothers, and those from racial/ethnic groups.[1] The disproportionate percentage of U.S. children who are poor is directly correlated with the employment and marital statuses of their mothers.[2] And mothers, even those who are employed, continue to be responsible for the majority of childrearing responsibilities.[3] One of the most pressing problems facing them is locating accessible, acceptable, affordable child care.[4] Earlier studies show that as many as one-forth of mothers are either unemployed or face constrained job opportunities because of child-care problems.[5] Child-related events such as unexpected illnesses, medical appointments, and school-related activities may result in absences from work.[6] Employed mothers who are frequently tardy or absent can face direct or indirect sanctions in terms of meaningful work, promotions, and lost wages.[7] And because employment is central for many poor and near poor mothers, child-care problems can exacerbate impoverished circumstances for them and their children.[8]

However, the literature on employment obstacles for mothers is incomplete for several reasons. Much of the research focuses on the problem of absences and does not consider chronic tardiness.[9] This study considers both tardiness and absences and mothers' human capital that may help minimize these problems. Next, research on this topic for non-White mothers is sparse or cursory. Few studies are based on a large, national sample of African Americans, Hispanics, whites, and Asians with varying marital statuses. Literature would also benefit from research on possible ways traditional (i.e., education, spouse's income) and nontraditional (i.e., self-esteem) forms of human capital affect absences and tardiness. Lastly, this research topic is important because of the continued challenges poor mothers have in balancing

employment and childrearing, the disproportionate percentage of minority mothers who face this dilemma, and how such employment problems can be linked to the juvenilization of poverty.

THEORETICAL FRAMEWORK AND BACKGROUND LITERATURE

According to human capital theory, a person's selection for employment and subsequent pay reflect their skills and employers' requirements. Individual "assets" or human capital such as education, experience, commitment, initiative, and personal knowledge make certain candidates more competitive than others. In addition to these traits, human capital also reflects having the time to commit, in an employer's estimation, to the job.[10] Historically, women of childbearing age were expected to exit the employment arena periodically in order to bear and rear children. For these reasons, many employers consider women to be less committed employees.[11] And poor mothers are often at a disadvantage because of varied employment-related human capital, the tendency to work in lower-paying jobs, residence in poor areas, and constrained child-care needs.[12] Because the human capital of mothers is often considered less viable than that of their male counterparts, they may find themselves "mommy tracked" into less demanding, less interesting, lower paying positions.[13] In such cases, the presence of dependents becomes a "liability" with economic consequences for mothers and their children. Thus, real and perceived human capital—assets needed to locate and maintain gainful employment—directly affect mother's opportunities. This theory has been used largely to explain pay inequities; it can also be applied to study factors that enable mothers to address child-care needs such that they can be employed. Applying this theory, the types of tangible and intangible assets (or human capital) mothers may have that minimize child-care-related employment issues are examined and whether variations exist based on marital status.

Applying this theory, mothers who have human assets that enable them to better balance child care and employment tend to fare better.[14] Thus mothers who have been able to balance work inside and outside the home can reap benefits in the form of enhanced identity, social status, self-esteem, privilege, stimulation, *and* economic support.[15] In addition to accessible, acceptable, affordable child care,[16] possible assets include a spouse, partner, or helper in the home[17] or assistance from extended family to help pay for child care or provide low-cost or free child care.[18] Several studies link the ability of mothers to balance multiple roles to age or education as well as previous childrearing experience that engenders confidence and self-efficacy.[19] In contrast, mothers who cannot afford child care or those without these types of resources are at a disadvantage. This analysis examines the influence of human capital such as marital status and education as deterrents to child-care-related employment problems.

Marital Status/Household Structure

Although not considered a woman's personal asset, marital status and household type can be considered forms of human capital that can greatly influence the ability

to balance child care and employment. For example, African American single parents, like female single parents in general, are often employed to stave off poverty[20] and may receive child care from extended family.[21] It has also been suggested that white female heads-of-households often have greater difficulty balancing employment and child care than some non-white mothers.[22] Unmarried mothers who are employed generally face a different set of economic and logistical obstacles.[23] Married mothers may benefit from spouses who assist in child care and other domestic tasks.[24] However, other studies suggest that married mothers, those who are white in particular, bear the brunt of child-care decisions and may have problems balancing employment and domestic responsibilities.[25] Furthermore, married mothers are more likely to be absent from work than their spouses.[26] More fluid gender roles and shared family responsibilities for married couples facilitate employment for some African American wives with children and often enable such families to maintain their economic status.[27] A spouse's income also enables some married mothers to more easily fund child care or to choose whether or not to seek employment.[28] Therefore employment problems such as tardiness or absences due to child care would be expected to be a greater challenge for single mothers, in general, and the disproportionate percentage of single parent African American and Hispanic mothers, in particular.[29] But the economic necessity of employment for single mothers may provide a stronger motivator for punctuality and attendance among those who are poor or working class. However, the added responsibilities as single parents may prevent punctuality and consistent attendance.[30]

Spouse's Income and Child-Care Costs

Household incomes as well as expenses such as child-care costs influence mothers' employment.[31] These factors are also confounded with race/ethnicity. For many African American and Hispanic mothers, child care via extended family is an asset that facilitates employment. [32] Studies also show that Hispanic mothers rely on kin contact for economic and social support as much as African Americans[33] or more than whites and African Americans.[34] Furthermore, research posits a direct relationship between household income and the ability to afford child care.[35] In this context, the additional income from a spouse or partner would be expected to help mothers pay for child care as compared to mothers without these additional finances. Yet higher household income does not guarantee access to needed child care, for unlike poor and near poor families that may receive subsidized child care and wealthy families who can afford child care, "middle class" families often have difficulty finding appropriate child care that they can afford.[36] In this analysis, household economics as captured by spouse's income are expected to be inversely related to tardiness and absences. This measure (rather than household income in general) provides a parsimonious assessment of household income, marital status, contributors, and may uncover effects for mothers with this additional income as compared to those without it. Findings may also inform studies that are inconclusive about the influence of spouse's contributions.[37] In addition, one would expect more costly child care to be more dependable[38] and expect that child-care costs will be inversely related to tardiness and absences.

Race/Ethnicity

Economic restructuring resulting in low-wage pink color jobs; lack of affordable housing and child care; absentee fathers; and, divorce have all been associated with the feminization and juvenilization of poverty. For example, 2000 census data show that about 34.3–46.4 percent of female-headed households with children under 18 and 5 years old, respectively, are poor; substantially greater representation occurs for racial/ethnic groups.[39] African American mothers (and those who are single mothers are more apt to be poor) are more likely than white mothers to be in the labor force. However, Hispanic mothers are the least likely to do so. Studies show that the income provided by African American mothers, married or single, is often more central to maintain household economic stability as compared to white mothers.[40] And such mothers (and many of Hispanic descent) are also more likely to be employed in the secondary labor market with lower wages and less favorable hours and conditions.[41]

Mothers who are economically able are more likely to forgo employment, at least temporarily, when they have children—especially when their children are young. This pattern appears to be more common among white and Hispanic mothers.[42] Other scholars[43] contend that, due to more traditional gender roles, labor force participation has little affect on the domestic responsibilities most Asian women have as wives and mothers. Other studies show similar findings for Taiwanese working-class wives[44] and Korean women.[45] Furthermore, poverty often requires married Puerto Rican and Filipino mothers to work outside the home and care for their children.[46] The above research suggests that the socioeconomic status of many African American, and to a lesser degree, Hispanic mothers, often necessitate balancing employment and child care. Extending these studies, tardiness, and absences due to child care are expected to vary by race/ethnicity. And for reasons presented above, African American mothers are expected to be less tardy or absent than non-African American mothers. However, limited research on this topic for Hispanic and Asian mothers precludes exact predictions about how they will be affected—hence the need to explore these issues.

Children Age and Number of Children

Balancing employment and child care can be challenging based on the age and number of children[47] and can be particularly problematic for poor and working-class mothers who are employed.[48] Child care for younger children often requires mothers to be late or absent due to emergencies.[49] Studies also suggest that mothers with younger children and multiple children face additional child care problems due to both increased costs of child care and increased time constraints to care for their children.[50] Yet older siblings may represent "human capital" for mothers if they assist with child care for younger siblings and thereby reduce child-care-related employment problems.[51] In general, the presence of younger children and more children is expected to increase tardiness and absences.

Formal and Informal Experiences (Education, Age, Self-Esteem, and Job Type)

Formal education results in positive labor market returns for many women[52] and can mediate potentially lower labor force involvement for mothers when their children are young.[53] More education can also translate into higher earnings and the ability to purchase substitute care for children. Thus, better educated mothers would be expected to reconcile employment and child care somewhat more easily than less educated mothers.[54] In addition, white and nonpoor women tend to be better educated—a form of human capital that can help balance employment and child care if they become mothers.[55] In addition, older, employed mothers are more likely to have childrearing experience and more experience balancing the two roles, as well as adolescent offspring who can assist with child care.[56]

Although not as commonly studied, sociopsychological variables play an important role in how mothers view their ability to balance work inside and outside the home. Self-esteem, defined as a level of personal acceptance that is associated with one's abilities and achievements and acceptance of one's limitations, has been directly correlated with self-efficacy.[57] Some studies show that working mother's self-efficacy mediates the relationship between greater levels of child care responsibility and psychological distress and lower personal well-being.[58] Self-esteem may help explain why some mothers decide to seek employment. For example, mothers who have higher levels of self-esteem may be more inclined to take on the demands of employment and parenthood simultaneously and may view child care concerns as surmountable. In contrast, those with lower levels of self-esteem may foresee child-care challenges and be less likely to pursue employment. When type of employment is considered, studies show that[59] dual-earner couples are more apt to "scale back" in order to balance work–family dynamics. Using one of the strategies (limiting the number of hours worked), mothers who are able to do so may opt to work part-time to reduce child-care-related issues. Four types of human capital are considered here, formal education, age (which may proxy for childrearing experience), self-esteem, and part-time employment. Older mothers are expected to be less likely to experience child-care-related employment problems; both education and self-esteem are predicted to be inversely related to absences and tardiness; and, part-time employment will result in fewer such incidents.

Summary of Hypotheses

This project raises the following broad research question—are child-care-related employment tardiness and absences variable based on marital status? When considered simultaneously, will "human capital" such as marital status, age, spouse's income, or education influence punctuality and attendance? The topic is particularly important for poor and near poor mothers given the potential for lost employment and wages, reduced quality of life—both professional and personal—and the subsequent effects on their children. Informed by the above noted literature, six hypotheses will be

considered. Married mothers will be less likely to be tardy or absent as compared to mothers who are single, separated, divorced, or cohabitating (Hypothesis 1). African Americans will be less likely to be tardy or absent as compared to Hispanic, Asian, and white mothers (Hypothesis 2). The presence of a young child and more children will increase tardiness and absences (Hypothesis 3). Part-time employment will result in less tardiness and fewer absences (Hypothesis 4). I also include the following five control variables and posit that they will be inversely related to tardiness and absences: child-care costs, spouse's income, respondent's age, years of education, and self-esteem (Hypothesis 5). Lastly (Hypothesis 6), the effects of not being married will be less severe for African Americans as compared to the three other groups [race/ethnicity and marital status interactions].

DATA AND METHODS

The study is based on a subsample from the Multi-City Study of Urban Inequality (1992–1994).[60] The secondary database is a national sample of households developed to broaden the understanding of how changing labor markets, racial attitudes and stereotypes, and residential segregation foster urban inequality. The multistage probability sample includes four metropolitan areas: Atlanta, Boston, Detroit, and Los Angeles. In addition, the sampling frame was designed to include: poor and nonpoor households, five racial/ethnic groups, and male and female respondents between the ages of 18 and 65. Attitudinal and behavioral data were collected during face-to-face interviews that lasted 50–95 minutes. Interviews were conducted in English, Spanish, Korean, Mandarin Chinese, or Cantonese, based on the needs of the respondent. Response rates range from 68 percent (in Los Angeles) to 78 percent (in Detroit). Data were only collected for the child-care questions studied here in the Los Angeles, Atlanta, and Boston areas. These data are weighted to reflect population percentages for each racial/ethnic group. This study focuses on married, single, cohabitating, separated, and divorced mothers from four racial/ethnic groups who are employed full-time or part-time and who have dependent children 18 years old or younger. Based on these criteria, there are 550 married, 147 single, 59 cohabitating, and 295 separated/divorced mothers for a total sample of 1,051. Although the data are 10 years old and thus traditional generalizability is cautioned, it is important because of its detailed information on the experiences of diverse marital statuses and racial/ethnic subgroups.

Study Variables

The dependent variable, *Tardy-Absent* measures whether a respondent's work punctuality and attendance have been negatively affected by child-care responsibilities. The variable is based on the following question: "In the past twelve months, has a concern about your child-care needs caused you: to be late for work or to be absent from work? Yes or no?" Bivariate results from these data suggest that tardiness and absences reflect degrees of a related problem. Therefore responses are coded as ordered possibilities;

"0" for neither tardiness nor absences, "1" if either occurred, and "2" if both occurred. The reader should note the strengths as well as limitations of use of a single-item question. This variable is broad in its reference to "child-care needs" (i.e., are the needs due to lack of affordable child care, inconsistent extended family child care, a young mother's concerns about a newborn, or some other issue). However, the specific child-care issues faced by the sample mothers cannot be ascertained in this secondary data source. The dependent variable is also not determined for mothers who may have had child-care problems prior to 12 months before the survey and those who do not need traditional child care (i.e., who may only have older adolescent children). However, the strength of the variable lies in its ability to directly link employment absences and tardiness to child-care issues as reported by mothers in the sample.

A total of 16 independent variables are considered based on demographic, social, and sociopsychological factors. Four 0–1 indicators identify whether respondents are married, separated/divorced, never married, or living with a partner; married serves as the reference. In the interest of preserving statistical power, separated and divorced are combined into a single variable. Four race/ethnicity variables are included to identify white, African American, Hispanic, and Asian mothers and white is the reference group. Years of education (0–17 or more years) is a continuous variable as is respondent's chronological age (21–69 years) and the amount paid in child care per week for the respondent's youngest child ($0–$500). The reader should note that, in the datafile, the child-care cost variable was developed such that it captures only costs for the youngest child. Based on the fact that most mothers in the sample have, on average, two children, this indicator should be considered a lower bound on child-care costs they incur. A question was not posed to capture total child-care costs. In order to examine the influence of children, two variables are included to determine the number of children in two contexts. This includes the total number of children 18 years old or younger (continuous, 1–8 children) and a dummy variable to identify employed mothers with a child 6 years old or younger. Although it would be ideal to consider the ages of the respondents' children, the latter variable reflects another limitation of the database and represents a lower bound on age-related problems employed mothers might face. Spouse's annual income ($0–$400,000) is included where zero captures both cases of spouses without incomes and respondents without spouses and a dummy variable is included to identify part-time employment.

A construct based on responses to four Likert-type items to gauge self-esteem is used: (a) I feel I do not have much to be proud of; (b) On the whole, I am satisfied with myself; (c) All in all, I am inclined to feel that I am a failure; and (d) I take a positive attitude toward myself. Responses are coded such that "0" corresponds to "strongly disagree," "1" to "moderately disagree," "2" to somewhat agree, and "3" to "strongly agree." Questions (a) and (c) are reverse scored such that the overall construct scores range from 0 to 12 where higher scores represent a greater sense of self-esteem. The indicators that make up this construct are theoretically related in the social psychology literature and are also correlated at the bivariate level. A rotated Principle Components Factor Analysis suggests unidimensionality (eigenvalue = 1.92) and Cronbach's alpha (0.62) supports construct reliability. While other ranges are feasible

Table 1.1
Means and Proportions for Study Variables by Marital Status from Multi-City Study of Urban Inequality [1992–1994]

	Marital Status			
Variable	**Married (M)**	**Single (S)**	**Div./Sep. (D)**	**Cohab. (C)**
1. Tardy & absent (0–2)	0.77	1.06	.67	.93
% Neither	53.60^{C}	40.71	60.36^{C}	29.78^{MD}
% Tardy or absent	46.40^{C}	59.30	39.64^{C}	70.22^{MD}
% Tardy & absent	30.71	47.14	27.10	22.87
2. % African American	10.31^{SD}	39.97^{MC}	23.46^{M}	16.02^{S}
3. % White	63.03^{SD}	35.43^{M}	49.75^{M}	37.81
4. % Asian	5.56^{SC}	0.51^{M}	1.59	0.55^{M}
5. % Hispanic	21.03^{C}	23.95	25.18	45.55^{M}
6. % Work w/child $\leq$ 6 yrs	40.32^{D}	57.86^{D}	26.19^{MS}	45.75
7. % Employed Part-time	37.32^{DC}	42.71^{C}	24.62^{M}	16.26^{MS}
8. # Children $\leq$ 18 yrs	1.91^{SD}	1.25^{MDC}	1.57^{MS}	1.73^{S}
9. Mean years of education	13.22^{SC}	12.19^{MD}	13.33^{SC}	11.70^{MD}
10. Mean weekly child care	\$25.51^{D}	\$22.71	\$13.44^{M}	\$22.72
11. Mean age	35.64^{SD}	29.20^{MDC}	38.34^{MS}	34.86^{S}
12. Mean spouse's income	\$30,965.25^{SDC}	\$0^{MC}	\$0^{MC}	\$18,108.90^{MSD} [a]
13. Mean self-esteem score	14.52	14.47	14.32	14.23
n	550	147	295	59

Note: Superscripts identify between-group mean differences that are significantly different: $p < 0.05$ based on *t*-tests: Div./Sep. = divorced or separated and Cohab. = cohabitating.

[a] Fifty cohabitating mothers identified a spouse's income. However, the data file does not indicate whether the mothers were referring to a live-in partner as a common-law spouse or an estranged spouse from whom they receive economic support. Including these amounts did not alter the modeling response patterns or levels of significance for predictive variables and were thus retained. $N = 1{,}051$.

based on assigning different values to the possible categories, it is the relative rankings of overall scores for each respondent that are important here.

Methods

A two-part analysis examines the relationship between child-care issues and employment tardiness and absences. First, demographic variables, including the dependent variable, are compared across marital status using *t*-tests (Table 1.1). Next, tardiness and absences are studied across marital status (Table 1.2). During the modeling phase, the dependent variable, *Tardy-Absent*, is regressed on marital status dummy variables (Model 1) as well as marital status and the other demographic controls such as race/ethnicity, number of children, child-care costs, age, education, and self-esteem (Model 2). The final model considers the aforementioned variables and possible marital status and race/ethnicity interactions by including eight 0–1 dummy variables

Table 1.2
Ordered Logit Regression Models for Mothers Employment Problems

	b **(std. error)**		
Variable	**Model 1: Marital Status**	**Model 2: Marital Status & Controls**	**Model 3: Marital Status, Controls, & Interactions**
Marital Status			
Single	.65 (.54)	.88 (.55)†	2.46 (.97)**
Separated/divorced	−.23 (.32)	.91 (.51)†	.91 (.84)
Cohabitating	.39 (.31)	1.07 (.47)*	1.39 (1.01)
Race/Ethnicity and Controls			
African American		−.64 (.43)	−.71 (.58)
Asian	.06 (.51)	.20 (.57)	
Hispanic		−.72 (.46)	−.52 (.60)
Work w/ child ≤ 6 yrs		.22 (.46)	.25 (.48)
Employed part-time	.53 (.36)	.50 (.36)	
# Children ≤ 18 yrs (1–8)	.35 (.18)†	.34 (.18)†	
Years of education (0–17)	−.04 (.06)	−.04 (.06)	
Child-care costs ($0–500 wk)	−.00 (.00)	−.00 (.00)	
Age (21–69 yrs)	−.09 (.03)**	−.09 (.03) **	
Spouse's income ($0–400K yr)		.00 (.00)	.00 (.00)
Self-esteem (0–12)		.05 (.09)	.04 (.09)
Race/Ethnicity Interactions			
AA*Single			−1.60 (1.05)
AA*Sep/Div			60 (.95)
AA*Cohab.			−1.04 (1.27)
Asian*Sep/Div	−.86 (1.10)		
Asian*Cohab.	−1.01 (1.16)		
Hispanic*Single			−2.31 (1.08)*
Hispanic*Sep/Div			−.14 (.98)
Hispanic*Cohab.			−.41 (1.20)
X^2 (Pseudo R^2)	4.25 (0.01)	34.28 (0.08)	47.88 (0.09)
n	871	641	641

Note: $^{***}p < .001$. $^{**}p < .01$. $^{*}p < .05$. $^{\dagger}p < .10$: Log odds provided first; std. error in parentheses. Asian*Single omitted in Mo.

that reflect interactions between African American, Asian, and Hispanic single, separated/divorced, and cohabitating mothers as compared to their white counterparts (Model 3) [the interaction variable representing single Asian mothers is omitted due to small sample counts, $n = 2$]. Because the dependent variable has ordered categorical measures, estimates are obtained using ordered logit models. This approach is

used because more than two outcomes were possible and the method does not assume equal distance between outcome categories. Similar to binary regression models, the ordered logit is nonlinear and the magnitude of change in the outcome probability for a specific change in the independent variables is dependent on the levels of all independent variables.[61]

FINDINGS

Profiles of Employed Mothers: Bivariate Results

Table 1.1 presents demographic summaries of the employed mothers by marital status. First, scores from the *Tardy-Absent* construct are similar (between 0.67 and 1.06) and not statistically different from each other. However, when percentage representations are considered, cohabitating mothers are most apt to note that they are *either* tardy or absent (70.22%) and their experiences differ significantly from those of married, separated, and divorced mothers. Furthermore, regardless of marital status, at least 23 percent of mothers note being tardy *and* absent as a result of child-care-related issues. Differences in marital status are apparent based on race/ethnicity. Asian and white sample mothers are more likely to be married; African American mothers are more apt to be single. Furthermore, single mothers (57.86%) are more likely to be employed with young children, while cohabitating and divorced mothers are less likely (26.19%) to do so; these differences are statistically significant. Demographic diversity is also apparent for indicators such as number of children, years of education, and average age. Furthermore, cohabitating mothers in the sample are the least likely of the four marital groups to be employed part-time (16.26%) and their experiences differ statistically from those of single and married mothers and child-care costs only differ between married and divorced/separated mothers. And regardless of marital status, patterns are similar in terms of self-esteem score. Preliminary results illustrate different profiles and experiences based on marital status; further analyses will explore nuances when variables are examined simultaneously.

Modeling Employment Tardiness and Absences

Review of ordered logit regression findings when marital status is considered alone (Table 1.2, Model 1) do not show significant differences across the groups. Single, divorced, cohabitating, and separated mothers are not more likely than married mothers to experience employment tardiness and absences due to child-care problems. Model 2 examines the possible effects of marital status after other demographic indicators are controlled. And the influence of marital status becomes evident in this test. Findings suggest that mothers without a spouse in residence are generally more apt to report tardiness and absences as compared to married mothers. In addition, the likelihood of such problems increases from mothers who have never been married ($b = 0.88$, $p < .10$), to those who *previously* had partners in residence ($b = 0.91$, $p < .10$), and is greatest for cohabitators ($b = 1.07$, $p < .05$). Although race/ethnicity is

insignificant, age minimizes tardiness and absences. And mothers with more children report more tardiness and absences. Next, Model 3 includes possible differences in the effects of marital status for each racial/ethnic group using eight interaction variables. The model's predictive ability improves ($X^2 = 47.88$) and one of the interaction variables is predictive. These data show that Hispanic single mothers are less likely ($b = -2.31, p < .05$) to report tardiness and absences as compared to white mothers, regardless of the latter group's marital status. As in Model 2, mother's age tends to minimize employment problems and number of children exacerbates such problems. And although most of the remaining interaction variables imply lower incidences of tardiness and absences as compared to the white reference groups, no significant differences are apparent.[62]

DISCUSSION

Hypothesis 1 is supported by these findings and parallel earlier studies because, after considering controls, married mothers are less likely to be tardy or absent than single, cohabitating, separated, or divorced mothers. Contrary to Hypothesis 2, the race/ethnicity variables are not directly significant in these tests. And contrary to existing literature,[63] these results only partially support Hypothesis 3 because the experiences of employed mothers with a young child do not differ from their employed counterparts with older children. However, as the number of children increases, so do instances of tardiness and absences. In addition, part-time employed mothers are no more or less likely to report these situations than their full-time counterparts—Hypothesis 4 is not supported by these findings. Furthermore, child-care costs, spouse's income, number of children, years of education, or self-esteem are not significant in these tests. However, older mothers appear to be able to balance employment and child-care issues more than their younger counterparts (Hypothesis 5). When interactions are compared, mediating effects are only apparent for Hispanic single mothers. Thus these data support Hypothesis 6—but for Hispanic rather than African American single mothers. Lastly, a more detailed review of the results in Table 1.1 help better understand the tendency for nonmarried mothers, especially those who cohabitate, toward more absences and tardiness in the modeling phase. Given the absence and/or relatively lower levels of spouse's income, similar child-care costs, the number of children, and need to work full-time, employment is central to nonmarried sample mothers, yet they are less likely to have certain forms of human capital required to minimize employment tardiness and absences. Although one can only postulate specific reasons for the child-care-related employment issues studied here, economic necessity appears to be a strong motivator in negotiating around such problems and in the inability to do so.

CONCLUSION

Employment, especially for poor, working-class, and single-parent mothers, is crucial to sustain their families. However, the very children they seek to provide for

are often associated with reasons for their constrained and challenging employment experiences. Furthermore, child poverty in the United States is indelibly linked to economic instability for mothers—many of whom are employed, unmarried, and face child-care issues. This research informs existing literature about child-care issues and tardiness and absences for mothers. This topic is important because problems that prevent employed mothers from working undermine their ability to provide for their children. Several findings here parallel previous studies; others require further inquiry. These results suggest that these employment problems were similar for almost 25 percent of sample mothers and slightly more problematic for cohabitating mothers. Controlling for variables such as race/ethnicity, income, and education, diminishes the effects of marital status, yet nonmarried mothers continued to be more apt to face such challenges. In addition, an interaction test only uncovered decreased chances of tardiness and absences for single Hispanic mothers. This is an important result that begs further study of ways in which mothers believed to embrace more traditional gender roles and who have entered the labor force less readily in the past may now have different employment experiences.[64] The profiles of the nonmarried mothers in this sample show that some may have to balance employment and child care to stave off poverty.

Paralleling others studies, findings suggest that mothers without a spouse tend to be at a disadvantage as compared to married mothers.[65] It is important to note that, although race/ethnicity is not directly significant, its affects are indirectly evident through marital status because a disproportionate percentage of African American and Hispanic mothers are unmarried.[66] Child-care challenges persist despite varying incomes. This finding also adds credence to the continued domestic role for mothers, regardless of their marital status, spouse's income, education, and age.[67] In addition, given that the cost of child care is not significant here suggests possible nonfinancial problems such as logistics or inconsistent care may be just as pressing as the need for low-cost child care. It may be the case that other nontraditional forms of human capital (i.e., fluid gender roles, coping strategies, or extended family, according to other studies) associated with marital status and economic needs emerge to minimize employment tardiness and absences. Future studies will be important to examine whether and how such dynamics may enable mothers to be adaptive and resilient such that employment and childrearing are more tenable.

NOTES

* This is a secondary data analysis. For more information, note the following bibliographical citation: Lawrence Bobo, James Johnson, Melvin Oliver, Reynolds Farley, Barry Bluestone, Irene Brown, Sheldon Danziger, Gary Green, Harry Holzer, Maria Krysan, Michael Massagli, and Camille Zubrinsky Charles. Multi-City Study Of Urban Inequality, 1992–1994: [Atlanta, Boston, Detroit, and Los Angeles] [Household Survey Data] [Computer File]. 3rd ICPSR version. Atlanta, GA: Mathematics/Boston, MA: University of Massachusetts, Survey Research Laboratory/Ann Arbor, MI: University of Michigan, Detroit Area Study and Institute for Social Research, Survey Research Center/Los Angeles, CA: University of California, Survey Research Program [producers], 1998. Inter-university Consortium for Political and Social Research [distributor], 2000.

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CHAPTER 2

The Not-so-Tender Trap: Family Violence and Child Poverty

Ruth A. Brandwein

In this chapter we will examine the many links between family violence, including both partner and child abuse, and child poverty. Because most children in poverty live in female-headed families, those families will be our focus. All too often discussions of both poverty and family violence tend to focus on individual "pathology," unhealthy family dynamics and cultural mores that are seen as the targets for change. In this chapter we will focus instead on the sociopolitical, economic, and larger societal forces that impact on poor children and their families.

We begin with an overview of the scope and demographics of family violence and of poverty, with special emphasis on female-headed families and families of color. Although family violence is ubiquitous in all socioeconomic classes, we will consider the particular ways in which it manifests in poor families. The term "family violence" includes violence among any family members including spouses, other intimate partners and children. (This term may even include related elders, but this group will not be a focus of this chapter.) Domestic violence, a form of family violence, refers to intimate partner abuse.

Specifically, we will consider the role that welfare plays in the lives of poor children and their abused mothers. We will address such issues as why abused women stay or leave and what effects these difficult choices have on their children. Following this discussion of how partner abuse affects children, we will present the dynamics of how child abuse is also linked to child poverty. Again, a Hobson's choice will be presented: removing the abuser from the home, leaving the home and risking homelessness, or risking the loss of one's child to foster care. Both short- and long-term consequences of these choices will be explored. The chapter will conclude with an exploration of policy alternatives that could make a difference in the lives of these families. The broader themes of patriarchy, racism, and classism will infuse the entire chapter but will be directly addressed in the conclusion.

INTIMATE PARTNER VIOLENCE

Intimate partner violence, a subset of family violence, is a problem for all women. It transcends race, ethnicity, and socioeconomic status. It is estimated that between 2 and 4 million women in the United States are battered each year by husbands, partners, or boyfriends.[1–3] In their lifetimes, one out of every four women will have experienced abuse at least once during her lifetime.[4]

Perhaps we need to digress here to define what interpersonal, or domestic violence includes. We most readily think of physical violence: pushing, slapping, hitting, punching, choking, or attacking with a weapon. These are criminal acts and are most likely to be included in official police and U.S. Department of Justice statistics. Other types of abuse can be as damaging, though less evident. Sexual abuse often accompanies other types of abuse, but until recently, forced sexual activity by a spouse was not considered to be rape in most states.[5]

A third, most ubiquitous form of abuse, yet least likely to be documented, is psychological or emotional abuse. Most commonly this precedes physical abuse, but even if it does not escalate to physical violence, it takes a heavy toll. It includes isolating, demeaning, threatening, intimidating, terrorizing, and other forms of harassing the victim. It often results in her losing her sense of self, autonomy, and human dignity. Isolation, a very common strategy employed by abusers, may leave the woman bereft of friends or family to whom to turn, making her completely dependent on him.

How does domestic violence get played out? The abuser (in 85 percent of incidents men are the abusers, so we will employ the male pronoun throughout this chapter[6]) is often jealous, so he prevents her from working or going to school where she might meet other men. He may also do this in order to isolate her so she has no one but him for emotional or economic support. He does not want her to get an education or have an income that might make her more independent. Raphael documents cases of men beating their wives before a job interview so they were ashamed to be seen with bruises; harassing them the night before an important test, so they would fail; even hiding their car keys or destroying their coat so they would be unable to leave the house.[7,8] There are exceptions, of course. In some situations male partners instead push the women to work, but they still maintain control of the finances.[9,10]

Women who are prevented by their abusers from gaining work experience or pursuing education or training opportunities are doomed to poverty. Numerous studies have documented the relationship between income and education levels. Every year of post high school education can increase women's earnings by 4–12 percent, and earning a 2-year associates degree can mean earning 19–23 percent more than those with a high school degree. One study found 65 percent higher earnings for those with a college degree. The difference in earnings is most pronounced for women of color.[11–16]

PARTNER VIOLENCE AND CHILDREN

Intimate partner abuse has secondary victims. These are the children. Children are not present in all cases of such violence, but when there are children in the family,

they are likely to suffer as well. In about half of all domestic violence situations, the children are also being physically abused.[17–21] In many cases the abuser will beat the children and when the mother intervenes, he beats her too—or the reverse—when the mother is being beaten the children may try to intervene and also endure his blows.

Even if the children are not physically assaulted, they may experience emotional abuse by witnessing the abuse.[22] Witnessing does not mean necessarily being physically present at the time of the abuse. Children pick up cues—from seeing their mother's black eye, to just feeling the unremitting tension in the home.

When advocates first began to explore the impact of domestic abuse on children, they hoped that such findings would result in further protection of women and their children. However, such findings are now sometimes used to remove the children from the home so they will not experience the effects of the mother's abuse, rather than protecting the mother and her children from the abuse. Because of the increasing awareness that children who are in a home where domestic abuse has occurred may be negatively affected, Child Protective Services (CPS) may be brought in to determine whether the children are at risk. The mission of CPS is to protect children. Because of societal acceptance of traditionally gendered sex roles, the mother is seen as the parent who has responsibility to protect the children. If the mother does not—or cannot—remove the abuser from the household, CPS may determine that the mother is guilty of "failure to protect," may remove her children and place them in foster care. Thus, a woman victim of partner violence who does not have the power to get rid of the abuser may be doubly victimized—first by her intimate partner and then by the system.

POOR FAMILIES AND VIOLENCE

Although all women are potential victims of abuse, there are additional issues for women who are poor. According to some studies, violence among poor families is more frequent and more violent.[23–24] It has been hypothesized that economic stress, and among poor families of color also the stress of racism, may exacerbate the violence. One study of homeless or poorly housed mothers found that over 60 percent had experienced severe abuse by their partner.[25] While poverty may be a factor in causing violence, domestic violence victims who leave their spouses may also become poor. Separation and divorce often lead to women's loss of income. As the activist lawyer Flo Kennedy once said, somewhat hyperbolically, "Every woman is one man away from welfare." And once a woman goes on welfare, her family is guaranteed to be poor. In no state does the welfare grant even come close to the federal poverty level (currently $19,350 for a family of four, $16,090 for a family of three[26]). In 2001, the average monthly welfare grant was $351 with another $228 in Food Stamps, for a combined annual income of just under $7,000.[27]

In 2004, the latest year for which statistics are available, nearly 13 percent of all families lived in poverty but almost 18 percent of all children under 18 and 20 percent of those under 6 lived in poverty. These figures are higher than any year since 1998. For female-headed families in 2000, the figure is almost triple—35.9 percent. For black and Hispanic women the 2004 figure is even more alarming: 43.4 percent and 45.9 percent, respectively.[28] Although the actual figures for all categories decreased

from the mid-1990s and then began to increase after 2000, the relative difference for female-headed families and female-headed families of color remained consistently higher in approximately the same ratios. Although figures are not available for poor children by family head, almost 42 percent of all poor children under 18 lived in families below half the poverty line. This is exacerbated for African American children, of whom over 49 percent live in such families.[29]

For all full-time, full-year workers, women's annual median earnings in 2004 were $31,223 in comparison to $40,798 for men. Women's wages actually fell by one percent between 2003 and 2004.[30] For those earning minimum wage—$5.15 per hour— and fortunate enough to have a full-time, full-year job, they can expect to earn only $10,712 annually.

Poor women do not have the same resources to deal with the violence as other women. They may leave the abuser temporarily to stay with family or friends, but more likely these people are also poor and may not have the room to house them for any length of time. With child care ranging in cost from a minimum of $4,000 annually, and with decreased federal funding for subsidized child care, they are less likely to be able to afford care for their children if they try to work. This is exacerbated if they have more than one child. They may be forced to leave the children unsupervised or with informal care, which may be unsafe or be of low quality. In 1996, when the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) was passed, requiring women on welfare to be involved in work activities, the Congressional Budget Office estimated if states all met their work requirement targets the funding it provided for child care would fall $1.4 billion short of need.[31]

The question is often asked about abused women, "Why does she stay?" Poor women are less likely to afford to stay in a motel or hotel, to buy an airplane ticket or to have access to credit. In an overwhelming number of situations they do not even own a vehicle or have a driver's license, so they have fewer means to escape a violent situation—or even to get to work or to the supermarket. They may end up in a homeless shelter, or if they are lucky, a domestic violence shelter. But these are only temporary solutions. There are time limits, after which they are required to leave the shelter. The federal McKinney Act provides funding only for temporary housing for the homeless, not for permanent housing. The lack of affordable permanent housing is a national concern, finally gaining some visibility. Many women with children cannot afford housing—they do not have the first and last month's rent and security deposit often required. The average rental for a two-bedroom home varies in this country from about $700 to over $1500/month. What housing that may be available is often in neighborhoods with poor schools and high crime. The National Low Income Housing Coalition has reported that the hourly wage, nationally, needed to rent a 2-bedroom unit is $15.78.[32] This is clearly a problem for poor women, but even those who were formerly middle class are likely to experience these problems with housing.

In many jurisdictions judges are reluctant to remove the violent offender, especially if he owns his home. The woman may be afraid that if he is forced to leave, he will stop providing support. She may also fear that by pursuing an order of support, the

violence will escalate.[33–34] Even when the court orders child support, only about 50 percent of orders are complied with either fully or partially. Although the abused mother may have an Order of Protection for herself, her abusive partner, if he is the father, is likely to be allowed child visitation by the court. After all, it is said, he is the child's father and if there is abuse only against her and not the children, most judges are loath to deprive fathers of their children. These visits may be fraught with danger for the mother, unless some kind of supervised visitation is ordered.

The cost of housing, the lack of transportation, other economic pressures already discussed and fear are often the reasons the abused mother may stay. She may also choose to bear his abuse rather than subject her children to leaving their home, their school and their friends. Moreover, evidence is mounting that women may be in the most danger when they leave their abusers. Because abuse is about power and control, her leaving is a direct threat to his power over her. Divorced and separated women are 14 times more likely to be abused as women who remain with their partners, according to statistics from the U.S. Department of Justice.[35] Stalking and murder are more likely to occur soon after the woman leaves. For some women, it is prudent for them to stay. In fact, the women this author and others have interviewed have reported that it was only when they believed their children were in danger or were being emotionally harmed by the abuse, that they finally gained the courage to leave.[36–37]

CHILD POVERTY AND WELFARE

If the abused mother leaves and she does not have other financial means, she can apply for public assistance. Even some women who were not poor prior to leaving, and who had an education, may decide that their children need them at home. In a focus group this author conducted one woman reported, when I asked her about getting a job, "My children don't have a father now, they need a mother."[38]

Public assistance for poor mothers began in the early twentieth century with some states providing a Widow's Pension. During the New Deal, Aid to Dependent Children (which later became Aid to Families with Dependent Children—AFDC) was incorporated in the Social Security Act of 1935. Its purpose was to enable single mothers to care for their children at home rather than having to send them to an orphanage because they could not support them.

In 1996 AFDC was abolished and replaced by Temporary Assistance to Needy Families (TANF). TANF, part of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), limits lifetime assistance to a total of 60 months (5 years) and requires recipients to be in some kind of work activity. This can be community service, workfare or paid jobs for a total of 30 hours per week, or 20 hours if the youngest child is under 6 years of age. TANF requires mothers with children older than 3 months (with state option of 1 month) to be engaged in these programs or face partial or full sanctions (partial sanction removes the mother from the grant; full sanction removes the entire family).[39]

In the original Act, higher education or training was explicitly excluded as a work activity. Now it is allowed by statute for no more than one year, however that is at the

discretion of the local welfare office to approve and most, like New York State, have a "Work First" emphasis. That means the mother can go to school to improve her financial potential, but only after putting in her 20–30 hours in some dead-end job or make-work activity, and with no subsidized child care for those educational activities.

Numerous studies have shown the correlation between increased level of education, higher income, and lower use of welfare.[40] Between 1995 and 1997, 41 percent of welfare recipients lacked a high school diploma, in contrast, to 29 percent of those who left welfare during that period.[41] Women who had some post-high school education were 41 percent less likely to return to welfare than women who did not finish high school.[42] A national longitudinal study of high school graduates, tracked over 14 years, found that each year of college increased earnings by 4–9 percent.[43] Gruber[44] found that in 1995 the gap in earnings between women with high school and college degrees was 68 percent. It is no surprise then, that women with less education are less likely to leave welfare and more likely to return. In Maine, the innovative Parents as Scholars program found that welfare mothers who were allowed to pursue a college education earned an average of almost $12 an hour after completion.[45]

States also have the option of imposing a "family cap," which means that no additional grant is given for any child born after the woman is receiving TANF. So even if she has been forced to have sex by an abusive spouse, gets pregnant and does not have an abortion (which is exceedingly difficult to obtain in some states and is not covered by federal Medicaid), there will be no additional funds provided to support this additional child.

A poor mother who needs financial assistance may be placed in a double, or even triple jeopardy.[46] TANF requires that she be involved in a work activity. If she cannot find accessible, affordable child care she has the "choice" of not working, in which case she will lose all or part of her family's grant. If she does work and the children are not properly cared for, Child Protective Services may find her to have neglected her children. This situation is exacerbated if the father has been abusive. If she succeeds in getting him to leave the home, she may need TANF for financial support. However, if she is working she is unable to supervise her children and she may be found guilty of "failure to protect." Brandwein[47] describes an actual case of a Utah mother who required her husband to leave because he was sexually abusing their children and subsequently lost custody of them.

Even when women on welfare are working, their grant is inadequate for them to afford decent housing. In no state is the TANF grant even equal to the federal poverty level, which is only about $16,000 for a family of three (the average size of families on TANF is 2.6.) The average monthly grant in 2001 was $351/month.[48] Women who leave TANF earn an average of just over $7.00 per hour. Working full time, full year (which is often not the case because of personal problems, illness or employer instability) the annual earnings would only be about $14,000. Because of cuts in the federal budget, they are unlikely to receive subsidized child care after leaving TANF. The cost of housing, child care, utilities, and transportation create overwhelming economic pressures on these poor mothers and their children.

Another program under TANF in which states can choose to participate is the Domestic Violence Option. A state choosing this option must attempt to identify any

applicants and recipients who have been victims of domestic violence. A number of studies have found that between 40 and 65 percent of women on welfare had experienced family violence some time in their lives—they were either abused as children, in an intimate relationship, or both. Fully 20 percent were currently experiencing abuse.[49]

POLICY ALTERNATIVES

The Violence Against Women Act (VAWA), first passed in 1994 and reauthorized in 1995 has provided greatly needed programs and policies to benefit victims of violence. Unfortunately, although this 1995 VAWA legislation authorized new programs for court training, grants for underserved populations, a focus on mitigating the effects of domestic violence on children, interdisciplinary training, and education for health professionals, the President's budget did not request funding for any of these new programs and most of the existing programs were slightly cut.[50]

The 2006 federal Budget Reconciliation Act will have even more severe consequences and will greatly exacerbate the poverty of poor children and their families. Earlier, we discussed the dilemma faced by abused mothers who face the choice of moving to housing they can afford, often in communities with poor educational facilities for their children. As of this writing, funding for the education of the disadvantaged was reduced by 3.5 percent for 2006, a total of $520 million and special education programs serving children with disabilities and other special needs was cut by $164 million (1.4 percent.)[51] Children who have suffered abuse directly or have lived in abusive homes are more likely to have special needs. Programs for vocational education, adult education and English literacy were cut by $45 million, or 2.2 percent. What this means is that even if local TANF officials were to allow welfare recipients to pursue education instead of a work activity, the resources for such programs are less likely to be available.

This budget reconciliation package provides funding for the Child Care and Development Block Grant (CCDBG) in addition to child-care funding provided in TANF legislation for mandated work programs. The CCDBG provides child-care funding for low- and moderate-income working families. Women who have left welfare, are in danger of going on or returning to welfare, or simply earn what the average woman in America earns, are eligible for this funding. A victim of violence or a mother whose child has been abused, and who leaves the abuser could obtain funding for child care so she could try to support her family. However, in the 2006 budget, this funding, in addition to failing to address inflation-driven cost, increases has been cut by an additional 1 percent. This results in a cut of 3 percent or $65 million. The Center for Budget and Policy Priorities has estimated that under-funding of child care will mean that by 2010, "*. . . 255,000 fewer children in low-income working families not on TANF will receive child care assistance than received such assistance in 2004*" [italics in original].[52]

We discussed earlier the need for more affordable housing, but the 2006 budget moves in the opposite direction. Section 8 Housing vouchers, which is the main rental assistance program for low-income families was also cut by 1 percent. This will

result either in 65,000 fewer such households obtaining rental assistance in 2006, or each recipient will receive a smaller grant for assistance.[53]

Medicaid is the major federal health insurance program for the poor. The Congressional conference agreement on the 2006 budget made major changes in this program, reducing benefits and increasing co-payments and premiums. Under existing legislation, $3 was the maximum charge for co-payments to Medicaid recipients. This new budget agreement could mean charges of $20–$100, at states' option. A poor mother will now have to choose to delay or avoid obtaining needed health care for herself or her children—or face the possibility of going without food, not paying her utilities or losing her housing. Abused women and their children have both short and long term physical as well as mental health needs that will be even less likely to be addressed when this punitive Medicaid program is fully implemented by the states.

These cuts could have easily been avoided had Congress decided to drop two tax cuts that did not take effect until January 2006. Virtually all these tax cuts (97 %) go to households with incomes over $200,000, with over 53 percent going to households with incomes exceeding $1 million.[54] So, if we are to discuss policy alternatives for poor families with children who have been victims of abuse, the overarching recommendation is that our domestic priorities need a 180-degree about-face. Instead of reducing taxes for millionaires, these funds should be redirected for better schools, health care, child care, housing, and other services to prevent and address the effects of family violence.

Short Term

In the short term, we need to advocate for full funding of the VAWA Reauthorization of 1995, the reversal of new tax cuts for the very wealthy and restoration of the budget cuts in the 2006 federal budget. The VAWA legislation contains provisions for providing unemployment insurance for abused women who lose their jobs because of time taken off for court appointments, health problems or other violence-related difficulties.

Some specific programs have been proposed and implemented at the local level and should be expanded nationally. In Suffolk County, New York, the Victims Information Bureau has developed a successful cross-training program for domestic violence and child protective service workers. They learn to recognize and appreciate the problems the other group faces, and domestic violence workers accompany CPS workers on home visits where partner abuse is also suspected.[55] In Maine, the Parents as Scholars program has used state "maintenance-of effort" funds to provide welfare grants to women so they can finish their 2- or 4-year-college program without running afoul of TANF legislation.[56] Rather than expanding this nationally, new federal legislation is threatening stats' ability to use such funding creatively. TANF should be amended, instead, to define post-high school education as a viable work activity to meet the work requirements. TANF programs should provide professionally trained case managers to individualize programs for TANF recipients and to provide guidance and support for them as they negotiate their way to financial self-sufficiency within the 5-year deadline. Early identification of children with emotional difficulties in preschool and

primary grades, followed by early professional intervention could go a long way to prevent the long term emotional scarring of children suffering from family violence.

Long Term

As important as these programmatic efforts are to alleviate some of the problems faced by poor children and their families, especially those touched by violence, other more comprehensive change is needed. The United States is the only major industrialized nation that does not provide universal health care and child care as a right. We are also the only such nation not providing paid family leave for a newborn, an adoptee or a seriously ill family member. All of these government programs would improve the lives of the families we have been discussing. Economic changes should include indexing the minimum wage to the cost-of-living, similar to those annual cost of living adjustments (COLA) to Social Security recipients. A number of municipalities have recently passed "living wage" legislation, although these are usually limited to municipal employees or contractors. This requires paying wages above minimum wage. A living wag is based on estimates of the minimum a family needs to live on. For single-parent families, this legislation, if universalized for all wage earners, could make the difference between choosing to either stay with or return to an abusive partner, or to be forced to go on welfare or a homeless shelter.

Education in our nation is the ladder to economic mobility. We need to assure educational equity for children, no matter where they live. This means decoupling education budgets from property taxes and local bond issues. This current method of regressive taxation assures that children in wealthier, usually white, communities get an educational advantage over poorer white and children of color. Our continued racial segregation in housing patterns reinforces these inequalities. Moreover, in the twenty-first century, when advanced skills are a necessity, all young people capable of benefiting from college or other advanced training should be guaranteed such an education. Higher education, like health care, should be a right, not a benefit based on ability to pay.

CONCLUSIONS

What such long-term changes imply is a basic redistribution of income addressing the built-in inequalities now experienced by women, all people of color and the poor. We must finally address the inequities in our society caused by patriarchy, racism and classism. These isms are intertwined. *Why* do women still earn less than men? *Why* do African American and Hispanic women still earn the least? To explain it by education and preparation is to beg the question. *Why* do African Americans and Hispanics, and the poor have inferior educations?

Referring back to our discussion of CPS and the courts, the question must be asked, *why* do mothers get punished for the abuse of their partners? *Why* do judges continue to ask, "Why do the women stay?" instead of asking, "Why do the men abuse?" *Why* are funds cut for health care, housing, education, and child care and *why* do we keep cutting taxes for those who already have so much?

Why has the proportion of white families on welfare (TANF) declined and the proportion of African American and Hispanic women increased? (From 1992 to2001 white enrollment dropped from 39 to 30 percent while African American enrollment rose from 37 to 39 percent and Hispanics from 18 to 26 percent.[57] *Why* are women on welfare, increasingly women of color, not allowed to get an education? Certainly there is no rational answer, as it is clear that if they got that education they would not only be less likely to remain on welfare, but they would also be contributing to the tax base. Could it be because our economic system benefits by maintaining a marginal, secondary labor force to keep wages low by assuring a source of cheap labor? Could it be that *we* don't want *them* competing with us for the shrinking number of well-paid jobs? Could it be that in a racist, sexist society we need to marginalize and exploit poor, abused women of color so that *we* can feel superior to someone?

We need to work for the short-term changes that can ameliorate the situation of children living lives of poverty and abuse. The long-term changes, however, cannot come about until we begin to ask the larger, more difficult questions. We must begin to make those connections between the concrete issues of child poverty and the larger constructs of racism, classism, and patriarchy, in order to move toward those changes.

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CHAPTER 3

DIVERSITY IN LIVING ARRANGEMENTS AND CHILDREN'S ECONOMIC WELL-BEING IN SINGLE-MOTHER HOUSEHOLDS*

Pamela R. Davidson

The sweeping reforms introduced to the federal welfare system in 1996 bolstered public scrutiny of single-mother households. The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) was signed into law with the explicit purpose of reducing the dependence of single-parent households on public assistance and decreasing the incidence of single-parent households. These goals have led to a plethora in educational programs to reduce unwanted pregnancies, changes in welfare policies to reduce the "marriage penalty," and similar changes in the tax code. Despite these efforts, both the number and percent of children living with single mothers is on the rise (Figure 3.1)

Supporting the goals of the PRWORA has been a wealth of research on single-mother households that demonstrates their lower economic status and their negative impact on children.[1] In a nutshell, this research makes the case that children growing up in single-mother households suffer academically in school, engage in premarital sex earlier, have an increased risk of early childbearing, and suffer higher levels of depression and aggression. This research supports the policy goal of integrating single mothers into the workforce since economic standing is viewed as a correlate of poorer outcomes in children raised by single mothers. In contrast, scholarship critical of the current policy emphasis points to the difficulties that single mothers face in finding stable jobs that allow them to earn enough to provide for their families.[2] Relatedly, the need to work extended hours makes it increasingly difficult for single mothers to simultaneously provide their children with a warm and nurturing environment so essential for child development and to provide quality supervision for adolescent children.[3]

Underlying research on single-parent households and policies designed to reduce them is the notion that all single-mother households are alike.[4] In contrast to this, I

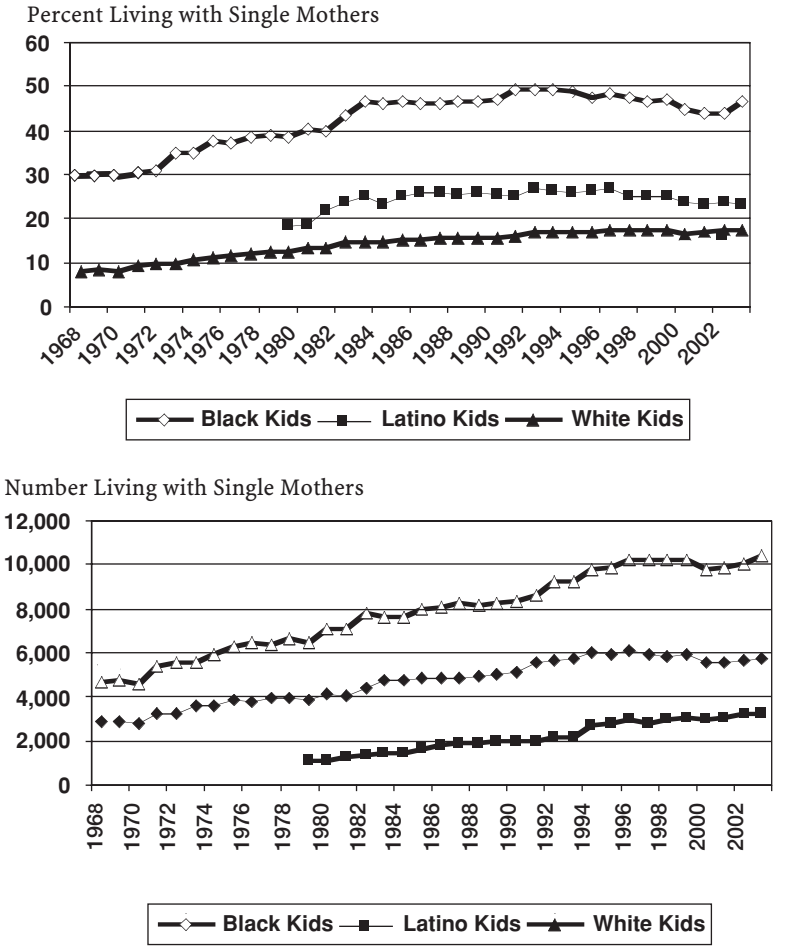

Figure 3.1
Trends in Children's Living Arrangements, by Race/Ethnicity, 1968–2004. *Source:* U.S. Census Bureau, Annual Social and Economic Supplement: 2003 Current Population Survey, Current Population Reports, Series P20-553, "America's Families and Living Arrangements: 2003" and earlier.

focus on the heterogeneity of children's living arrangements in single-mother households. Most studies do not consider that the category of single mother can have different meanings in different households.[5] In some households, single mothers live with boyfriends; in others with their own parents; and in still others they live with both their minor-aged and adult-aged children. This heterogeneity is not captured under the rubric of "single mother." In this chapter, I consider the impact that children's living arrangements have on their economic well-being and vulnerability.

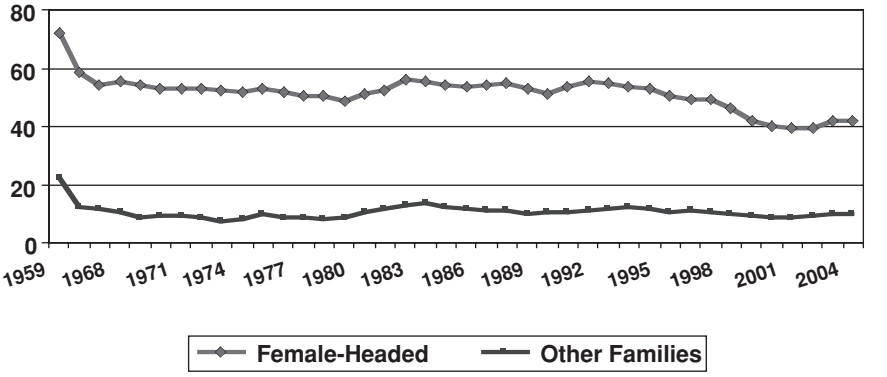

Figure 3.2
Poverty Rates of Related Children in Female-Headed, Other Households, 1959–2004. ***Source:*** **Congressional Research Service, based on U.S. Bureau of the Census data. Current Population Reports, Series P-60 and CRS tabulations.**

In considering children's economic well-being, supporters of current policies point to poverty rates for both children and single mothers that have declined notably over the past decade since the start of welfare reform in 1996 (Figure 3.2). In their view, this is a positive trend and has only been possible because of the long-term incorporation of single mothers into the labor market. The argument made is that, while initially difficult, single mothers have been able to work their way up into better jobs thereby qualifying many for unemployment benefits in times of economic downturn.[6] With childhood poverty rates currently on the rise, this argument may now be put to the test. As many researchers have been quick to point out, however, the poverty rate may not have ever been an adequate measure of economic well-being.[7] The official poverty measure sets the threshold to poverty too low by failing to consider expenses that constitute a large part of every family's budgets including the cost of housing and work-related expenses such as child care and work clothes.[8] While there has been growing criticism of the official poverty measure, there is also agreement that no one measure can capture the multidimensionality of economic well-being.[9] Using different measures in addition to the official poverty rate, I hope to identify groups of children most vulnerable to shifts in social policy and most in need of attention.

DATA AND METHODOLOGY

The data for this study come from the March Supplement of the Current Population Survey (CPS) for 2001. The 2001 CPS includes a nationally representative sample of 128,729 persons (excluding persons living in group quarters) and 49,596 households. An important advantage in using the CPS data is that its large sample size allows for a more detailed classification of household structures than smaller

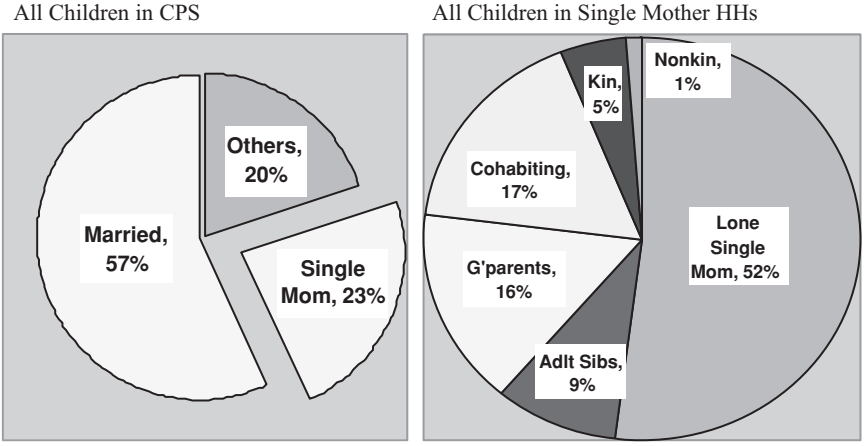

Figure 3.3
Types of Households in Which Children Live. ***Source:*** **2001 CPS March Supplement, author's own calculations.**

surveys. In addition, the CPS provides detailed information on income sources. The unit of analysis is the child. Children selected into the analysis include those living in single-mother households or in married parent households in which no additional adult besides the married parents live.[10] A mother is considered single if she is unmarried or married, but with no spouse present. While the CPS distinguishes between primary families and (related and unrelated) subfamilies, in this study, the presence of a single mother anywhere in the household constitutes a single-mother household. This operationalization deviates from that used to report official poverty statistics, but is more in line with the object of this study.

The dependent variables in this study measure children's economic well-being and include: mother is 125 percent above the poverty line, the household is 125 percent above the poverty line, and disposable household income covers basic household expenses. Further description of these variables is provided below. The central independent variable is household structure. The CPS consists of 34,664 children in 18,138 households. Most of these children (57.3%) live in married couple households in which no other adults are present (Figure 3.3).[11] Close to one-fourth live in single-mother households. The residual group of other children includes those living in extended married parent households, single-father households, or no-parent (e.g., grandparent-headed) households.

Households identified as single-mother households are further categorized by the type of living arrangements and fall into six categories: lone single mother, adult sibling, grandparent, kin, nonkin, and cohabiting households. Over half (52%) of children in single-mother households live with lone single mothers, that is in households in which no other adults are present besides the single mother.[12] Another 16 percent live in households where a single mother lives with her underage children

and at least one of their grandparents. These multigenerational households can either be headed by the children's parents or their grandparents. Kin households consist of at least one adult who is related to the single mother and are home to approximately 5 percent of children in single-mother households. In most cases (ca. 62%), the single mother is the head of household and the adult relative is usually the mother's sibling (in 55% of the cases). Approximately 9 percent of children in single-mother households coreside with their adult siblings. Similar to kin households, adult sibling households can contain other adults besides single mothers, but at least one must be the adult child of a single mother. Only less than 2 percent of all children in single-mother households reside in nonkin households, that is in households in which all adults in the households are not related to the single mother (and are not her cohabiting boyfriend). In most cases (69%), the single mother is the head of household. The CPS contains 722 cohabiting single-mother households in which close to 17 percent of all children in single-mother households live. Because of the difficulties in using the CPS to classify cohabiting households, special steps were taken to operationalize this category.[13] Cohabiting single mothers include single mothers who indicated that they are cohabiting based on a CPS variable introduced in 1995. Because this variable is associated with a known downward bias, I additionally classified single mothers as cohabiting if they live in households with unrelated, unmarried men over the age of 15 who meet certain established age criteria to qualify them to be male partners.[14] In the event of an overlap with other household structure categories, households designated as cohabiting are retained as such and excluded from other categories.

RESULTS

Studies that rely on simple comparisons between children in single mother and married parent households overlook the internal diversity that exists on a number of levels. A demographic profile of the sample children included in this study is given in Table 3.1. Since the focus of this study is on children's economic well-being, all results are presented using children in households as the unit of analysis. Most children (73%) in married parent households are white compared to children in single-mother households.[15] Within the population of children in single-mother households, there is great variability but with a notable pattern. Children in households with nonrelatives (nonkin and cohabiting boyfriend households) are more likely to be white than nonwhite. The reverse is true for the remaining categories in which relatives "double up." Particularly notable, Latino children are much more strongly represented in extended households with kin. Close to half (40.4%) of all children in kin single-mother households are Latino.

Not all children in single-mother households are being raised by single mothers. This is mostly true in extended single-mother households, but is also true in married parent households in which less than 1 percent (0.6%) is not related to either parent. In multigenerational households, over 3 percent (3.2%) of children have no parents in the home. In a nontrivial number of kin households, at least three complete

Table 3.1
Characteristics of Children in Single-Mother and Married-Parent Households

	Households with Children Under 18 Who Are Not HH Heads						
	No Other Adult but		Extended Households: Single Mothers and. . .				
Characteristics of Children	**Married Parents**	**Lone Mother**	**Grand parents**	**Other Kin**	**Nonkin**	**Cohabiting Boyfriend**	**Adult Sibs**
Race/ethnicity							
White (non-Hispanic)	73.0	44.8	35.9	16.4	63.8	52.8	39.4
African American	8.0	37.9	32.7	34.4	10.2	21.0	30.2
Hispanic	13.6	13.6	26.8	40.4	20.5	21.7	26.5
Other	3.68	3.7	4.6	8.8	5.5	4.5	3.9
Child's status in HH							
Has foster parent	0.2	0.8	0.2	0.0	0.0	0.2	1.2
Has no parents	0.6	0.9	3.2	7.7	4.4	1.8	4.5
Household composition							
Mean number of children	2.4	2.4	2.6	3.3	2.4	2.4	2.2
Number of persons in HH	4.4	3.4	5.7	6.3	4.6	4.7	4.6
Has employed male	96.5	0.0	45.4	66.5	27.1	93.9	47.2
Number of parent units[a]							
One	100.0	100.0	94.7	51.0	76.8	80.1	91.0
Two	0.0	0.0	5.3	41.1	23.2	19.6	7.7
Three	0.0	0.0	0.0	7.9	0.0	0.4	1.3
Characteristics of mother[b]							
Never-married mother	0.0	39.2	64.9	57.1	37.4	44.8	19.5
Has HS Diploma	81.3	89.1	70.4	65.5	85.2	77.1	70.6
In fair or poor health	5.2	14.9	13.0	6.3	10.4	9.8	16.4
Mean age	36.2	34.8	27.9	30.3	33.1	31.3	43.2
Housing characteristics							
% Homeowner property	77.5	33.6	63.5	49.2	37.6	37.6	48.9
% Rental property	20.9	64.8	36.0	47.2	60.9	61.2	50.4
% No-cash rental	1.6	1.6	0.5	3.7	1.5	1.2	0.7
Unweighted sample size	19,743	4,186	1,267	413	113	1,380	691

[a] Married parents count as one unit, as does a single parent. A cohabiting couple each with their own child counts as two family units as does a grandmother with underage child and her parenting daughter.
[b] In cases in which the minor-aged child has no mother in the household, the value of the adult next of kin is used.

families live under one roof: Close to 8 percent live in households in which there are three sets of parenting units (7.9%) and the same proportion have no parents at all (7.7%).

Various other household composition characteristics set single-mother households apart from each other and from married parent households. Children in cohabiting

households (94%) come closest to children in married parent households (97%) in terms of the likelihood of there being an employed male in the household. Most children with lone single mothers (61%) do not have never-married mothers. Instead, children in multigenerational and kin households are much more likely to have never-married mothers as young mothers are more likely to continue residing in their parents' homes or turn to relatives, in particular siblings, in times of need.[16] Consistent with previous research, children in married couple households have mothers who are in better health than their counterparts in single-mother households. One-sixth of children who live alone with their single mothers or only with their mothers and adult siblings have mothers who are in fair or poor health. Partly contradicting research emphasizing married mothers' higher levels of education, children living alone with their mothers or with other nonkin are only slightly less likely to have mothers with high school diplomas than children with married parents. Marital status is, however, a more foreseeable indicator of living conditions. Over three-fourths (78%) of children of married parents live in homes owned by their parents. Even children in multigenerational households do not have higher homeownership rates. Particularly notable, only over one-third (38%) of children in cohabiting households live in homes owned by one of the tenants.

Descriptive Results for Children's Economic Well-Being

A comparison of various measures of economic well-being by household structure is presented in Tables 2a and 2b. Tables 3a and 3b present the results for a subset of these measures broken out by race and ethnicity. The results indicate that children's economic well-being varies significantly by the type of household in which they reside. As seen in Table 3.2a, children living with lone single mothers and in cohabiting households are most likely to have low-income mothers (both 52%) closely followed by children in nonkin households (45%). A mother is classified as low-income if her family income falls at or below 125 percent of the official poverty line based on the size of her family. Because the official definition of poverty excludes the income from nonfamily members (including boyfriends), the rates for low-income status may be artificially high for households in which there are household members unrelated to the single mother. Nevertheless, the family-based measure of poverty is the official measure that is most widely used to report economic well-being.

By adding in the contributions of nonrelatives and using income threshold values based on household composition instead of that for family, there is a shift in the character of children's economic well-being.[17] In cohabiting households, notably fewer children live in low-income households than with a low-income mother (17% versus 52%). This is best explained by the fact that almost all cohabiting households have an employed male (see Table 3.1). Low-income rates decrease for children in nonkin households (25% versus 45%), in kin households (28% versus 34%), and actually in every other household type considered. These differences emerge because the family definition of income ignores the incomes of unrelated adults, but also of children who may be coresiding, such as foster children and other unrelated children

Table 3.2a
Children's Economic Well-Being, by Living Arrangement, Weighted Average, Percent Experiencing Hardship Using Three Different Measures

Child's Living Arrangement	Sample Size	% With Income Mother [a,b]	% in Low-Income Households [a,c]	% HHs: Expenses Exceed Income [d,e]
Married parents, no other adults	19,743	11.9	9.3	10.1%
Lone single mother	4,186	51.8	52.8	47.7
Mother and				
Grandparents	1,267	30.9	22.7	26.9
Other kin	413	34.1	27.6	35.6
Nonkin	113	44.9	24.8	32.4
Boyfriend	1,380	51.8	17.3	28.8
Grown sibs	691	37.4	32.4	35.7

[a] Low-income refers to 125% below the poverty level.
[b] In cases in which the minor-aged child has no mother in the household, the value of the adult next of kin is used.
[c] Based on the official poverty measure applied at the household level (using the incomes of all household members).
[d] Expenses include projected costs of rent (using the fair market value formula), food (using the low budget method), transportation, and child care. Estimates take into account differences in family size and region of the country.
[e] Disposable income includes income from all cash sources plus the value of EITC, capital gains (or losses), and the family market value of food stamps, school lunch, and housing subsidy minus taxes.

who may have independent sources of income. By considering the incomes of all household members, the gulf between children with lone single mothers and those in extended single-mother households widens. Over half of children living with lone single mothers are low-income compared to about one-fourth for children in extended family living arrangements. Extended family living arrangements clearly improve the economic standing of single-mother households.

The official measure of poverty has come under fire in recent times, with one reason being that the thresholds are antiquated. Low-budget food baskets that vary by family size are used as the basis for drawing poverty thresholds despite the fact that food consumes a much smaller portion of the family budget today than 40 years ago when the poverty measure was first created. Those critical of the measure argue that the budgets used to determine poverty thresholds should take into account budget items that are more relevant to families today, including housing, transportation, and work-related expenses such as child care.[18] To address this issue, I created a measure of economic well-being that relies on the EPI Guide to Family Budgets and relies on two pieces of information: household income and household expenses.[19]

First, I estimated income. Due to the weaknesses of a family-based measure, I sum income at the household level, using the same income definition used to

measure poverty. This income definition is a measure of gross cash income and ignores a number of income sources that do not take the form of cash. To address this weakness, I utilize a household level measure based on net income (e.g., I subtract out Federal Insurance and Contribution Act or FICA, state and federal taxes) that adds in the value of Earned Income Tax Credit (EITC), capital gains (or losses), the family market value of food stamps and school lunch, and housing subsidies. Second, I impute household expenses for four expenditure categories drawing on officially published estimates that take family size and region of the country into account.[20] For housing, I impute the fair market value of rent for a household of a given size by state and metropolitan statistical area (MSA).[21] For food, I rely on estimates using the low budget method.[22] Transportation cost estimates take into account not only the region of the country, but also residence within or outside metropolitan areas and the number of (potential) drivers.[23] For child-care costs, I rely on state-level estimates broken out by region (urban/nonurban), averaging the cost of age-appropriate (e.g., using three age categories) family and home-based care and imputed this value only to those families who indicated that they paid for child care.[24] Finally, I compare the imputed value of household food and total work-related expenses to the total disposable household net income to determine if basic expenses exceed income, to create my third measure of child well-being that captures the dimension of economic hardship.

Based on this measure of economic hardship, a greater proportion of all children except those in lone single-mother households face economic hardship than would be estimated using the household-based variation of the official poverty measure. Regardless of the measure of economic well-being, however, children in lone single-mother households face the greatest financial hardship. Close to half live in households in which it is not possible to make ends meet even for only the essential items. Also vulnerable are children in kin and nonkin households, and in households in which children coreside with their adult siblings. Approximately one-third of these children live in households in which disposable net household income probably will not cover basic expenses. Many children in married parent households also face serious economic constraints, with 10 percent being in households in which making ends meet appears to be impossible.

Total income is comprised of income from varying sources, some of which, from a policy perspective, have been more strongly emphasized than others. Gaining a general understanding about the sources of household income may provide more insight into the children's possible vulnerability to policy shifts and economic downturns. Throughout the welfare debate, low-income mothers have been encouraged to reduce their reliance on public assistance by becoming more integrated into the labor market. Thus, from a policy perspective income generated in the labor market through wages or even unemployment compensation is valued above the same amount of income garnered through public assistance. There has also been increased attention to the role of nonresident fathers through increased enforcement of child support and alimony rulings. Child support enforcement has been an integral component of welfare reform with income collected through the state's enforcement efforts used to offset the cost

Table 3.2b
Children's Economic Well-Being, by Living Arrangement, Mean Household Income from Four Sources[a] (in Thousands), Weighted Average

Child's Living Arrangement	Sample Size	Labor Income	Welfare Income	Child Support Alimony	Asset Income
Married parents, no other adults	19,743	72.8	0.2	0.3	9.0
Lone single mother	4,186	18.7	1.3	2.1	1.9
Mother and Grandparents	1,267	42.2	1.3	0.7	5.4
Other Kin	413	46.6	0.7	1.0	2.8
Nonkin	113	49.0	0.8	1.0	2.5
Boyfriend	1,380	44.0	0.8	1.3	2.9
Grown sibs	691	30.5	1.3	1.8	3.3

[a] Assets: Interest earned, dividends, net return on equity, capital gains, and rent income.
Labor income: Income from earnings, unemployment, workers's compensation.
Welfare: Income from public assistance (TANF), SSI, housing subsidy, family market value (FMV) of food stamps, and FMV of school lunch.

of public assistance. From a policy perspective, income from child support is valued over equivalent amounts of income from public assistance since many feel that child support payments are typically accompanied by increased involvement by the absentee father in his child's life, resulting in the provision of moral and emotional support, and often even additional financial contributions. Finally, asset income has been touted as being more valuable than its actual value in dollars.[25] Assets gained through savings, dividends, and property ownership provide a buffer in times of economic downturn, foster long-term economic security, and is sometimes thought to have a positive impact on fostering a life perspective consistent with a long-term financial planning horizon.

The results in Table 3.2b indicate that the mean amount of income from the various sources varies widely among the different living arrangement categories. Mean labor income is highest among children in married couple households ($72.8K) and lowest in lone single-mother households ($18.7K) and in single-mother households with grown siblings ($30.5K). Despite the fact that there are notably more people in extended family households, labor income in all categories thereof is almost half of the level found in married parent households. The highest average annual welfare payments ($1.3K) are available to children in lone single mother, adult sibling, and multigenerational households.

Some income portfolios render children in certain living arrangements economically more vulnerable than others. Children in lone single-mother households are not only more likely to be low-income (Table 3.2a), but the sources of income also place them into a more precarious economic status (Table 3.2b). The income profile of children in lone single-mother households reveals their significant reliance on public

assistance and child support. For every $100 a lone single mother brings home in labor income, close to $13 comes in from public assistance or child support. This nontrivial portion of the household budget is a tenuous source over which the mother may have little control. Public assistance eligibility rules may be poorly understood and personal conflicts with the children's father may translate into fluctuating or even rapidly shifting amounts from one month to the next. A similar situation faces children in adult sibling households, whose household income from labor market activities is only somewhat higher than in lone single-mother households.

In grandparent households, levels of income from public assistance is comparable to those in lone single mother and adult sibling households, but not child support payments, most likely due to the youthfulness of single mothers in that population. That reduction is more than compensated by higher-income levels from labor market activities. Labor market income remains low, however, despite the fact that multigenerational households are larger, on average, than other living arrangements and at least some of its members should have greater seniority in the labor market. Their weak economic standing is evidence of the multigenerational effect of poverty in which economic hardship brings together two generations of low-income families into one household. The situation is, however, rendered somewhat less tenuous since household asset income in multigenerational households is second only to that found in married parent households. Most of this asset income is likely to be home equity, since close to two-thirds of children in multigenerational households live in privately owned (not rented) homes (Table 3.1).

The income portfolio of cohabiting households is quite similar to that found in multigenerational households with their decreased reliance on public assistance being compensated by an increased reliance on child support. Given the current living arrangements, income from child support is more likely to be even more tenuous due to potential hostility instigated by the introduction of a "substitute father" into the child's life. Adding to this are issues of resource pooling in cohabiting households. While household income from labor market activities is comparable to that found in multigenerational households, there is no guarantee that this income will be shared equally.[26] More research is needed to assess the extent to which cohabiting partners pool incomes, but it can be assumed that cohabiting boyfriends might be less inclined to share their earned incomes in an egalitarian fashion, particularly if the single mother's child is from another relationship. About one-third of labor market earnings in cohabiting households is generated by single mothers.[27] Their ability to tap into the other two-thirds can depend on many factors, making the economic situation of children therein more tenuous than in multigenerational households.

From a policy perspective, children's income portfolios in kin and nonkin extended households appear to be the strongest. Their reliance on public assistance and child support is lowest, while income from labor market activities is highest, second only to children with married parents. Nevertheless, even more so than in cohabiting households, there are certainly issues as to how income gets pooled in kin and nonkin households and these decisions have concrete implications for child economic well-being. Like in cohabiting households, about one-third of labor market earnings in

kin households stems from single mothers. Single mothers in nonkin households contribute more, roughly 40 percent.[28] With less public assistance and child support in hand and lower contributions to the total household budget in a household with others who may not be immediate kin, single mothers may find themselves in a poor bargaining position which may, in turn, translate into a weaker or at least more precarious economic situation for their children. Conversely, the single mothers in these households also tend to be the household heads (close to three-fourths of children living in these households have single mothers as heads), which may increase their bargaining power. Very little research to date has been conducted on the impact of living arrangements on resources pooling making it difficult to assess children's economic well-being under these different living conditions.

Descriptive Results by Race and Ethnicity

The results broken out by race and ethnicity reveal a relative pattern that is very similar to that found at the aggregate level. Regardless of race or ethnicity and regardless of the operational measure, children in married parent households have a higher level of well-being than their counterparts in single-mother households (Table 3.3a). What is notable, however, is the additional penalty that children pay for being African American or Latino.

White children are never as negatively impacted by alternative family structures to the same extent as African American or Latino children. Close to three-fourths (72%) of Latino children and two-thirds (63%) of African American children in lone single-mother households are low-income. The same is true for only 37 percent of white children. Even children living in socially desirable and publicly promoted married parent households are at risk of experiencing economic hardship if they are black or Latino. While 6 percent of white children with married parents live in low-income households, the same is true for 11 percent of their African American and 25 percent of their Latino counterparts. Latino children in married parent households are the most disadvantaged ethnic group and face similar economic constraints as white children in single-mother households with adult siblings and even worse economic conditions than white children in every other extended single-mother households using either household measure of economic well-being.

In comparing measures of economic well-being, the similarity in results using either operationalization (low-income rates or income gap rate) is striking. Nevertheless, there is a 10 percent or greater difference between the two measures for every racial/ethnic group for children in cohabiting households. For example, whereas 12 percent of white children in cohabiting households are in low-income households, 22 percent are in households in which disposable net income does not cover basic expenses. This suggests that children in cohabiting households face a greater financial crunch than would be suggested by considering income alone. Even measures of income that more closely reflect disposable income do not take into account life cycle or geographic residence differences that may distinguish certain family types. Cohabiting families may be more likely to live in metropolitan areas in which

Table 3.3a
Children's Economic Well-Being, by Living Arrangement, Percent Living in Low-Income Households (LIHH)[a,b] or in Households with an Income Gap[c]. (Weighted Averages)

	White Children			African American Children			Latino Children		
Child's Living Arrangement	Sample Size	% in LIHH	% Inc Gap	Sample Size	% in LIHH	% Inc Gap	Sample Size	% in LIHH	% Inc Gap
Married parents, no other adults	13,762	5.9	6.5	1,147	10.8	10.9	3,795	25.3	27.0
Lone single mother	1,927	37.9	34.5	1,233	63.3	57.3	866	71.5	66.2
Mother and									
Grandparents	415	13.9	15.9	310	26.6	32.4	477	29.4	35.4
Kin/Nonkin	127	12.6	15.0	105	39.0	45.7	249	26.9	38.2
Boyfriend	708	11.5	22.4	205	21.1	35.6	384	26.7	36.8
Grown sibs	254	21.2	26.0	153	42.1	42.7	244	38.2	42.0

[a] Low-income refers to 125% below the poverty level.
[b] Based on the official poverty measure applied at the household level (using the incomes of all household members).
[c] The "gap" is the difference between household disposable income and basic household expenses. HH Income is disposable household net income and includes income from all cash sources plus the value of EITC, capital gains (or losses), and the family market value of food stamps, school lunch, and housing subsidy minus taxes. Basic expenses include projected costs of rent (using the fair market value formula), food (using the low budget method), transportation, and child care. Estimates take into account differences in family size and region of the country.

transportation costs are higher. Cohabiting mothers are more likely to work and to work longer hours than other single mothers (not shown), which taken together, might increase transportation costs further. Similarly, the work habits of cohabiting couples may entail a greater demand for child care while geographic location might result in higher per hour child-care costs. A similar explanation might apply for the 10 percent difference between economic well-being measures for Latino children in kin/nonkin households. Taken together, these differences provide evidence of the difficulty of capturing economic well-being with a single measure and suggest the need to draw on multiple measures.

Labor market income in white children's households is consistently higher than in the households of their black or Latino counterparts (Table 3.3b). Once again, the meaning of having married parents differs notably by race and ethnicity and it is among the married population that there are the biggest differences by race and ethnicity. Mean labor income in married parent households is almost twice as high in white children's households as in Latino children's households ($80K versus $43K) and it is approximately 40 percent higher than in African American children's households ($58K). In contrast, in all categories of single-mother households, labor income in African American and Latino children's households are remarkably similar and always between $10K and $20K less than in the households of their white counterparts. African American and Latino children's households, thus, always have less income than their white counterparts in comparable living arrangements. Not surprisingly then, income from public assistance is higher in African American and Latino children's households regardless of living arrangement. Nevertheless, the higher average income from public assistance sources in black and Latino households does not make up for the gap in labor income. For example, the highest average amount of public assistance ($1.6K) goes to Latino children in grown sibling single-mother households, but added to the average labor income for this group ($27K), it is still several thousands of dollars less than the average income in the households of their white counterparts from labor income alone ($35.6K versus $28.8K).

Results from Logistic Regression Analyses

To follow up on the results from descriptive analyses, multivariate analyses were conducted to better assess the relationship between children's well-being and living arrangements controlling for other factors. Because the dependent variables are dichotomous, logistic regression is used. To simplify interpretation, the log odds coefficients are presented as odds ratios. The logistic regression models rely on white standard errors which are robust to within cluster correlation by household or family.[29] Table 3.4 details the odds ratios from nested logistic regression models. This modeling strategy is useful in confirming or eliminating reasons for differences in children's well-being between children in married parent and single-mother households. The dependent variables are coded to express a positive state of child economic well-being and include: child does not have a low-income mother, child does not live in a low-income household, and child's household can make ends meet (basic expenses do

Table 3.3b
Children's Economic Well-Being, by Living Arrangement, Mean Household Income[a] from the Labor Market (Thousands) and Public Assistance (Weighted Averages)

Child's Living Arrangement	White Children			African American Children			Latino Children		
	Sample Size	Income Source		Sample Size	Income Source		Sample Size	Income Source	
		LM	PA		LM	PA		LM	PA
Married parents, no other adults	13,762	80.1	0.1	1,147	58.2	0.4	3,795	42.6	0.3
Lone Single Mother	1,927	24.1	0.8	1,233	14.4	1.6	866	13.4	1.6
Mother and									
Grandparents	415	53.4	0.8	310	35.6	1.5	477	34.1	1.5
Kin/Nonkin	127	55.5	0.7	105	39.0	0.9	249	39.3	0.8
Boyfriend	708	48.3	0.5	205	38.3	1.2	384	40.1	1.0
Grown sibs	254	35.6	1.2	153	27.1	1.3	244	27.2	1.6

[a] Labor income: Income (in thousands) from earnings, unemployment, workers's compensation.
Public assistance: Income from TANF, SSI, housing subsidy, family market value (FMV) of food stamps, and FMV of school lunch.

Table 3.4
Logistic Regression of Family Structure and Other Characteristics on Children's Economic Well-Being, Odds Ratios (Weighted Estimates)

	Child Has a Nonpoor Mother		Child Not in a Low-Income HH		Child's Household Makes Ends Meet	
	Simple Model	Full Model	Simple Model	Full Model	Simple Model	Full Model
0 = Lone single mother						
Married parents	8.00	3.69	10.88	6.35	8.11	3.67
SM and grandparents	2.41	4.09	3.81	11.25	2.48	2.87
SM and other Kin	2.08	4.21	2.94	8.97	1.65	2.13
SM and nonkin	1.32	0.47	3.40	3.53	1.90	1.06
SM and grown siblings	1.00[ns]	0.47	5.37	9.12	2.25	1.56
SM and male partner	1.80	1.19	2.34	2.17	1.64	1.03
Race/ethnicity (0 = white)						
African American		0.62		0.54		0.64
Latino		0.42		0.38		0.46
Other		0.53		0.49		0.68
Youngest SM's age		1.03		1.02		1.02
Mother: HS diploma		2.87		2.56		2.42
Mother: Fair/poor health		1.00		1.10		1.08
Number of kids in hh		0.60		0.55†		0.72
Metro (0 = Nonmetro)						
Pop. 100k-1M		1.60		1.92		2.04
Pop. 1M+		2.04		2.33		1.56
HH income sources:						
Asset income		2.60		3.07		2.77
Child support/alimony		1.96		2.20		1.92
Welfare income		0.23		0.26		0.67
Labor income ≥ $10K		30.74		47.45		15.52
Pseudo R^2	.1358	.4728	.1519	.5313	.1231	.3846

NOTE: All coefficients are significant at the $P < .001$ level. The two exceptions are indicated by ns (not significant) and † ($P < .01$).

not exceed disposable income). The full models introduce controls including race, characteristics of the child's mother, number of children in the home, metropolitan residence, and dummy variables for income sources. The complete models are a good fit to the data as indicated by the pseudo-R-Squares.

The first simple model illustrates how children's economic well-being varies along the lines of living arrangement using the low-income status (above 125%-poverty level) of the child's mother as the dependent variable. I set the reference category to lone single mother in order to assess the effect on children of adding different categories of persons to their households. The first model shows the odds of improved

economic well-being (e.g., of not having a low-income mother) are eight times higher for children in married parent households than for those living with lone single mothers. Children living in other types of single-mother households are also more likely than children with lone single mothers to have mothers who are nonpoor. There is no significant difference between children living alone with their single mothers and those whose extended households also include adult siblings.

The full model reveals that child and household characteristics explain part of the relationship between well-being and living arrangements since the estimates make notable shifts after adding in the control variables. The odds ratio for married parents decreases by more than one-half, indicating that a large part of the advantage that children of married parents have over children in lone single-mother households is explained by demographics and income sources. In contrast, the odds ratios for grandparent and kin households doubles in size indicating that the potential for economic advantage among these children is diminished by the demographics of their households. The odds ratios for nonkin and adult sibling households change direction indicating a greater advantage among children in lone single-mother households compared to children in nonkin or grown sibling households. As the inverse odds ratios show, children in lone single-mother households are 2.13 (1/.47) times more likely to have nonpoor mothers controlling for the demographic characteristics and income sources than children in these two household living arrangements. For a child living in nonkin extended households, lower economic standing may simply be a measurement artifact related to the use of a family and not household based measure of income. In contrast, the inverse odds ratio for adult sibling households suggest that children who return back to the "nest" or never leave, present a real economic hardship to single-mother households net of any effects related to the demographic or socioeconomic composition of these households.

Using a family-based measure of children's economic well-being may produce distortions since children are embedded in households and benefit from the income and availability of nonrelatives. In addition, children's mothers may react to the presence of other working adults in the household by, for example, working less, making it appear that children's well-being had worsened, when in fact it may have improved due to the financial resources of other household members. The second simple model illustrates how children's economic status varies along the lines of household living arrangement using household low-income status (125%-above poverty level) as the dependent variable. Not surprisingly, the odds ratios for household structure are all larger in the second simple model than in the first. After taking into account the income from all household members, there is an even greater advantage experienced by children not only in married parent households, but also in extended family living arrangements.

As seen previously, adding control variables attenuates the estimate for married parent households and increases it for grandparent and kin households. The main difference with the second full model is that the direction of the effect of nonkin and adult–sibling households does not switch. Instead, it increases suggesting an even stronger economic advantage among these children compared to children in lone

single-mother households after controlling for demographic variables and income sources. This result is not surprising for nonkin households since the dependent variable in the second model counts the income of nonfamily members whereas this was not the case in the first model. The reversal for grown sibling households is more surprising and indicative of the important role of nonfamily members in potentially lifting children out of poverty. Grown sibling households are the most likely to have foster children[30] and this may be a nontrivial source of nonfamily income. They are also more likely than most household categories to have other unrelated other children who may have additional income available (e.g., social security and SSI for orphaned or disabled children). Controlling for household demographics and based on a household measure of income, three of the five extended single-mother households have larger odds ratios than for married parents. This result is consistent with the idea that much of the advantage of children in married parent households has to do with demographics and the failure to consider all income sources, instead of marriage being the ideal arrangement per se to accumulate economic resources.

Compared to children in lone single-mother households, children in any other living arrangement are more likely to live in households in which disposable household income covers basic expenses (third model in Table 3.4). Compared to previous models, the estimates remain relatively stable, with the exception of married parent households, even after adding in the control variables. Nevertheless, an odds ratio of 3.67 indicates that the odds of living in households that can "make ends meet" is still almost four times higher for children in married parent households than those in lone single-mother households. The odds ratios for nonkin and cohabiting households also decrease after controlling for household demographics, remaining statistically significant, but substantively irrelevant since an odds ratio close to unity (here 1.06 and 1.03) suggests that the odds of living in a household that makes "ends meet" is almost the same in both lone single-mother and nonkin or cohabiting households. This finding differs from that found in the previous two full models. It suggests that children living in these households fare better than children in lone single-mother households largely because their demographics are different. For example, 64 percent of children in nonkin households are white compared to 45 percent in lone single-mother households. Race and, relatedly, earnings power are likely to be important demographic factors that set these two household types apart in terms of economic well-being.

CONCLUSION

This study examines the well-being of children in single-mother households and sheds new light on the factors that contribute to children's economic standing with a focus on different categories of single-mother households. This study demonstrates the need to consider not only marital status but also living arrangements when determining children's well-being. It also reveals the need to rethink measures of economic well-being since the poverty measure may be flawed on a number of levels.

There are notable differences not only between children in married parent and single-mother households, but also between children in different categories of living arrangements. On every measure of well-being, children in married parent households fare better than children in single-mother households. Consistent with previous research, children in married parent households are less likely to be low income (using both a family and household definition) and more likely to live in households that are able to "make ends meets." Children in lone single-mother households appear to be the most vulnerable with respect to economic well-being even after controlling for demographics and income sources. A large component of this difference is likely to be attributable to compositional differences between married family and lone single-mother households. Both the economic advantage of cohabiting households and the disadvantage of multigenerational may also be attributable to compositional differences.

IMPLICATIONS

Beginning with welfare reform efforts in 1996, policymakers and researchers have advocated the relevance of marriage for reducing child poverty. Policies and proposals to promote marriage assume that marriage as an institution provides both direct and indirect paths to improved child well-being through such mechanisms as combined income, better parenting, and long-term orientation. Research conducted under such efforts as "Building Strong Families" (BSF) or by Child Trends recognize the challenges policymakers face in encouraging more marital unions among soon-to-be or unwed parents and recommend such measures as increasing EITC, more generous child-care subsidies, and greater assistance with educational expenses to enable poor parents to qualify for higher paying jobs.[31] While laudable, these recommendations have a blind spot in failing to recognize the relevance of demographics for the poor economic standing of single-mother families. As demonstrated here, children in single-mother families are more likely to be non-white. Within the category of single-mother households, children in cohabiting and nonkin households are more likely to be white compared to children in multigenerational, adult sibling, and kin households who are more likely to be non-white. This racial divide in living arrangements coincides closely with economic well-being. Taken together, the results suggest that policymakers need to redirect their attention back to the salience of race and ethnicity for economic well-being if they seek to reduce child poverty.

What are the factors that vary along racial lines that may be responsible for the disparities in economic well-being? In their work on the BSF project, Carlson et al. provide relevant statistics.[32] They cite as a challenge to marriage the fact that between 33 percent and 42 percent of the fathers of unwed mothers in their sample have prison records. They also state that between 74 percent and 80 percent of unwed mothers earn less than $10,000 while the median earnings of unwed fathers is between $16K and $21K. Between 79 percent and 82 percent of their sample is either African American or Latino. Given these statistics and the results of this study, it is not unreasonable to assume that racial disparities are at least as important a factor, if not a more important factor, than marriage in determining the economic well-being of

children. African Americans have the highest incarceration rates which affects their future earning ability both directly and indirectly. A criminal record is looked upon negatively by employers and even explicitly disqualifies candidates from certain (e.g., federal) jobs. Some criminal records even bar incumbents from federal student loans due to the Drug Provision of the Higher Education Act federal aid provision. The income gap between whites and non-whites remains notable for these same reasons, in addition to many more that scholars of race have long studied. Nevertheless, most policy researchers make only passing reference to the relevance of race and ethnicity for children's economic well-being and instead focus on encouraging marriage. In line with this, the results of this study show that children of married parents are less likely to be poor and have higher labor market earnings regardless of race or ethnicity. The results also show, however, that low-income status is more common among non-white children regardless of marital status or living arrangement. In addition to considering the effectiveness of enlarging single-mother households with fathers, there is an urgent need to direct more attention to the barriers facing fathers—and mothers—who are predominantly minority and who continue to encounter racially linked barriers in the labor market that prevent them from earning livable wages. Ultimately, successful strategies to reduce economic disparities between children in different living arrangements may depend on reducing labor market disparities by race and ethnicity.

Finally, this study demonstrates the need to consider other measures to describe economic well-being. On the one hand, there is some confirmation of recent criticism that the poverty thresholds are too low. Results using an "income gap" measure suggest that children living 125 percent below the poverty line may be worse off than the threshold implies since officially designated near-poor households include many in which household income does not suffice to cover even basic expenses. On the other hand, the family-level unit of aggregation produces distortions not only in cohabiting and nonkin households, but also in other kinship-based extended and married parent households. This distortion arises due to omission of the income contributions of nonrelatives in the household, including unrelated children (e.g., foster children) with independent sources of income (e.g., social security). This omission takes on even more importance in light of the fact that single mothers tend not to be the main contributors to household income. As cited elsewhere,[33] the earnings of other family members are the most important factor for lifting poor women's family incomes in the post-welfare reform era. This speaks for the need for research on resource pooling to assess whether decreased disincentives for coresidency (e.g., built into the current food stamp program) and increased support for other family members (e.g., besides for 'potential' fathers) may be effective tools in increasing the economic well-being of low-income children.

NOTES

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John D. and Catherine T. MacArthur Foundation Network on the Family and the Economy and also in part from a postdoctoral fellowship grant from the NICHD.

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2. Nancy K. Cauthen and Hsien-Hen Lu, *Employment Alone is Not Enough for American's Low-Income Children and Families*. National Center for Children in Poverty Research Brief No. 1, August. (Columbia University: Mailman School of Public Health, 2003).

3. Karen Randolph, Roderick Rose, Mark Fraser, and Dennis K. Orthner, "Examining the Impact of Changes in Maternal Employment on High School Completion Among High School Youth." *Journal of Family and Economic Issues*, 25 (2004): 279–299; Robin A. Douthitt, " 'Time to Do the Chores?' Factoring Home-Production Needs into Measures of Poverty." *Journal of Family and Economic Issues*, 21(1) (2000): 7–22.

4. But see, Karen Fox Folk, "Single Mothers in Various Living Arrangements: Differences in Economic and Time Resources." *American Journal of Economics and Sociology*, 55 (1996): 277–292.

5. But, for research on the effect on children of cohabiting living arrangements, see: Wendy D. Manning and Kathleen Lamb, "Adolescent Wellbeing in Cohabiting, Married, and Single Parent Families." *Journal of Marriage and the Family*, 65 (2003): 876–893; Gregory Acs and Sandi Nelson, "The Kids are Alright? Children's Well-being and the Rise in Cohabitation." New Federalism Paper. National Survey of American Families, Series B, No. B-48, July (Washington, DC: The Urban Institute, 2002); Elizabeth Thomson, Sara McLanahan, and R. B. Curtain, "Family structure, gender, and parental socialization." *Journal of Marriage and the Family*, 54 (1992): 368–378; for research on the effect of multigenerational households, see: William S. Aquilino, "The Life Course of Children Born to Unmarried Mothers: Childhood Living Arrangements and Young Adult Outcomes." *Journal of Marriage and the Family*, 58(2)(1996): 293–310.; Thomas Deliere and Ariel Kalil, "Good Things Come in Threes: Single Parent Multigenerational Family Structure and Adolescent Adjustment." *Demography*, 39(2) (2002): 393–413; for research on the effect of extended households, see M. Sanford, J. Merrill Carlsmith, Steven J. Bushwall, Phillip L. Ritter, Herbert Leiderman, Albert H. Hastorf, and Ruth T. Goss. "Single Parents, Extended Households, and Control of Adolescents." *Child Development*, 56 (1985): 326–341.

6. Julia Isaacs, "Receipt of Unemployment Insurance Among Low-Income Single Mothers." ASPE Issue Brief. (Washington, DC: US Department of Health and Human Services, 2005).

7. Constance, F. Citro and Robert T. Michael, *Measuring Poverty: A New Approach*. (Washington: National Academy Press, 1995).

8. For example, child-care costs constituted only 1 percent of the total costs required to raise a child in 1960. By 2000, this percentage had increased to 10 percent. United States Department of Agriculture (USDA), *Expenditures of Children by Families*. Miscellaneous Publication 1528–2000, May (Washington, DC: U.S. Department of Agriculture, 2001).

9. Kathleen S. Short, "Material and Financial Hardship and Income-Based Poverty Measures in the USA." *Journal of Social Policy*, 34(1) (2005): 21–38.

10. The underlying logic was to use as a comparison group to single mother households a category of married parent household that best approximates the idealized "nuclear family," given data constraints (e.g., using CPS data, it is not possible to distinguish between biological and stepfathers).

11. These households can contain other children such as the parents' grandchildren to the extent that these children's parents are also not present in the home. This is true in 14 households. A somewhat larger number (83 households) contain children who are not related to the parents. Together these households make up less than 1 percent of the total number of married parent households included in this study.

12. Lone single mother households can contain other children such as the parents' grandchildren to the extent that the child's parent is not coresiding in the household.

13. Lynne M. Casper, Phillip N. Cohen, and Tavia Simmons, "How Does POSSLQ Measure Up? Historical Estimates of Cohabitation." Population Division Working Paper No, 36. (Washington, DC: US Bureau of the Census, 1999).

14. Single mothers cannot be over 10 years older than the single man and the man can not be over 20 years older than the woman. Adult foster children are explicitly excluded from being considered for cohabitation. A little over half (52.4%) of all single mothers designated as cohabiting are captured through the use of the CPS variable. The remaining 47.6 percent are categorized as such using the age rules just described.

15. As discussed previously, the married parent households studied here are but a subset of the total population of married parents and are restricted to households without any other adults (including no grown children) besides the parents.

16. Larry L. Bumpass and R. Kelly Raley, "Redefining Single-Parent Families: Cohabitation and Changing Family Reality." *Demography*, 32(1) (1995): 97–109.

17. It should be noted that Bauman cautions against the use of household income based on the analysis of SIPP data from 1900 to 1992 that suggested that nonfamily members (with the exception of cohabiting boyfriends) contribute least to the family budget. See, Kurt Bauman, "Shifting Family Definitions: The Effect of Cohabitation and other Nonfamily Household Relationships on Measures of Poverty." *Demography*, 36(3) (1999): 315–325. There remains, however, little consensus in the literature. Schoeni and Blank argue that welfare reform measures have increased the relevance of resource pooling, making low-income mothers now more dependent on the earnings of other household members. See, Robert F. Schoeni and Rebecca M. Blank, "What Has Welfare Reform Accomplished? Impacts on Welfare Participation, Employment, Income, Poverty, and Family Structure. Labor and Population Program." Working Paper DRU-2268, March (Washington, DC: RAND, 2000).

18. Citro and Micheal, op. cit.

19. Economic Policy Institute (EPI). *EPI Issue Guide on Poverty and Family Budgets*, Available at http://www.epinet.org/issueguides/poverty/poverty_issueguide.pdf (Washington, DC: EPI, 2001).

20. These estimates of household expenses are closely aligned with recommendations by EPI (2001). They are conservative since other essential budget items are not considered (e.g., utilities, clothing, books) and only the low budget diet was utilized despite the fact that full-time employment makes a low budget diet increasingly difficult. See, Douthitt, op. cit.

21. Department of Housing and Urban Development, "50th Percentile and 4th Percentile Fair Market Rents, Fiscal Year 2001; Final Rule." Federal Register, 1-2-01. Available at http://www.huduser.org/Datasets/FMR/Jan50th.pdf (Washington, DC: National Archive and Records Administration, 2001). My estimates for housing allow for the tripling up of children (but not adults) in bedrooms.

22. USDA-based food cost estimates for low-cost food plans account for members' sexes and ages. See, United States Department of Agriculture (USDA),"Official USDA Food Plans: Cost of Food at Home at Four Levels, U.S. Average, March 2000." Available at http://www.usda.gov/cnpp/FoodPlans/Updates/foodmar00.pdf (Washington, DC: USDA Center for Nutrition Policy and Promotion, 2000).

23. National Household Travel Survey, "2001 NHTS Average Annual Vehicle Miles of Travel Per Driver: Mean VMT/Driver for MSA Size by Count of HH Members with Jobs." Table generated by author at http://nhts.ornl.gov/2001/index.shtml; Oak Ridge National Laboratory, *1995 NPTS Databook. Based on Data from the 1995 Nationwide Personal Transportation Survey (NPTS).* ORNL/TM-2001/248. Available at http://www-cta.ornl.gov/cta/Publications/Reports/ORNL_TM_2001_248.pdf (Oak Ridge, TN: Oak Ridge National Laboratory, 2001; accessed on January 23, 2007). Here, estimated transportation costs rely on NHTS for per driver estimates of annual vehicle miles traveled (VMT) for households with varying numbers of workers. Based on information provided in Tab 7.2 of the Oak Ridge Lab Report, VMT was multiplied by a multiple to eliminate recreational driving and to account for shared driving. The multiples include: .85 for employed heads (of households and subfamilies); .61 for nonworking heads; .36 for working nonheads; 0 for nonworking nonheads. This product was multiplied by .325, the 2000 IRS cost-per-mile rate to attain an annual cost per driver and then summed by household.

24. Karen Schulman, *The High Cost of Child Care Puts Quality Care out of Reach for Many Families*: Available at http://www.childrensdefense.org (Washington, DC: Children's Defense Fund, 2000). The CDF survey did not include some states or regions within states. These missing values were imputed based on the results of online searches of official websites (e.g., state Web sites).

25. Lingxin Lao, "Family Structure, Private Transfers, and the Economic Wellbeing of Families with Children." *Social Forces*, 75(1) (1996): 269–292.

26. Anne E. Winkler, "The Living Arrangements of Single Mothers with Dependent Children." *The American Journal of Economics and Sociology*, 52(1) (1993): 1–18; Bauman, Shifting Family Definitions.

27. A separate analysis not shown here revealed that the mean earnings of single mothers in cohabiting households is $15.7K and of others in the household is $27.4K.

28. In a separate analysis not shown here, it was found that the mean earnings of single mothers in kin households is $14.1K and of others in the household is $30.8K. The mean earnings of single mothers in nonkin households is $20.6K and of others in the household is $27.3K.

29. Robust standard errors were estimated using the cluster technique in Stata. Estimates aggregated at the family level use family and those aggregated at the household level use household as the cluster variable.

30. As shown in Table 3.1, 1.2 percent of children in these households are foster children.

31. Kristin Anderson Moore, Susan M. Jelielek, and Carol Emig, "Marriage from a Child's Perspective: How Does Family Structure Affect Children, and What Can We Do About it?" Child Trends Research Brief, June (Washington, DC: Child Trends, 2002); Marcia Carlson, Sara McLanahan, Paula England, and Barbara Devaney, "What We Know About Unmarried Parents: Implications for Building Strong Families Programs." Building Strong Families Brief, January, Number 3 (Princeton, NJ: Mathematica Policy Research, Inc., 2005).

32. Carlson et al., "What We Know About Unmarried Parents."

33. Schoeni and Blank, "What Has Welfare Reform Accomplished?"

CHAPTER 4

Family Context, Income Adequacy, and Child-Care Needs: The Bottom Line for San Antonio's Future

Juanita M. Firestone

As a result of recent demographic changes, child-care issues have become an important concern. The Southern Regional Task Force on Child Care[1] states that "child care is perhaps the most critical work-support measure in which the federal government, states, and the private sector can invest." Adequate, affordable, quality child care is necessary to maintain viable workforce, to sustain the ability of families to move off welfare, and to assure that all children are given the opportunity to participate in early childhood development programs.[2] This need for child-care services crosses all classes and race and ethnic groups, and extends across the United States. The unique demographic profile of San Antonio, with a majority of Latinos/as and high percentages of families in low socioeconomic context means that these problems are more extensive.

San Antonio MSA, is located in Bexar County in South Central Texas and includes the city of San Antonio which had a population of 1,144,646 based on the 2000 Census. The majority of the population is of Hispanic origin (approximately 58.7% based on 2000 Census; most are Mexican American). About 6.8 percent of the population is African American (2000 Census). The population is growing at about 1.4 percent, which is slightly above the 1.3 percent average for metropolitan areas nationwide.

According to the 2004 American Community Survey, approximately 17 percent of families and close to 20 percent (19.8%) of individuals live in poverty. These percentages compare to 10.1 percent of families, and 13.1 percent of individuals in the United States. As a result, a disproportionate number of families in San Antonio confront the many ancillary problems associated with living in poverty. All of these problems are more typical of women than of men, especially women in single-parent households. The high proportion of Hispanics (58.7%), as well as the

young median age of residents (31.7; 32.9 for women), further contribute to these difficulties. Approximately 80 percent of residents of Bexar County reside within the city limits of San Antonio; the remaining 20 percent reside in either other wholly incorporated cities or unincorporated areas within and surrounding the San Antonio area. Like many U.S. cities, an inner city/business core, expanding suburban areas, and a slow-growing older area geographically define San Antonio.

The city is often viewed in quadrants—the west and south sides are largely Mexican American (the "West Side," especially the inner city located inside Loop 410, is the traditional Mexican and Mexican American barrio), the Eastside African American (also predominantly inside Loop 410) and the Northside (especially the suburban areas outside Loop 410) largely Anglo, with ethnic minorities with higher socioeconomic standing gravitating toward perceived better service and retail areas, better schools, and newer bedroom communities. Like many Hispanic barrios, San Antonio's "West Side" is a residential neighborhood characterized by dense housing, higher rates of crime, poverty, unemployment, and lower educational attainment and economic development compared to other areas in the city. This area, in particular, suffers from a lack of affordable, quality day care.

CHILD CARE IN SAN ANTONIO: ISSUES OF SUPPLY

There is a clear and documented need for affordable, quality day care. Because many cannot afford quality care on their own, they rely on government subsidies. In 1998, 85,865 children received state-subsidized child care in Texas.[3] This was a substantial increase from previous years and has meant that waiting lists persist for subsidized child care. According to a report prepared by the City of San Antonio Children's Resources Division.[4] there were 1,352 child-care facilities available in Bexar County in 1999. Of those, 43 percent were child-care centers and 47 percent were registered family home-based providers. Of the private centers, 4.8 percent were accredited, while only 1.1 percent of the family-based facilities were accredited. Between 2000 and 2001 the percent of parents utilizing subsidized child-care services increased to 40.5 percent (from 32,222 to 45,275).[5] Because so few care providers opt to become accredited by national accreditation organizations such as the National Association of Education of Young Children (NAEYC) and the National Association of Family Care Centers (NAFCC), the state of Texas developed its own system similar to accreditation, although the standards are not as strict as for the national associations.[6] The Texas-based ratings are based on "stars" and range from 0 to 4 stars with 4 stars being the highest level. A minimum of two stars is necessary in order to be licensed in Texas. Of the private centers in San Antonio, only 4.3 percent were rated as four-star vendors.[7]

The majority of care providers provide only full-time care (89%), while 53 percent provide part-time care only. Most provide care only during traditional business hours 6:00 AM–6:00 PM. Only 4.7 percent of care providers offer evening or overnight care, and only 5.2 percent offer weekend care. This is an important issue tied to the types of jobs available for individuals living in poverty who typically have lower levels of

education than the city average. Often available jobs are in the service sector (e.g., fast food, cleaning, sales clerks) and demand nontraditional hours at least part of the time. A related issue is finding care for children who are not feeling completely well, but are not really ill (e.g., with a minor cold). Most care facilities will not accept sick children, so one of the parents (more often than not, the mother) must stay home using his/her own "sick leave." This can have a secondary negative impact because, if parents then become ill, they often must go to work ill because they have used their sick leave to care for their children.

The average weekly price for full-time care for one child in San Antonio area day-care centers in 1999 was $82.00 for infants/toddlers, $71.00 for preschoolers, and $44.00 for school-age children. These figures compare closely to state averages for day-care centers of $83.00, $73.00 and $48.00 respectively. Home-based care was slightly lower at $72.00 for infants/toddlers, $68.00 for preschoolers and $49.00 for school-age children. State averages for home-based care were $75.00, $70.00 and $45.00. Average daily price of part-time care in day-care centers ranged from $16.00 for infants/toddlers to $10.00 for preschoolers and $9.00 for school-age children. Average daily cost for part-time care with home-based providers was $14.00 for infants/toddlers, $10.00 for preschoolers and $9.00 for school-age children. The average hourly wage for food service workers in San Antonio in 1999 was $5.99.[8] This translates into a monthly take home of about $814.00. For a single mother with an infant, employed 40 hours/week that would mean that about 40 percent of her take home would be spent on child care.[9]

Of course, additional children increase the cost of care, and according to the *1999 Texas Child Care Portfolio*, average family size in San Antonio was 3.4, and according to the 2000 Census, the average family size in San Antonio in 2000 has increased to 3.6. While additional children do not double the cost of care, the second child adds about 25 percent to the cost. Thus, an average of $82.00 for one infant would become about $103.00 with the addition of another child. In addition, child-care expenses consume a relatively large share of poor family's budgets. In 1993, estimates based on Current Population Data indicated that poor families who paid for care spent 18 percent of their income on child care compared to 7 percent for nonpoor families.[10]

A Report by the Children's Defense Fund in 2000 indicated that the shortfall between what 10 percent of their income buys and the average annual cost of child care using a child care center was $2,020 for one child and $7,376 for two children. Other analyses on national level data indicate that the cost of child care impacts the labor force participation of women with children such that increases in cost increases the likelihood that women are less likely to be employed.[11] If women have no choice in whether they must be employed, they often seek child-care assistance. Unfortunately, the demand for assistance far exceeds the supply of care providers who will accept federal or state vouchers because both limit the amount, which can be paid for care. Thus, due to insufficient funding, families eligible for assistance may not always receive help. According to information from the City of San Antonio

Children's Resource Division, there was a waiting list of 4,000 children for child-care assistance in 2001.

Focus group participants in San Antonio reinforced the lack of quality day care centers, especially those willing to accept vouchers, and the Texas Association of Child Care Resource and Referral Agencies indicate varying rates of care availability based on geography—those areas in South and Southwestern parts of the county, where there is a higher concentration of poor families, have the fewest available care facilities. Thus, even if subsidized care became available, often it requires transportation arrangements, which cannot be met. This is especially true for jobs outside the traditional 6:00 AM–6:00 PM hours.

One important factor that impacts the availability of quality care is the low hourly wages for child-care workers. In 2006, average wages for child-care workers in the San Antonio Metropolitan Statistical Area (MSA) was $6.90/hr. These low wages are unlikely to pull many new workers into the area in spite of high levels of demand. In particular such low wages are unlikely to attract workers with educational credentials beyond a high school diploma. Clearly the developmental needs of very young children would benefit from workers with higher levels of education and a better understanding of how to instruct and educate them. The low wages associated with care workers is likely to continue to reinforce the disjuncture between the credentials of workers desired and those willing to accept the jobs.

Child-Care Arrangements

Data from, the 1988 National Longitudinal Survey of Youth and the 1983 National Longitudinal Survey of Young Women indicated that the most common form of child care was by relatives, although use of child-care centers was more common for children between 2 and 4 than for infants.[12] Employed mothers who worked full time outside the home were less likely to use a relative and more likely to use child-care centers, those with lower educational attainment were more likely to use relatives, as were African Americans and Hispanics.[13] Ehrle and her colleagues[14] found that 30 percent of African American children and 24 percent of white children are cared for in child-care centers, while only 10 percent of Hispanic children are. They found that Hispanic families most often rely on relatives (39%, compared to 25% of white children and 27% of African American children). Interestingly, reliance on relatives does not necessarily mean no cost. Hofferth et al.[15] found that in 1990 close to 33 percent of employed mothers who relied on relatives to care for their children paid for the care.

Economic variables also had significant influence on choices related to child-care arrangements. Households in which the husband's and the wife's income are high were more likely to rely on child-care centers, although increased family size increased the likelihood that a babysitter rather than a child-care center would be used.[16]

Using data from the Current Population Reports, Casper[17] found similar results in 1993, 41 percent of respondents used relatives, while 30 percent use organized child care-facilities, and 17 percent used family day-care settings.

Demographic characteristics were associated with those choices. Children whose mothers were employed in nonday shift hours were more likely to be cared for by relatives, while women working day shifts were more likely to use commercial child-care facilities.[18] As in previous studies, African American and Hispanic mothers were more likely to use relatives than whites, as were children in one-parent households.[19] Poor families and families receiving governmental assistance (Food Stamps, WIC benefits) were also more likely to rely on relatives, although families receiving AFDC were no more likely to rely on relatives than those not receiving AFDC.[20] Single parents are more likely than two parents to rely on relatives,[21] which is likely associated with economic context. An update of that report in 2002[22] indicated that a higher percentage of fathers (36%) and grandparents (22%) were taking care of preschoolers when the mother was employed part time than were enrolled in either day-care centers (15%) or family day-care providers (9%). This may be in part due to the increasing cost of day-care centers and providers, as well as the greater flexibility of mothers employed part-time in arranging times in the workplace. For mothers employed full-time, day-care centers (26%) and family day-care providers (12%) were most used forms of care.

Not surprisingly, the cost of child care is increasing, and those increases are more of a burden for poor families. In 1993, families earning less than $1200 per month spent about 25 percent of family income on child care compared to families earning $4500 or more per month who spent 6 percent of their monthly income in child care.[23] On an average, families below poverty level spent about 18 percent of their monthly income on child care compared to 7 percent for those above the poverty level.[24] Based on data from the 1997 National Survey of America's Families, Giannarelli and Barsimantov[25] found that 27 percent of low-income families in the United States spend more than 20 percent of family earnings on child care. This proportion varies across states with a range of 19 percent in Washington to 37 percent in Mississippi.[26] In Texas, 28 percent of low-income families spend more than 20 percent of family income on child-care expenses.[27] A family living in Texas in 1998 earning minimum wages before taxes would have spent about 33 percent of their income to purchase center-based care for an infant and a 3-year-old.[28] Costs often increase for single parents whose children spend more time in day care because they do not have another adult to help transport them.

Increasing costs of child care has been documented to impact the labor force participation of women such that increasing costs decrease the labor force participation of women.[29] Lack of affordable child care has been documented as one of the major barriers to women's participation in the labor force,[30] in particular women in low-income situations.[31] This may have important consequences for poor families given the recent changes in welfare policies. These findings were supported using various simulations of the effects of changes in the federal child care tax credit.[32] Berger and Black[33] found that single mothers who received child-care subsidies were more likely to be employed,[34] and were dramatically more likely to be satisfied with their child-care arrangements than those who did not. The higher levels of satisfaction

derived from increased choice in child-care options.[35] While based on data from families in Kentucky, the consistency of the impacts of cost of child care on labor force participation rates suggests that the satisfaction findings might also hold up.

Young and Miranne[36] and Sonenstein and Wolf[37] found that mothers on welfare expressed the same concerns about child care as do mothers working outside the home. Convenient hours and location, good adult supervision, low child-to-adult ratios, learning opportunities and the child's happiness were the most important factors in choosing among child-care options. Additionally, many of the women in their samples needed child-care services before 7:00 AM and after 6:00 PM, hours that are incompatible with using private child-care centers. Clearly many of the service oriented jobs available to individuals moving from welfare to work require hours outside the "normal business day" and may require informal rather than formal child-care arrangements.

While the need for child-care arrangements is high, the supply does not meet that need. Chronic shortages in regulated, quality child care exist, and those shortages are exacerbated by children with special needs, sick children, and care during nontraditional hours and holidays.[38] Shortages are particularly acute in low-income neighborhoods, which increases the likelihood that low-income families must rely on informal, unregulated arrangements.[39] The latter shortage is mirrored in the low percentages of subsidy-eligible parents receiving assistance (about 10% nationwide in 1999) and the low percentages of available subsidized slots in licensed facilities.[40] Most states in the U.S. report waiting lists for child-care subsidies.[41]

Latinas/os and Child Care

In spite of stereotypical representations of an idealized model of motherhood reputedly common among Hispanics, which supports a patriarchal system that devalues female employment[42] recent research indicates that the labor force experience of Hispanic women is becoming more similar to other racial and ethnic groups.[43] Furthermore, demographic data show larger increases in the educational attainment of Hispanic women compared to white, non-Hispanic women, along with increasing rates of labor force participation and average number of hours in paid labor.[44]

In addition, there is some evidence that Hispanic cultural values (such as strong familism) changes with increasing contact with U.S. mainstream culture.[45] Stereotypical gender role expectations may become less restrictive toward women with respect to child-care responsibilities, as groups become more acculturated into typical U.S. value systems.[46] Increasing labor force participation is associated with less traditional gender role attitudes. Thus, as Hispanics become the largest growing minority group in the United States the need for day care for children may increase rapidly. The high levels of poverty and low levels of education among Hispanics increases the likelihood that women must rely on relatives for child care, or will remain unemployed thus remaining in poverty and in need of government assistance.[47] San Antonio, as one of the areas in the United States with a majority Mexican American population, provides

an interesting arena for assessing child-care needs among different race and ethnic groups.

Demographic Changes Shaping Child-Care Needs: The Demand Side

The percentage of women 16 years and older who are in the labor force has steadily increased since 1970. The overall percentage increased from 39.4 percent to 56.4 percent in Bexar County and from 29.5 percent to 55.3 percent in San Antonio. The largest percent increase was seen for Hispanic women whose labor force participation went from about 35 percent to about 55 percent.

Data indicate a concomitant increase in the percentage of women 16 and over living in San Antonio with children under 6 who are in the labor force. This has been one of the important trends in the female labor force nation wide and clearly San Antonio is following national trends. While the increase was largest for white, non-Hispanic women, with an increase of over 14 percent, Hispanic women followed closely with an increase of over 11 percent. The increase for African American women was less dramatic (over 7%), but a larger percentage of women with children under 6 were in the labor force in 1970 than was true for the other two groups. Finally, there has been an important increase in women in San Antonio in managerial and professional jobs between 1990 (45.6%) and 2000 (52.4%) for all race and ethnic groups. This increase is important with respect to day-care needs because these types of jobs require large time commitments and have less flexibility than many other occupational categories.

The clear increases in labor force participation of women from all race and ethnic groups, even those with young children indicate a growing need for affordable, quality day-care providers in the San Antonio area. In addition, female householder families may have even greater need for child care. If the female is the sole provider, she must maintain employment or receive public assistance. Recent changes in welfare policies limit the time individuals can receive benefits without employment, so after 2 years women must return to paid work. In addition, a higher percentage of female householder families, even those where the householder is employed full time, live below the poverty level. Individuals in this situation have even more difficulty in affording quality day care.

The proportion of African American female householder families living in Bexar County and in San Antonio has increased dramatically from about 50 percent in 1970 to close to 72 percent in 1990 and to 87.6 percent in 2000. In 2000, the percentage of Hispanic female householder families was 85.3 percent, and for white, non-Hispanic female householders was 82.3 percent. Some of the important demographic characteristics of female householder families in Bexar County and in San Antonio impact child-care needs. The proportion of these families living in poverty has been increasing over time and is about one-third for white, non-Hispanic (32.3%) families, close to 40 percent for Hispanic families, and close to 50 percent for African American (47.6%) families. Almost all of these percentages for race/ethnic groups include female householders with the presence of children under 18.

Table 4.1
Median Income of Female Householder with Children in Bexar County and San Antonio, City, Texas

	Bexar County			San Antonio City		
	1980	**1990**	**2000**	**1980**	**1990**	**2000**
Panel A: Median income of a female householder with own child under 18 years old						
Total	$6,657	$11,127	$18,810	$6,370	$10,402	$18,021
White	$7,306	$12,934	$20,723	$6,996	$12,109	$19,886
Black	$5,794	$9,716	$18,569	$5,575	$8,103	$17,509
Hispanic	$5,066	$7,683	$16,022	$4,955	$7,371	$15,723
Panel B: Median income of a female householder with own child under 6 years old						
Total	$3,894	$7,292	$9010.05	$3,641	$6,572	$8109.45
White	$4,455	$9,607	$9943.00	$4,199	$8,328	$8948.70
Black	$3,390	$6,773	$8754.50	$3,291	$6,774	$7879.05
Hispanic	$2,938	$5338	$7861.50	$2,813	$5612	$7075.35

These high percentages of female headed households living in poverty is not offset much even when the householder is in the labor force, especially for members of minority race/ethnic groups. In part, because their lower levels of educational attainment, and years and type of job experience mean that they are often employed in part-time jobs, seasonal work or jobs paying less than the minimum wage. These types of jobs also often require shift work outside typical 8:00 AM–5:00 PM employment, which makes affordable, quality day care more difficult to obtain.

The median income of female householders with children under 18 was very low in 2000 and even lower for those with children under 6 years (see Table 4.1). According to the U.S. Census bureau, in 2006 the poverty threshold for a family of two, where one was a child was $9,800.00, and for a family of three, where two are children was $13,200.00 (http//census.gov). For all race and ethnic groups female householders with children under 6 earned well below those amounts. In particular, Hispanic female householders, who are more likely to have younger children in their household, fell well below the poverty levels.

CHILD CARE AND DEVELOPMENTAL NEEDS IN SAN ANTONIO, TEXAS

Clearly, universal access to affordable, quality early education and care for children from birth to age 12 is an important community goal. The following individual-level survey data complements the census data discussed in the previous section. The issue of affordable quality child care was raised repeatedly in the focus groups, which were used to help design a telephone survey conducted in San Antonio, Texas. The following section describes the survey sample, instrumentation, and results.

Description of Survey

Instrumentation

The survey instrument was created using the MicroCase Analysis computer-assisted data entry system (CATI). The questionnaire began with a brief introduction of the purpose and the origin of the survey. A series of sixty-four questions related to attitudes about various services provided by the San Antonio Department of Community Initiatives, and related to community needs for which respondents believe services should be provided. In addition eight demographic questions were asked for analysis purposes and to insure that the sample adequately reflected the population of interest. Both English and Spanish language versions of the questionnaire were created. Questions appeared on the computer screen and responses were entered directly into a computer file. This allows daily monitoring to insure that completion rates within target populations are being met.

Administration

All interviewers received a combination of telephone survey techniques training and computer data entry training prior to beginning data collection. Calls were completed Monday through Thursday evenings from 5:00 PM–9:00 PM and Saturdays and Sundays from noon until 6:00 PM. These times optimize availability of respondents, including those employed full time. In addition, the initial screen excluded anyone answering the phone who was not eighteen years or older.

Sample

Actual telephone prefixes were paired with four random digits to produce the phone numbers. This process insures that all necessary phone prefixes are included, and that unlisted numbers are part of the sampling frame. As is typical of most telephone surveys, results for the Community Initiatives telephone survey slightly over-represent women in all race and ethnic groups compared to their demographic representation in the community. To compensate, a weight variable was created using 1990 U.S. Census data for each sex by race and ethnic category. When applied to any analysis involving race, ethnicity or sex of respondent, results will conform to the demographic distribution of men and women 18 years and older in San Antonio. The weight variable is irrelevant to any analysis where race, ethnicity or gender makes no difference. The random sampling process as well as the size of the sample combined to produce findings representative of the San Antonio adult population.

Survey Results

Of the respondents to this survey, 19 percent (243) reported having children requiring day care. The majority of respondents had one child (20%) needing care, an additional 11 percent had two children needing child care, and smaller percentages had more than that. While the percentages reporting 3, 4, 5, or 6 children needing

care are small they typically represent those with greatest need. The more children in day care, the higher the cost to the respondent.

The majority of respondents reported their children needed day care for 5 days out of the week (60%, n=99), although six respondents (4%) reported needing care for 7 days of the week. Another 17 percent (28) reported needing care for their children for 4 or fewer days. The remaining 19 percent (31) reported needing day care, but not having any currently available. Again, although the percentage is small, those needing care for 7 days have greater difficulty in finding available options and incur greater costs.

Analyses indicated that, higher proportions of individuals living inside Loop 410 report the need for child care across all weekly categories. Residents inside Loop 410 are those residing in the older, more inner city areas of San Antonio, most of them, especially on the West Side are predominantly Hispanic and of lower socioeconomic backgrounds. While individuals living outside (45.4%) Loop 410 report a greater monthly cost for day care ($153.00) than those living inside (54.6%) the Loop ($93.00) this could arise because some of the needs of individuals inside the Loop are not being met. Much of the areas inside Loop 410 are poor, inner-city neighborhoods with higher percentages of Hispanics and little access to necessary services including child care.

Twenty eight percent of respondents reported child care occurs in their home, and 72 percent reported that they take their children elsewhere for day care. Further analyses showed that of those who report that their children are cared for in their home, the majority (57%) says their primary child-care arrangements are with relatives. Of this same group (30%) hire someone to come into their home to take care of their children. Another 7 percent report leaving their children with friends, and 5 percent report their children come home after participating in after-school or sports activities. A higher proportion of individuals living inside Loop 410 reported that child care took place in their home than those living outside Loop 410. This is probably in part accounted for by the higher proportion of children in older age categories for individuals living outside the Loop.

The majority of respondents with children in need of day care report that relatives are the primary source of care (29.3%) and that use of commercial day care facilities (28.6%) was a close second. After school activities (17.2%) were third in reported utilization. When comparing respondents who live inside and outside Loop 410 we found that a larger percentage of those living outside the Loop use relatives (29.8% compared to 28.7%), a non-relative or friend paid to come to their home (10.2% compared to 6.7%), after school and sports programs (22.7% compared to 11.8%) and commercial day-care centers (29.6% compared to 27.3%). Individuals living outside Loop 410 have a larger percent utilizing friends (10.5% compared to 1.9%) and non-profit day-care facilities (12% compared to 5.1%). Additionally those living outside Loop 410 are more likely to say their children are left home alone until they return (3% compared to 0.7%). This finding again may relate to the slightly higher proportion reporting children in older age categories (18.5%) compared to respondents living inside the Loop (17.6%).

The proportions of individuals living inside and outside Loop 410 who are very satisfied or satisfied with their child-care arrangements are roughly equivalent (92.9% inside Loop; 95.4% outside Loop). Interestingly, a much larger proportion living inside Loop 410 said they were dissatisfied with their child-care arrangements (5.4% compared to 1.6%), while a larger percentage living outside Loop 410 said they were very dissatisfied with their child-care arrangements (3.0% compared to 1.7%). The latter finding could result from the larger proportion among these respondents who reported that their child stayed home alone. Also because a larger percentage reported their child(ren) engaged in sports activities this extreme level of dissatisfaction could also reflect the need to insure that the children have appropriate transportation to get to practice and to games.

While the number of cases was not large (155) overall a higher percentage of respondents reported dissatisfaction with their current child-care arrangements than reported satisfaction with them (83.8% compared to 74.4%). **T**he largest percentage of individuals who are very dissatisfied with their child-care arrangement is of those who report their child staying with relatives as their primary care arrangement (58.6%). The next highest percentage among those very dissatisfied was of those who reported that their child(ren) stayed home with someone other than a relative or a friend (25.2%). Finally, a fairly large percent of the respondents who used commercial day care reported they were very dissatisfied with the arrangement 16.3%). Among those who reported being dissatisfied, the largest proportion left their children at home with someone other than a relative or a friend (50.9%). Those reporting their children were in after-school programs, in commercial day-care centers (18.6%), and who were left home alone (12%) also had noteworthy percentages reporting dissatisfaction. Interestingly, none of the individuals who said their children stayed home alone until they got home reported they were very dissatisfied with that arrangement.

Among those who reported satisfaction with child-care arrangements, the largest percentages used either a commercial day-care center (38.8%) or said their child(ren) were part of after school programs (25.1%). A large percentage of respondents who reported their children stayed with a relative also reported being very satisfied (34.3%). Additionally, a small but meaningful proportion of respondents using commercial day-care (24.4%) and after school programs (13.7%) reported they were very satisfied with the arrangement. While the percentage of individuals whose children were in sports programs was quite small, they all reported being very satisfied with that arrangement. This finding is likely to reflect the belief that sports activities teach a variety of important skills and values to children.

Respondents were asked about desirability of services to help them meet the developmental needs of their children, and the percent of individuals reporting specific unmet needs that they would like answered were calculated. Responses depict a high level of desired services and unmet needs in the San Antonio community. Close to 50 percent of respondents indicated they would like to see more educational programs for children, and about 20 percent reported a need for more recreational training and for more religious/moral training. Fifteen percent of respondents expressed a desire for career counseling and about 14 percent indicated a need for more group-based

experiences such as Boy Scouts and Girl Scouts. Over 10 percent requested more cultural arts training, over 5 percent saw a need for personal counseling and for vocational training.

With respect to unmet needs that would support the positive development of their children, over 8 percent of respondents reported their children had behavioral problems for which they currently received no help. An additional 6 percent reported that their children needed after school programs, which were not provided, and over 5 percent reported children with learning disabilities for which they were not receiving help. Just fewer than 5 percent reported that needed recreational activities were unavailable for their children, or that their children had health care needs for which they were unable to obtain services. Finally, slightly over 1 percent of respondents reported their children experienced either mental health needs or needs created by physical disabilities that were unmet by current service provisions. The patterns displayed here were similar for individuals whether they lived inside or outside Loop 410.

Clearly members of the San Antonio community express high levels of interest in a variety of programs designed to positively influence the development of children. Additionally a smaller but significant percent of respondents reported various needs currently experienced by their children, which they are unable to meet by accessing current levels of available services. Furthermore high levels of dissatisfaction with current child-care arrangements indicate a large need in the community for various types of child-care services. While affordability is always an important issue, quality day care is needed to provide the opportunity for parents to become self sufficient as well as to provide optimal levels of development for the children of San Antonio.

Conclusion

The growing demand for quality child care is well documented and is occurring in conjunction with critical shortages and problems on the supply side. The economic context of large demand and shortage of supply suggests increasing cost to consumers. This will undoubtedly create even more problems for city officials concerned with both boosting the Bexar County economy and providing citizens with employment opportunities that provide a living wage. Those individuals at the lower end of the socioeconomic spectrum will be most affected by a lack of quality and affordable child care. In spite of recent changes with regards to father's participation, child care remains primarily the responsibility of women. On an average, women's wages still fall below those of men, and female-headed households are far more likely than other families to be poor. Thus these issues will impact women directly to a greater extent than men. However, to label this issue a "woman's issue" is to miss the point. Children are the future of San Antonio and Bexar County. Without affordable, quality care systems many of those children will grow up in economically disadvantaged households with all of the well-documented problems associated with being poor.

It is important to keep in mind the benefits to the local economy associated with investing in adequate, quality child care. Direct benefits include the generation of jobs, and increased employment and earnings for parents. Indirect benefits include decreasing the need for government-supported services as individuals become employed. One study focused on San Antonio[48] stated that assistance to families needing child care should bring a simple annual return of about 46 percent. Thus a good child-care assistance program would not only cover its own cost, but add 46 percent in additional tax revenue for each dollar spent to the community.[49] Benefits also accrue to companies providing child-care services. Employers providing child-care benefits report higher worker morale, reduced absenteeism, increased productivity and lower turnover.[50] Despite these benefits, very few private sector companies provide benefits for child-care services, and those that do often require employees to "choose" among available benefits (e.g., health care, life insurance, child care).[51]

While this chapter has focused on care for children, there are indicators that elderly care is also becoming increasingly important. While only about 1.5 percent of the respondents to our survey indicated a need for elder care in 1999, this would have translated into about 30,000 individuals who needed this service in the MSA at that time. Given population increases and aging among some race/ethnic categories, this figures has increased substantially. All of the same issues (of demand and of supply) are likely to apply in these circumstances as well. In addition because when elderly need care they often also have health problems, the concerns addressed above may be exacerbated by the need for attendants trained in health care.

The solutions are not simple. Given the changing structure of the workforce, the increasing numbers of female-headed households and the types of jobs available in the San Antonio area (tourism, health services, educational services, retail stores), child-care systems must include school-age as well as infant/toddler programs, sick child care, transportation, and after hours care. These increasing services will be necessary, while maintaining affordable rates. Child-care assistance will produce dividends immediately and in the future. Ignoring the increasing demand will cost the community dearly, in terms of building workforce capacity, decreasing the demand for public assistance, and meeting children's developmental needs. Children are our most vulnerable group. How our children are treated reflects on all of San Antonio and Bexar County, and in the end will be the best measure of our future.

NOTES

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CHAPTER 5

CHILD CARE AND THE POTENTIAL FOR BREAKING INTERGENERATIONAL POVERTY

Josefina Figueira-McDonough

Whether measured by physical and mental development, health and survival rates, educational achievement or job prospects, incomes or life expectancies, those who spend their childhood in poverty of income and expectation are at a marked and measured disadvantage.[1]

BREAKTHROUGH EVIDENCE ABOUT THE BENEFITS OF CHILD CARE OR AT-RISK CHILDREN

The case that good child care is the most effective method for preventing intergenerational poverty of at-risk children is founded on evidence about its long-term effects that have been verified by research and experiments carried out in the United States. At the same time, examination of the shortage of public programs in the United States suggests either ignorance or indifference on the part of policy makers. Comparisons between the United States and European countries that offer universal early education programs document a stark contrast in political will and commitment to the development of children.

Theories of the Development of Early Childhood

Interest in child care grew in tandem with the speedy rise of women in the labor market. The ranks of employed women included mothers of young children. Furthermore, attention to the quality of child care was triggered by brain research highlighting the extraordinary capacity for learning from birth to age five.[2] As a child learns, her/his experience of the world changes, and a new world emerges. Knowledge

formation is a relation between children and the world around them. All of us are born with the ability to organize, classify, and impose order on our environment. In effect, children construct theories of the world. Very little of this is the result of instruction. Instead, the process involves the interaction of biological, cultural, and life experiences that shape how perceptions become organized in specific ways. As children encounter new experiences, the theory goes, existing memories in the brain are reshaped. This feedback impacts on linguistic, cognitive, social, and emotional development over time.[3] Important research on early childhood education and care (ECEC) validate this theory.

The Impact of Child Care on the Development of Children from Birth to 5

Since the mid-1980s, research into the effects of child care on the development of infants, toddlers, and preschoolers has expanded significantly.[4] This body of work varies in terms of ages of the subjects, the sizes and characteristics of the samples, the characteristics of the services, and the outcomes measured. Nonetheless, the results are astonishingly consistent.

Studies of infants have mostly addressed the effect of child care on attachment and security. The combined results of 13 studies of infant ages 1 and 2 show that while attachment and security tend to be higher among children who stay at home with their mother than those in care, the difference narrows for those who start care before 7 months of age.[5] Research on older children (3–5) has focused more on affect, behavior, peer integration, and cognitive development, and it has paid greater attention to the characteristics of the services providing care. Parental stability and structured care result in better behavior and allow for more complex play.[6] Engaged, permanent, college-educated teachers, who engage in high interaction with the children in a setting with low children/teacher ratios, promotes greater affect, social reasoning, joint play, language, communication proficiency, and cognitive development. Nonprofit centers and those following federal interagency day-care requirements are likely to have more positive characteristics.[7]

Other studies have looked at the impact that child care has on the subsequent development of the children. These follow-up studies test the original samples up to second grade. Children who had experienced high quality child care show good outcomes on cognitive, social, and emotional outcomes through kindergarten and up to the second grade. What's more, they rate higher in competence and happiness. Such beneficial long-term outcomes are absent among children in low-quality care, more likely to exist in states with minimal child care standards.[8]

The "Cost, Quality and Outcomes Study" used more diverse samples that permitted researchers to separate out the effects of child-care quality on cognitive, emotional, and behavioral outcomes. Good care showed higher positive results, both at the time and in the follow-up studies, for children from at-risk backgrounds, compared to other children. Conversely, low-quality child care turned out to have more negative consequences for the first group than for the second.[9]

In sum, competent child care has demonstrably significant effects on cognitive, behavioral, and emotional development, and these effects carry over at least through the second grade. The ingredients of adequate child care are empirically known to include well-trained, engaged, and stable teachers as well as low child/teacher ratios (preferably 6 or 4 to 1). Standards of child care adopted by states or of child-care associations have an impact on the quality of service-providing centers. Strikingly, the benefits of competent care are heightened for at-risk children.[10]

Experiments: Life Outcomes of Early Education

The research just outlined attests to the benefits of child care for cognitive and behavioral development. Some studies have gone even further in the assessment of the impact of early experiences during later years. The two experiments described below followed careful procedures that have earned the respect of the research community.

The Perry School Study

High Scope, a program geared to the cognitive development of preschoolers, was designed to serve at-risk children in the largely blue-collar township of Ypsilanti in Southeast Michigan. The purpose of its founders was to improve the academic development of children living in the south part of the city, a section of rundown public housing, extensive poverty, and high crime. In the better-off schools of the city, students averaged in the 90 percentile on national achievements tests; in the area served by the Perry school, no one scored above 10 percent.

High Scope was inspired by the ideas of Jean Piaget and clearly emphasized the cognitive development of 3- and 4-year olds. These children were to spend 2 years in the program, 3 hours a day for 5 days a week. The curriculum emphasized problem solving, and the daily routine involved planning, carrying out the plan, and reviewing what had been learned. Teachers were well trained and decently paid, and the child/teacher ratio was 5 to 1. Visits to parents had the purpose of encouraging them to teach their own children and to get the parents to read to them.[11]

The experiment got underway in 1972 and involved a random sample of 127 at-risk 4-year-olds of whom half had frequented High Scope and another half who had not been part of the program. Early results were disappointing. Differences between the two groups at age 7 and 8 were not significant. Follow-up studies at ages 11, 14, 15, 19, and 27, however, came up with remarkable results.

The High Scope children were less often assigned to special classes. They had better attitudes toward school, their parents were more supportive of their schooling, and their high school grade-point average was higher. By age 19, 73 percent had finished high school as compared to 45 percent of the control group.[12] In addition, a follow-up study conducted at age 40 turned up significant differences between the two groups in education, income, crime, and family stability. Nearly twice as many of the Perry School students had earned college degrees, more had gotten jobs, and about only half as many had been arrested for crimes and sentenced to prison. Among the males, nearly twice as many of the alumni sample of High Scope raised their children on

their own, as compared to the control group.[13] The economic return of the program benefits was estimated to be $17 for each dollar invested.[14]

The Carolina Abecedarian Program

This program started in 1972 under the auspices of the Frank Porter Development Child Development Center in Chapel Hill, North Carolina. It offered quality developmental child care for high at-risk children from 4 months to 5 years of age. Care was provided 6–8 hours a week, 5 days a week, and focused on developing cognitive, social, language, and motor skills. All children were born in poverty, mostly to single mothers (75 percent) who were African American (97 percent). The caregiver to infant ratio was 3:1 and increased to 6:1 as the children got older. Activities were customized for infants and children based on readiness. As children reached three years, the preschool program was designed to be playful but targeted toward cognitive development, social and self-help skills, language and fine and gross motor skills. Children were encouraged to speak about their daily experiences. Nutritional, social work, and medical services were available to the families and children.[15]

The evaluation phase of the program included 111 children born in poverty between 1972 and 1977. Fifty-seven of the children had been in the program for 6 years, while fifty-four with the same demographic characteristics had not, although they had received the same nutritional, medical, and social work services. Follow-up data were gathered through age 21: the two groups were assessed at ages 3, 4, 5, 6.5, 8, 12, 15, and 21. At age 3, the children in the program had significantly higher IQ scores than the control group, and those who benefited most were children of mothers with low IQ scores. Through ages 8 to 21 they also had higher scores on reading and math tests, and had fewer grade retentions and special education referrals. By age 21, 35 percent of the treatment group had graduated from high school compared to 14 percent of the control group. Those in the first group were, on average, one year older at the birth of their first child. A more detailed analysis showed that those who had been in the program from 4 months old through kindergarten or until second grade showed better outcomes than those entering the program later.[16]

There is no doubt about the cumulative, consistent nature of these experiments. The results have been replicated in many countries of Europe. The key question now becomes whether care services operated by public agencies reaching vast numbers of children would produce the same outcomes.

Early Childhood Programs Supported by Government Agencies

Head Start

The Equal Opportunity Act of 1964 created the Office of Economic Opportunity (OEO) whose mission was to fight "the war on poverty" and to pay special attention to the needs of the young. Its mandate was to concentrate on local communities. Community Action funds were distributed in direct proportion to the number of indigent children in each state.

Head Start emerged from the implementation of these mandates. Community Action required the involvement of parents in planning the centers and their involvement as teachers' aids. An eight-week Head Start program was launched in the summer of 1965. Its policies stemmed from four premises:

- Universal opportunities for normal growth and development are a right for all children;
- disadvantaged children should be provided selected experiences to increase their level of opportunity;
- activities with sound development principles should be integrated in the home setting of families; and
- the program should eventually become available to the whole nation.

Health, nutrition, and social services were required services for the success of the program. In sum, political and professional leaders who developed Head Start called for a child-centered program that was to be locally controlled, comprehensive, and family-oriented.[17]

Head Start accorded with other programs like High Scope both with regard to the importance it attributed to early childhood education for breaking the cycle of poverty and its insistence on opening opportunities for children born in poverty. But its goals were more ambitious. The program was designed to serve as a channel for parental and community empowerment. This was the aim of Community Action. The broader objectives, the institutional diversity of the program, its size, budgetary constraints, and changes in the philosophy of the federal administration, have all made evaluation more difficult than has been the case for other, smaller programs framed from the outset as test cases for research.

For example, while some early assessments reported positive examples of parental and community empowerment, extensive documentation at later times testified to a virtual breakdown in the implementation of such goals during the decades following the War on Poverty.[17,18] And studies that showed improvement in cognitive and socioemotional development have been criticized on methodological grounds.[19] Subsequent research on academic gains indicates that progress of this sort seem to fade by the second grade, even though former students in adulthood have records of less referrals to remedial education and lower rates of dropping out.[20]

To counter findings that initial academic gains seem to disappear by the second grade, some states have tried to build continuity between preschool programs and public schools, often by having them located on the same campus. Evaluation of these transitional programs indicates that this has resulted in greater rigidity in the management and implementation of ECEC (Early Children Education and Care) as the organizational style of the public schools takes over. By contrast, physical health has been an area of great success of Head Start. Children participating in the program have received more preventive and remedial services and their immunization rates are higher than is the case among other low-income children.[21]

The failure to explore whatever long-term impacts might be associated with Head Start has to do with the lack of precise follow-ups on life outcomes of the sort captured by the samples used in High Scope and the Abecedarian programs. It is worth noting that the earlier High Scope evaluations also showed a loss of cognitive advantages among program participants by the second grade, and this happened with Head Start children as well. Positive life outcomes were discovered in later follow-ups not engaged in by Head Start. Another important difference between the Abecedarian and Head Start programs is the length of children's participation: six as compared to two years, respectively.

Finally, Joseph Califano's prediction that Head Start would become a national program for at-risk children did not come to be. In fact, while 40 percent of poor children under the age of 6 were in the program in 1990, by 2004 only about 20 percent participated. Budget cuts, population growth, and higher poverty rates took their toll.[22]

The Chicago Child-Parent Centers

The Chicago Child-Parent Centers originated in the mid-70s, led by the superintendent of one of the poorer school districts of Chicago. The goal was to build academic success on early intervention and parental involvement in preschool education. Early education would follow instructional approaches, tailored to children's learning styles that developed their speaking and listening skills. This would occur in small classes that permitted individual attention. Health and nutritional services would be part of the program.

Currently there are 34 centers throughout the Chicago public schools. The centers provide preschool to disadvantaged children 3 and 4 years old. In 13 centers, the program is extended from kindergarten to third grade. Each year about 2,500 children take part in CPC. All teachers have bachelor's degrees and early childhood certificates. Each center has a parent resource room staffed by a full-time teacher. Until recently, all parents had to sign an agreement to participate for the equivalent of half a day a week. After 1996, because of TANF work requirements, this stipulation was removed. The program is funded through State of Illinois Title I.[23]

A large-scale, long-term scientific evaluation has been tracing 1,500 disadvantaged minority kids for the past 20 years. About 75 percent of the youngsters attended CPCs, and the remaining subjects came from equally impoverished neighborhoods. The study clearly shows that the program yields substantial benefits. By age 20, the CPC graduate has a 30 percent advantage in completing high school, and by age 21 nearly two-thirds achieve that goal. Furthermore, 40 percent fewer than in the comparison group were held back in school, and had one-third fewer juvenile arrests.

The researchers calculated that for every dollar invested in the preschool component of the program, $7.14 returns to society in increased earnings of participants and in reduced costs for remedial education, crime control, and rehabilitation.[24]

The findings of these two publicly supported ECEC programs demonstrate their viability and, in addition, underpin plans for future national policies. The programs have the same purpose: to equalize opportunities by means of early education for

children in poverty. One program was supported by federal money, the other by state funds.

However, there are evident differences between the two. Head Start has had multiple goals, has been less focused on learning goals, and was designed for shorter periods of intervention. These differences contributed to the more favorable of CPC's impact. The conclusion, nonetheless, is that good public early education programs are viable and that they can have strong, long-term benefits for at-risk children.

THE 1996 WELFARE REFORM AND CHILDREN CARE

Antecedents of Temporary Assistance to Needy Families

Richard Titmuss, the English pioneer of policy analysis, argued that welfare encompassed any government economic advantage given to citizens not based on compensation for work or private exchange. Thus, tax breaks to the middle class and corporations, any type of incentive as well or compensation for farming and failing industries, as well supplements for occupational security, constitute welfare.[25]

In the United States the term "welfare" has acquired a restrictive and negative connotation inasmuch as it is applied exclusively to social assistance for the poor. This pejorative resonance has its source in the charity meanings attached to such programs. American political culture distinguishes so-called charitable beneficence from the notion of rights identified with social insurance, and this tradition has resulted in marginal entitlements.[26]

Aid to Dependent Children, one of the public assistance programs included in the Social Security Act of 1935, reflected the traditional, puritanical interpretation of poverty as self-made. The poor are poor because they are wanting in moral fiber and civic norms. Hence, they have to be treated very strictly so that they embrace the prescribed virtues. Both AFDC and subsequent programs for poor families (AFDC and TANF) perpetuate these beliefs, translated in the form of policies geared to exclude many needy families, punitive regulations applied to families that are included and marginal funding.[27]

The burgeoning of AFDC rolls by the 1960s, together with the creation of the Office of Economic Opportunity and related programs, as well as the passage of civil rights legislation, and urban riots in the wake of Martin Luther King's assassination, gave rise to a white conservative movement. AFDC was blamed for creating poverty. New theories emerged supporting the necessity of obligatory work for the poor.[28]

The eventual outcome was passage of the welfare reform act, signed by President Clinton in 1996. TANF took the place of AFDC. The new policy proclaimed its goal: promoting self-sufficiency. It did away with entitlements, and administration was delegated to the states. Federal contributions were limited and made proportional to the decrease in welfare rolls. Time limits were set on welfare recipients. Work requirements were required for benefits, while special programs encouraged marriage and chastity.[29] Contrary to the evidence, these policies were inspired by the conviction that women were on welfare because they did not want to work, that they were

unmarried because of loose morals, and that they kept having children to prolong their stay on welfare.[30]

Evidence of the Reproduction of Poverty

Gosta Esping-Andersen has argued that occasional, short-term poverty is not an indictment of the state of social justice in liberal democratic societies. However, long-term, persistent poverty *does* represent an unjust entrapment of citizens.[31] The repercussions of life-long poverty on the vulnerability of the next generation exacerbate this entrapment. This situation is incompatible with the principle of equal opportunity central to democracies.

The goal is for children to grow up to be self-sufficient and to contribute to society. The tragic irony is that the vast numbers of children living in poverty in the United States (more than 9 million in 2004, half of whom are below the age of 6) are unlikely to reach or foster that goal. They often drop out of school, have children very young, and by the age of nine have accepted a marginal future.[32]

Frequently such outcomes are blamed on single motherhood. These women form the largest group among welfare recipients. Research on intergenerational poverty has focused on poor single mothers. An analysis of five different surveys concluded that children who grow up in households with only one biological parent are worse off than those raised by both biological parents. Regardless of parental education and race, children living with a single parent are twice as likely to drop out of high school, to have a child before the age of 20, one and a half times to be idle—out of school and out of work by their late teens and early twenties.[33]

In fact, children living with single mothers are five times more likely to be poor than those in two-parent families. Forty-two percent of single mothers are poor. The assumption implicit in TANF policies is that it is single female parenthood in particular that causes poverty. However, an alternative hypothesis holds that the causal sequence is the reverse. Single mothers find themselves in poverty not because they are unmarried; rather, they are unmarried because they are poor. Various studies confirm this explanation for divorced or separated mothers, teenage mothers, and mothers on welfare and living in depressed neighborhoods where male unemployment is widespread.[34] Interestingly, the United States, as compared to western European nations, has the highest percentage of single mothers in poverty, and four times as many as in northern European nations.[35] Regardless of the beliefs that shape TANF policies, the determining reality is that children of poor families live in contexts conducive to failure and inimical to equal opportunity.

TANF Child Care

With the implementation of TANF the obligation of adult recipients to work became inescapable. This requirement triggered a corollary need for child care. It raised, in turn, the importance of the government's role in underwriting child care. The welfare reform of 1996 combined federal programs of child-care subsidies under

the Child Care Development Fund (CCDF). The devolution of welfare to the states meant that they could exercise discretion regarding eligibility and benefits. State governments could use TANF money for child care, either directly or by transferring up to 30 percent of TANF monies to CCDF, and they could add their own funds as well.[36]

Since half of the parents receiving assistance have offspring aged 6 or under, child-care subsidies grew rapidly from 1996 to 2000, and state TANF funds exceeded the primary CCD funding. The number of children receiving subsidies nearly doubled, reaching 1.9 million.[37] The subsidies are generally provided through vouchers set at 75 percent of child-care costs in the community of the recipient. The guidelines for the voucher program are parental choice, work requirement, and priority given to families leaving welfare for work. Co-payments, income eligibility, and reimbursement vary from state to state.

Despite the increase in state funding, a large proportion of low-income working families do not get subsidies. In thirteen of the sixteen states studied, 30 percent or more of eligible children do not receive subsidies. Because funds are insufficient to meet demand, states have rationed services in several ways. In nearly all (47) states, eligibility levels have been lowered. More than half (35) of the states have excluded low-income working parents who are not receiving welfare. Thirteen states require a minimum of work hours for eligibility. All states have limited outreach efforts, leaving many low-income working parents in the dark about the subsidies.[38]

A number of the usual bureaucratic obstacles have cropped up. Intakes have been frozen and waiting lists created. Priorities are set so that only excluding many applicants. Procedures to apply have become more complex, requiring lengthy paper work and office visits, forcing parents to take time from work.[39]

Other barriers stem from the inadequacy of child-care centers in areas where low-income families live. Compounding the problem is the fact that these centers charge high fees, relative to family budgets. As income declines, the proportion of child-care costs goes up. Forty-two percent of families who left welfare for low-skilled, low-wage jobs paid an average of $232 a month for child care in 1999.[40] Another hindrance is that the tight schedules that many low-income women encounter at work reduce their child-care options.

This mismatch between child-care funding and demand worsened in 2001, when many state budgets went into crisis. By then, the states served 18 percent—one in seven—of federally eligible children. The situation has deteriorated further. Thirteen states decreased their investment in child-care assistance in 2002. In one of these states, California, over 200,000 eligible children are on the waiting list.[41]

The costs of services and restrictions on these services jeopardize poor women trying to keep up their work commitments, and lack of access to quality child care aggravates the problem. Parents who get child-care subsidies in the amount calculated for services in their neighborhood are faced with hard choices. Nearly all live in poor neighborhoods, with limited choices, where child-care options may be unsuited to the mothers' work schedules. Faced with these hassles, almost 30 percent of parents with

subsides have recourse to unregulated child care. This means that not even health and safety standards are monitored.[41]

Although states were instructed to devote some of their child-care money to improve ECEC services, there is no evidence that they have engaged in interventions, recommended by child-care experts, such as lower child/adult ratios and improved staff training. By 2003 about two-thirds of a million children of TANF recipients have been cut from Medicaid, SHIP, and other state health insurance programs in 36 states.

Two factors make the deficiency of child care under TANF the Achilles heel of the program. The first concerns the sheer number of children in need. According to 2001 TANF statistics, half of the parents receiving assistance have children under 6 years of age. Second, as evidenced by the research reviewed at the outset, adequate child care offers the best chance to break the intergenerational cycle of poverty.[42]

Other research shows a strong connection between the availability of child care and the participation of mothers in the work force. Child-care subsidies increase the duration of employment for welfare recipients *and* for those off welfare. Forty percent of women receiving this type of assistance are more likely to stay employed at least for two years, compared to those who go without. The impact grows to 60 percent for former welfare recipients, and the benefits show up in the quality and stability of child care.[43]

We know, then, that child care has two crucial effects. It makes it easier for low-income women to work in a sustained manner, and it helps give children a better future.

UNIVERSAL EARLY CHILDHOOD EDUCATION AND CARE

Barriers at Home

Some commentators point out that, at least for low-income workers, child care should not be left to the market, which by definition responds to competitive pressures and profit. But attempts to move toward universal child care have been met with failure in the United States.

By the mid-80s, when millions of children under 5 had mothers who worked, more than half attended day care, the Child and Care Federal Income Tax Credit expanded to cover 60 percent of child-care expenses. Although low-income families are eligible, they have small tax obligations to offset to begin with. At the end of the 1980s, federal expenditures for child care, which benefits mainly low income families, fell by more than 13 percent.[44] Head Start, a promising program in child care for poor children, presently covers only 20 percent of children in need. The Chicago Child-Parent Centers are a successful model but they are limited to that city. The 2006 reauthorization of TANF projects a further decline in child-care opportunities for the beneficiaries of the program. Increases for child care have been limited to 1 billion dollars over the next 5 years. Because states are required to increase the

number of clients meeting the work requirement, this fixed amount will perpetuate or augment the present shortfall.

A concrete example of what will happen in California clarifies the consequences for states battling deficits. California will receive about $24 million annually for child care. But the state will also be required to increase the number of people obliged to work by 45,000. Assuming that only half these families have children under the age of 6, $320 million would be necessary to meet child-care needs. California's budget for 2006 will reduce funding for the state work program by $198,800, and 58 percent of this comes from child care. This is taking place in a state where more than 200,000 eligible children are on waiting lists.[45] For all the knowledge we have gained about how to break the cycle of poverty, the political will to equalize opportunities for children has faltered.

Lessons from Europe

Demographic pressures in western Europe are similar to those experienced in the United States: an aging population, declining fertility, and a female labor force edging close to the participation rates of males. Similarly, the economic restructuring that accompanies globalization has produced a flight of manufacturing jobs to developing countries with low-wage labor.

These similarities notwithstanding, the response of governments has differed sharply on the two sides of the Atlantic. In the United States, top priority goes to cutting back on public expenditures on entitlements while offering market alternatives that, by definition, discriminate against low-income citizens. In most countries of Europe, the objective is to support programs that facilitate women's work and child development. These measures show ingenuity. They try to remedy the demographic imbalance by framing a new gender and family contract, one that increases the number of active workers without decreasing fertility. Most countries in northern Europe, and more and more in southern Europe, have managed to respond to growing demands for health, education, and assistance by creating jobs that are attractive to women because they offer decent pay and schedules consistent with family needs. In spite of fears of gender segregation, in a country like Sweden, women make about 77 percent of what their male counterparts earn, as compared to 52 percent in the United States. Furthermore, the poverty of single mothers in northern European countries ranges from about 10 to 20 percent as against 46 percent in the United States.[46]

An important policy tying women's work to fertility is maternity leave. Among the 12 countries surveyed in 2001 by the OECD, all the European members, including the Southern tier of countries like Italy and Portugal, have maternity leaves for 15–21 weeks with wage replacements over 80 percent.[47]

A parallel concern is with the education of children. The view that has taken hold in Europe is that in a global labor market the future of developed countries depends on creative and innovative individuals able to contribute to new technologies. Economic success and employment depend on the education of future citizens.[48]

Research on child development in Europe shows the same results as in the United States,[49] though the lead remains with United States in terms of the sheer quantity of investigative work.[50] The consequential difference lies in how governments in Europe have reacted to scientific findings through public policies. A 2001 report of the Organization for Economic Co-operation and Development (OECD) on *Early Childhood Education and Care* (ECEC) permits an evaluation of existing policies in 10 European countries.[51] In all countries, with the exception of the United Kingdom, there is a funded provision to give full time ECEC to children aged 3–6. All children can have at least 2 years of early education before beginning compulsory school. The ECEC entitlement was introduced earlier in Sweden, Norway, and Denmark. At the end of the last century, the coverage topped 90 percent in the 3- to 6-year-old group. In other countries, with the exception of United Kingdom, similar rates were expected by mid-decade.

Care for infants and toddlers below age 3 is predominantly offered in centers and family care homes, and all these places charge parental fees albeit on a sliding scale. The number of public *créches* is growing. The simultaneous decrease of informal arrangements indicates widespread acceptance of the quality of these public, affordable systems.[52]

As in the United States, the quality of ECEC programs is defined by staff training, child/staff ratio, and pedagogical orientation. These characteristics are in turn influenced by funding, by the ministry in charge, and by national/local management. Staff training for ECEC of the 3–6 age group requires college education in all countries. In public programs for younger children, training criteria are specialized, but a university degree is not required. One of the factors influencing this difference is the fact that most of the later programs are under welfare rather than education departments.[53]

Only in Sweden have both programs been nationally planned and managed by the education ministry. Because the ECEC is integrated in the education department, staffing requirements are the same across the system, as are salary and professional status. This also facilitates the mobility of staff from ECEC to regular school programs.[54] Other countries prefer national/local joint responsibility. This arrangement gives more flexibility of implementation, allowing for adjustments to community needs, including the development of special strategies for reaching out to at-risk children. This is the case with the Capabel project in Amsterdam. It added neighborhood family groups who could use play facilities, mother–child home instruction, service referrals, and organized social and political support. Similar programs have evolved in Denmark, Belgium, and Italy.[55] In many of these cases, national regulations focus on curriculum and expected outcomes to avoid inequality in the delivery of ECEC goals.[56]

The child/staff ratios recommended by the ECEC network are somewhat larger than those favored by research teams in the United States: 1:4 for children under age 1; 1:6 for children aged 1 and 2; 1:8 for children aged 3and 4; 1:15 for children aged 5 and 6. All programs goals include cognitive, social, and value dimensions (civic and/or moral) of development.

These public programs operate with practically universal coverage of young children, and most have statutes that give priority to those with special needs or to at-risk children. Conversely, evidence from studies in United Kingdom and the United States suggests that market-driven approaches have contributed to an uneven growth in ECEC. In particular, supporting the provision of ECEC through subsidies has led to shortages in low-income areas, where private and nonprofit operators find it difficult to survive.[57] These shortfalls become even more serious once it is recognized that in the late 1990s nearly three times as many children, proportionately, were in poverty in the United States than in Denmark.[58]

According to projections based on OECD data for the same period, eliminating child poverty in the United States would represent an added cost of 0.30 percent of the GDP.[59]

While the disconnect between know-how accumulated in the United States and public policy in the implementation of ECEC has been highlighted here, it would be a mistake to infer that important groups have not attempted to improve the situation. Since the 1990s the National Council of Teachers of Mathematics, the American Association for the Advancement of Science, the National Teachers of English, the National Commission for the Social Studies, the National Association of Elementary School Principals, the National Association of State Boards of Education, the Association for Supervision and Curriculum Development have all joined forces to call for early childhood curriculum and assessment guidelines.[60] More recently, the Office of Educational Research and Improvement in the Department of Education has funded the National Center for Early Development and Learning to conduct multi-state prekindergarten programs. This includes center-based programs for 4-year-olds that are fully or partially funded by state education agencies operated in schools or under the direction of state and local education agencies.[61]

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52. See OECD (n. 47 above), pp. 129–130.

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CHAPTER 6

UNDER A WATCHFUL EYE: PARENTS AND CHILDREN LIVING IN SHELTERS

Donna Haig Friedman

"BECAUSE YOU SEE ME, I EXIST"

With these six words, two mothers who had been homeless with their children opened a celebratory event in Boston.[1] Later in the program, one by one, 20 other previously homeless mothers took the microphone and each in turn addressed the audience of supporters with the words:

> "Because you see me. . . . "

Each finished her statement with a uniquely personal achievement or aspiration.

> "Because you see me, I am two weeks away from graduating with a Masters degree in communications."
>
> "Because you see me, my children are doing well in school."

Not being seen is the worst hardship a human being can suffer. Consider the words of Joseph Wresinski, the founder of the international Fourth World Movement that works to break down social exclusion across the globe:

> "For the very poor tell us over and over again that a human being's greatest misfortune is not to be hungry or unable to read, nor even to be out of work. The greatest misfortune is to know that you count for nothing, to the point where even your suffering is ignored. The worst blow of all is the contempt on the part of your fellow citizens. It is contempt that stands between a human being and his rights. It makes the world disdain what you are going through and prevents you from being recognized as worthy and capable of taking on responsibility. The greatest misfortune of extreme poverty is that for your entire existence you are like someone already dead."[2]

To place this perspective in context, bear in mind that:[3] "40% of the world's population does not have electricity; 33% of the world's children under five suffer from malnutrition; 47% of the world's population lives on less than two US dollars per day; while, the total wealth of the 200 richest people in the world is 1.14 trillion dollars." A little closer to home, the income gap between the wealthiest and poorest persons in the United States continues to grow,[4] and with it, homelessness of both families with children and lone individuals.

FAMILIES IN POVERTY AND HOUSING INSTABILITY

Over the past 25 years, the U.S. government has disinvested in the production of low cost housing units and housing assistance, redirecting its resources toward urban revitalization and home ownership[5], and, in response to the subsequent growth of homelessness in the country, toward homeless assistance support services and residential programs. Likewise, radical policy shifts and budget cuts have impacted families poor enough to use or be eligible for public assistance.[6] In particular, the entitlement to welfare ended in 1996; five-year lifetime limits for welfare receipt were established; and the majority of welfare-reliant families were required to enter the paid workforce. Work as the pathway out of poverty was widely supported by both policymakers and the general public. As of 2000, only 16 percent of families in poverty in the United States were utilizing welfare; down from 46 percent in 1973.[7]

By 2006, more poor U.S. families did indeed have a head-of-household in the workforce; however, the squeeze between housing costs and incomes continues to threaten the housing stability of large numbers of working poor households. In no part of the United States can a full-time minimum wage worker pay for private market housing with just 30 percent of his/her income, a HUD standard for housing affordability.[8]

According to the U.S. Department of Housing and Urban Development, nearly 5 percent of all households in the country (5.1 million households) have worst case housing needs, that is, they pay more than 50 percent of their income for housing; they have no housing assistance, are renters, and have incomes below 50 percent of the area median income (AMI). Most of these households have extremely low incomes (below 30% of AMI) and pay an average of 76 percent of their incomes for rent; many adults heading these households work in low-wage jobs.[9] Households headed by persons of color, elders, sole women with children and, renters are more affected by the income-housing squeeze than are others.[10]

The demand for low-cost housing far outstrips the supply of housing subsidies or low-cost units. On average, an eligible U.S. household would have to wait nearly $2^1/_2$ years for a Section 8 housing voucher.[11] The wait is much longer in many communities across the country. One estimate of need, highlighted in the 2002 Millennial Housing Commission Report and cited in Bratt, Stone, and Hartman, indicates that 250,000 low-cost housing units would need to be created each year for the next 20 years to meet the demand.[12]

MORE SHELTERS, FULL SHELTERS

Based upon the most extensive and conservative analysis to date, 23–35 million people are homeless in the United States annually, 1 percent of the United States population, 6–9 percent of those in poverty and 6–9 percent of children in poverty.[13] An estimated 3 percent of the country's population is homeless over a 5-year period.[14] Contrary to widely held assumptions that lone individuals living on the street are the most typical "face" of homelessness, children comprise 39 percent of those who are homeless in the United States each year.[15] However, many children are living apart from their parents when homelessness hits the family; homeless men and women report that 74 percent of their children are not living with them when they are using homeless assistance services.[16]

Families' use of shelter nationally has increased over the past 15–20 years. Between 1987 and 2001, emergency shelters increased in size and were more likely to be full each day and night.[17] As of 1996, emergency shelters in the United States served 239,600 persons per day on average;[18] 40,000 homeless assistance programs in 21,000 locations were providing service to homeless men, women, and children across the country's urban, suburban, and rural communities, nearly half located in central city areas.[19]

THE COSTS OF HOMELESSNESS AND SHELTER LIVING

The Economics

Sheltering low-income families is much more costly than providing them with rental assistance and/or other homelessness prevention resources. For example, Washington, DC, spends $7,000 on average per family household for prevention as compared to $11,500 per household for shelter. In its first 4 years, 70–80 percent of families served by its prevention program were successfully housed and had not fallen into homelessness.[20]

In Massachusetts, the state spends $43,000 to $56,000 per family each year to secure shelter space for the families the state expects to shelter.[21] In contrast, the state spent only $16,200 per family per year for a pilot transitional housing program with a history of success that allows each family to live in a private apartment and receive intensive service support.[22] The state spends an average of $3,000 or less for families served by its homelessness prevention program.[23]

For the past decade, Hennepin County, Minnesota, has been a leader in implementing a community-wide homelessness prevention network and has evidence of its success. In 2002–2003, the County spent $472 on average per family for prevention services, with a 95 percent success rate—no use of shelter for at least 12 months after intervention.[24] Using a rapid-rehousing approach for homeless families, the County significantly reduced the time families lived in shelters and have documented an 88 percent success rate; the average cost per family was $800 for this intervention. Finally, the cost of an intensive transitional housing program, an alternative to shelter, was $3,668 on average per family, resulting in a 96 percent success rate.[25]

The lion's share of resources to fight homelessness in the United States is nonetheless tied up in maintaining and expanding the country's residential emergency shelter system.[26] Housing assistance resources, on the other hand, have been inadequate for over 40 years and subject to relentless cuts, even though having a housing subsidy or access to low-cost housing clearly prevents families from falling into homelessness or returning to the shelter system.[27]

The Human and Social Costs

Shelter as an acceptable housing option for low-income families is costly in other ways as well. The impacts of family homelessness on children and their parents are well documented. The humiliation of not being able to house one's children rips at a parent's core sense of self.[28] When a mother feels this way, her children feel the pain as well.

Children are highly vulnerable.[29] Forty percent of children in families surveyed in New York City family shelters[30] , representing 75 percent of all children in shelters in the city, had asthma; half had symptoms consistent with mild to severe asthma; over half had used emergency rooms for medical care.[31] Childhood homelessness is a risk factor for homelessness as an adult.[32] Homeless mothers have reported that 39 percent of their children under 18 were not living with them and, for those children who were with their mother or father in a homeless assistance program, 46 percent of their parents reported that one or more of their children had had an alcohol, drug, or mental health problem in the past month.[33]

Relentlessly high levels of stress, frequent dislocations that result in cut off from friends, family, and familiar surroundings, discontinuity in educational experiences, and a sense of social exclusion are but a few of the realities in children's lives when they are without a home; they share these realities with their parents, whose well-being is intricately intertwined with their own.[34]

Children are also resilient.[35] Developmental, social, and emotional setbacks for children can be ameliorated if the surrounding environment provides safety and is conducive to development of their competence, curiosity, sense of empathy, and connection to at least one responsive and caring adult.[36] Parents have a greater chance of creating such an environment for their children when they themselves have a sense of economic and housing security. When families have no other alternative than shelter, the presence of a supportive, respectful, safe, and predictable environment has the potential to reverse the damage sustained by both parents and their children on their traumatizing homelessness journeys.

UNDER A WATCHFUL EYE

Families who have secured living space in shelters in which they share kitchens, living rooms, bedrooms, and laundry facilities with others find themselves under the watchful eye of other parents and children, as well as shelter staff; the staff have the power to offer resources that lead to housing and the power to take away shelter.

Paradoxically, support for parents and children may be close at hand, however the closeness may contribute to unwanted staff intrusions into private family matters.

Inherent Complexities of Shelter Life

Shelter Life Is Anything but Easy for Families

> "My whole family was living in one room. Granted it was the biggest room in the house, but it was barely big enough for the five beds, a crib, and one large dresser. My children previously had their (own) room, a large backyard to play in, and a screened-in porch with their own bathroom. We had to adjust to sharing the room with several different mothers who each had one small child and didn't seem to stay more than a few days . . ." [37]

The potential exists for parents living in shelters to have their *best* and *worst* moments. At times hardship brings out the best in people. However, when stress is unrelenting, it is hard to shine. In shelter settings, parents may experience their authority with their children being at odds at times with staff who have a responsibility to ensure predictability and security for all who live in the shelter. The intimacy that housed parents have with their children in the privacy of their own homes is hard to come by for families living in congregate shelters. Parental routines with children have been disrupted for extensive periods of time during families' harrowing journeys prior to entering shelters. This disruption continues in shelter settings where so many routines of daily living are alien to those of the individual families.[38] When children begin to feel safe in a shelter setting, they may need to let down; predictable clashes are likely to take place between and among children in shelters. These moments may be embarrassing for parents if support and understanding from staff is lacking. Add to this circumstance the challenge of mixing parenting and family routines, norms, and traditions with families of different ethnicities who are living together in shelters, and you have a recipe for the exacerbation, rather than amelioration, of the effects of long-standing stress on individual children and their parents.

Working in and Managing Shelter Programs Is Also Challenging

> "At times, the issues were so great for a family that they just couldn't see beyond their situation. . . . I have been cursed out, I have been called every name in the book. At times, I've wanted to throw in the towel . . . and then at that moment someone or something would happen to remind me why I was doing the work . . . I know that my life was changed and I would say that (the family's) life was changed by our interaction."[39]

Frontline staff and shelter directors also face challenges as they attempt to create environments that will ensure order, predictability, fairness, safety, and flexibility for all. For shelter staff, help-giving fatigue is not unexpected; absorbing family pain can and does take a toll. Limited time and space boundaries in shelter settings create a heightened intensity, one that is more taxing on shelter staff than is the case for help-givers who work in nonresidential human service settings. The pressure on shelter staff is considerable. At times, the chemistry among parents, children, and staff may

be problematic and undoubtedly affects staff members' stress levels on the job. They are held accountable if conflicts between and among family members get out of hand or if anyone's safety is put at risk on their watch. Finally, shelter staff constantly face dilemmas related to responding flexibly to unique family circumstances and requests, while trying to apply shelter policies and rules fairly.

MAXIMIZING SUPPORT AND MINIMIZING HARM

Being under a watchful eye and being seen are qualitatively different experiences for parents and their children in shelters. Parents speak of negative encounters as ones in which they feel as though they are under a microscope; while they view positive helping encounters, "being seen," as the triggers for transforming their lives.[40] The paradox of help-giving, simply stated, is that seeing and accepting a man, a woman, a child *as is* opens the door for growth.

Help-Giving Approaches[41]

Professional or paraprofessional helpers, shelter staff in this case, have options regarding how they intervene in the lives of the families living in their shelters. Senge and his colleagues offer a relevant help-giving framework: helper as expert or helper as partner.[42] Determining when to use which approach and assessing the impacts of each approach is worthy of reflection.

The Helper As Expert: Diagnosing, Giving Advice, Taking Charge

> "Parents in shelters have many outside influences pressing down on them. The anger has to go somewhere . . . An asset-approach to helping parents in crisis can prove very effective, rather than using a deficit-approach or assuming that parents have negative intentions. I remember the phrase 'Keep hope alive!'. It picked me up when I felt myself sinking too low. The negative attitude of a staff person can bring down the best."[43]

An "helper as expert" model of help-giving is one in which helpers fix the problems at hand, through taking charge or giving advice aimed at changing behaviors perceived by the helper to be causing the problems. Such a "take charge" approach may be critically important for shelter staff to use during emergencies or when the safety of children and/or parents is threatened or when, after soliciting considerable input from those affected, a staff member makes a decision that simply has to be made. At its worst extreme, a "helper as expert" approach may be harmful to families; a diagnosis orientation can inadvertently become a deficit-oriented lens[44] that obscures *seeing*. Recently, a woman who directs an activist community organization in California likened her experience of being a human service client to feeling like a "turtle on its back," completely helpless and at the mercy of help-givers. She had experienced the worst impact of a help-giving framework that emphasizes pathology, dysfunction, and an obsession with compliance. These are the very barriers that lead parents to feel as though they are being treated like children or prisoners when they live in shelters.

These are the very forces that drive men, women, and youth to live on the streets, in their cars, or in their own tent cities rather than seek shelter.[45] Parents submit to oppressive shelter situations because of their children. And, when treated badly, they leave shelter with a sense of bitterness and shame.[46]

The Helper As Teammate, Learning Partner and Facilitator

> "There are many who would challenge crossing the sometimes sterile boundaries between professional and relational roles . . . It is our experience that moves us to cross those boundaries. For among all of us who are first of all human beings, there is a search for meaning, a human cry for connecting, bonding . . . the experience of community." [47]

An "helper as partner" model of help-giving is one in which helpers and families enter into a relationship with a vulnerability that opens the door for both to be changed in the process,[48] a "power with," rather than "power over" relationship. Using this way of building relationships with families, helpers are called to be reflective, to let go of fixed, win-lose mindsets and to work toward equality in the relationship, to actively intervene without judgment.[49] Each person has a core role to play; each holds the self and the other accountable. Both parties pay attention to active listening, teamwork, reciprocity, and the minimization of indebtedness.[50] Two-way reflection on the relationship takes place in a context of safety. Helpers invite parents to actively question their suggestions. Parents expect to actively question and to share their insights. Together helper and parent consider alternative pathways to growth grounded in a parent's dreams for herself and children. This way of working can be scary, as it requires professionals to let go of control and make a commitment to an inherently uncertain process.

This asset-oriented framework focuses more on how parents have overcome adversity and sustained their families and less on how they succumbed to hardship.[51] "Strength spotting"[52] is the detective work undertaken in assessment processes grounded in this way of seeing; professional energy is focused on recognition of parents' and children's capabilities, positive intentions, and adaptive survival strategies.[53] The result is that both helper and parent see something new; the seeing together has a "healing quality."[54] Such encounters can lead to a deep internal transformation, a radical shift in the ways in which parents see themselves and tell their life stories, from stories of self-blame and victimization to ones that acknowledge external influences on the family's circumstances and recognize parents' resiliency in the face of hardship, and efficacy and hope as they move forward into the future.[55]

Organizational and Programmatic Approaches that Promote "Seeing"

> A fundamental principle of communication is this: if we change our perceptions, we can change our feelings and ultimately our behavior . . . Staff are challenged to identify themselves not exclusively by what they do—by their roles and tasks—but to go deeper and understand their primary identity, the spirit from which behaviors flow. Our roles and functions do not define who we are! We are, first of all, human beings who on life's

> journey have developed significant assets, capacities, and gifts, while still having multiple needs that yearn for fulfillment. This experience has a leveling effect on all of us.[56]

As reflected in the words above by the visionary leader of an agency that, among other services, operates a family shelter in Boston, an extraordinary commitment at an organizational level, from the top down, is required for reflective, respectful, and collaborative practice to become the norm as staff members interact with each other and with the families they serve. Learning to act from such a trusting and collaborative stance takes skill and time. This organizational environment is not easy to create and is always a work in progress, even for those leaders and staff who are highly committed to these values.

A Culture of Reflectivity

Leaders and staff of learning organizations have to actively work toward establishing a culture of reflectivity that invites ongoing organization-wide self-examination, creativity, and imaginative thinking.[57] Across the whole organization, leaders will need to provide board, management, staff, and families with concrete and practical ways of committing themselves to building a holistic organizational environment that fosters transformational relationships and community.[58] Kofman and Senge's design principles provide a framework for building the capacities of managerial leaders to promote such an organizational environment:

> (1) The learner learns what the learner wants to learn, so focus on key managerial issues; (2) The people who need to learn are the ones who have the power to take action, so focus on key operational managers, as opposed to staff; (3) Learning often occurs best through "play," through interactions in a transitional medium where it is safe to experiment and reflect; (4) Learning often requires slowing down the action to enable reflection to tacit assumptions and counterproductive ways of interacting; or at other times, speed up time to reveal how current decisions can create unanticipated problems in the long term; (5) Learning often requires "compressing space," as well as time, so that the learner can see the effects of his or her actions in other parts of the system; (6) This transitional medium must look like the action domain of the learners; (7) The learning space must be seamlessly integrated into the work space for on ongoing cycle of reflection, experimentation and action.[59]

Concrete evidence of a dynamic learning environment, as applied to shelter settings, is the creation of leadership opportunities for staff and families, established avenues for them to have substantive decision making roles regarding the shelter's daily operations, particularly those that directly impact the quality of their lives.[60] Another example is the creation of time and space for planned, reflective conversations at staff and house meetings and using these dialogue spaces productively to reexamine organizational mission, values, purpose, and effectiveness. Success in such efforts is dependent upon effective professional development approaches that build staff competencies in teamwork, the de-escalation and mediation of conflicts, community building, and respectful, asset-oriented, and culturally competent practice.

Shelter Spaces

Organizations desiring to lay the groundwork for transformational relationships and to bring out the best in parents, children, and staff will need to create shelter spaces that foster community building and convey a message of respect, safety, and warmth. The physical environment matters and deserves attention. Nearly half of the country's emergency shelters serve over 100 people at a time.[61] Barrack shelters are less common currently than they were 20 years ago; however some version of shared living is still characteristic of 69 percent of emergency shelters in the United States.[62] Only about one-third of emergency shelters have indoor or outdoor play spaces for children.[63]

To create a sense of home and to build community in shelters, while limiting tensions resulting directly from a lack of privacy and overcrowding, organizations will need to determine how many families they can maximally shelter at any given time. What are the possibilities and constraints of the physical environment? In what ways can shelter environments be designed to enable family members to remain together[64] and to ensure that they are accessible for persons with disabilities?

RESISTANCE TO PERPETUATION OF THE SHELTER INDUSTRY: INVESTMENT IN PERMANENT SOLUTIONS

Organizations that provide shelter to homeless men, women, and children are part of an extensive industry in the United States. Originally, shelters were established as "emergency" housing; they are now woven into the fabric of most communities in the country. National, state, and local homeless assistance organizations rely for their survival on resources directed specifically for those who are homeless. Without considerable soul-searching and intentional redirection, such organizations could *inadvertently* find themselves engaged and invested in sustaining the problem, becoming dependent upon the continuation of homelessness and of ever increasing public, private, philanthropic, and other homelessness-oriented resources.

An alternative pathway for sheltering organizations is to become change agents, building up alternative futures for their organizations that are directed toward implementing and advocating for the long-term solutions, planning as if homelessness was on the decline. Such organizations, with deep knowledge of low-income households' circumstances, hopes, and capabilities, are in a strong position to contribute to the development of low-cost housing in their communities, to develop educational, income promotion and neighborhood safety net supports, and to advocate for a significant redirection of public resources toward low-cost housing, housing assistance, and homelessness prevention.

CONCLUSION

In conclusion, it is time to invest in what are known solutions for ending family homelessness in the United States. As a country, the disinvestments and cuts in low-cost housing and housing assistance, as well as income support and education

have inadvertently led to a perpetuation and institutionalization of shelter as a viable long-term family housing option; in many cases, shelter life has exacerbated family stress as well as parental depression and internalized self-blame.

Some states and local communities are mobilizing to put an end to homelessness through system-wide prevention efforts that seek to enable families to hold on to their housing before they lose it. Such efforts will fail to be successful without substantially higher federal investments in low-cost housing, housing assistance, and income supports for low-income households, as well as effective workforce development and education initiatives.[65]

Nonetheless, for now and the foreseeable future, many families without homes are left with no alternative but to live in a shelter for long or short periods of time. Real attention needs to be given to the quality of the shelter experience so that, rather than being *watched*, these families experience help-giving that effectively taps their aspirations, sets high expectations, provides high levels of support, and enables both parents and children to come out the other side full of pride, feeling whole as individuals and as a family, feeling connected, having sparkled, having been recognized, honored, and *seen*.

NOTES

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2. J. Wresinski, *The Very Poor, Living Proof of the Indivisibility of Human Rights*. Translation of a contribution to a fundamental review of Human Rights by the National Advisory Committee on Human Rights (Paris, France: Editions Quart Monde, 1989); See also Jona M. Rosenfeld and B. Tardieu, *Artisans of Democracy: How Ordinary People, Families in Extreme Poverty, and Social Institutions Become Allies to Overcome Social Exclusion* (Lanham, NY: University of America Press, Inc., 2000).

3. Y. Arthus-Bertrand, *The Earth From Above: 365 Days* (New York: Harry N. Abrams, Inc., 2000), 1.

4. Chris Tilly, "The Economic Environment of Housing; Income Inequality and Insecurity," in *A Right to Housing*, ed. Rachel Bratt, Michael Stone, and Chester Hartman (Philadelphia, PA: Temple University Press. 2006), 25–26; Chuck Collins, "The Economic Context: Growing Disparities of Income and Wealth," *New England Journal of Public Policy* (Fall/Winter, 2004/2005): 49–56.

5. National Low Income Housing Coalition (NLIHC), "FY 07 Budget Chart for Selected Programs," http://www.nlihc.org/pubs and NLIHC, "The Crisis in America's Housing: Confronting Myths and Promoting a Balanced Housing Policy," http://www.nlihc.org/pubs. According to the NLIHC's calculations, for the entire period from 1976–2006, relative to other programs that target low income people (income security, food and nutrition, social services, and Medicaid), federal funding for housing assistance has been much lower; when federal expenditures for those other programs began to rise in the 1990s to its current levels ($150–$360 billion range), housing assistance remained low ($30–$40 billion range). Over the past 40 years, HUD's Budget Authority, resources primarily directed at low income households, decreased by 59 percent from $76.9 billion in 1976 to $31.5 billion in 2006, while federal housing-related tax expenditures, primarily benefiting investors and homeowners who have incomes high enough to file an itemized tax return, increased by 353 percent, from

$29.4 billion in 1976 to $133.2 billion in 2006. See also the Center for Budget and Policy Priorities (CBPP), "Initial Assessment President's 2007 Budget: Impacts on Housing Voucher Program and Hurricane Recovery," Barbara Sard, Douglas Rice, and Will Fischer, Revised February 17, 2006, www.cbpp.org/2-17-06hous.htm. According to the CBPP, the President's FY07 proposed budget cuts $622 million from the HUD budget (1.8%)—most cuts hit HUD programs other than homeless assistance which is proposed to increase over last year's expenditures by 15.8 percent. A slight funding increase over 2006 is proposed for HUD's housing voucher program; this increase will fund the same number of vouchers as in 2006, and will not fully make up for past cuts (65,000–100,000 federal vouchers were lost nationwide between 2004 and 2005).

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7. Mimi Abramowitz, "Saving Capitalism from Itself: Whither the Welfare State?" *New England Journal of Public Policy* (Fall/Winter 2004/2005): 21–32.

8. National Low Income Housing Coalition, Out of Reach (Washington, DC: NLIHC, 2005).

9. U.S. Department of Housing and Urban Development, *Affordable Housing Needs: A Report to Congress on the Significant Need for Housing* (Washington, DC: December 2005).

10. Michael Stone, "Housing Affordability: One-Third of a Nation Shelter-Poor," in *A Right To Housing*, ed. Bratt et al. (Philadelphia, PA: Temple University Press, 2006).

11. Bratt et al., "Why a Right to Housing Is Needed and Makes Sense," Editors' introduction. In *A Right To Housing*, 2006.

12. Bi-Partisan Millennial Housing Commission, *Meeting our Nation's Housing Challenges*, Submitted to the House of Representative's and United States Senate's Committees on: Appropriations and subcommittee for VA, HUD and Independent Agencies and other committees, Washington, DC, May 30, 2002; Bratt et al., 2006, 12.

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17. Y-L Wong, and H. Nemon, *The 2001 Survey of Homeless Service Providers: A Profile of Programs Providing Residential and Non-Residential Services for a Sample of U.S. Jurisdictions*, Report prepared under contract with Aspen Systems Corporation for the U.S. Department of Housing and Urban Development (Philadelphia, PA: University of Pennsylvania, 2001).

18. Ibid.

19. Burt et al., *Homelessness*.

20. Center for the Study of Social Policy. An Assessment of the District of Columbia's Community Care Grant Program (Washington, DC: June 2003).

21. One Family, Inc. *An Unprecedented Opportunity*. Presentation by Susanne Beaton at the Massachusetts State House (Boston, MA: Author, February 7, 2006).

22. John McGah and Amy Carlin, *Massachusetts Department of Transitional Assistance Homeless Prevention Pilots*, A report prepared for The Boston Foundation (Boston, MA: The Boston Foundation, June 2005).

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26. Center for Budget and Public Priorities, 2006.

27. Cushing N. Dolbeare, *Changing Priorities: The Federal Budget and Housing Assistance, 1976–2006*, NILHC, May 2001 at www.nlihc.org/pubs; Dennis Culhane, *Family Homelessness: Where to from Here?* Presentation to Associated Grant Makers foundations (Boston, MA, May 23, 2005); Marybeth Shinn and Jim Baumohl, "Rethinking the Prevention of Homelessness," *Proceedings of Practical lessons: The 1998 National Symposium on Homelessness Research,* cosponsored by the U.S. Department of Housing and Urban Development and the U.S. Department of Health and Human Services (Washington, DC, 1998); Marybeth Shinn, Beth C. Weitzman, Daniela Stojanovic, James R. Knickman, Lucila Jimenez, Lisa Duchon, Susan James and David H. Krantz, Predictors of Homelessness Among Families in New York City: From Shelter Request to Housing Stability, *American Journal of Public Health* (1998): 1651–1657; Debra Rog, C.S. Holupka, K.L McCombs-Thornton, Implementation of the Homeless Families Program: 1. Service Models and Outcomes. *American Journal of Orthopsychiatry* (1995): 502–513.

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43. Deborah Gray, *Parenting in Public*, 114.

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57. F. Kofman and P. Senge, "Communities of Commitment; The Heart of Learning Organizations," *Organizational Dynamics* (1993): 5–23.

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CHAPTER 7

THE WORK OF COORDINATING CHILD CARE FOR RURAL LOW-INCOME MOTHERS*

E. Brooke Kelly

Transformations in the nature of employment and the demographics of families have prompted increasing attentiveness to the interface of work and family life. Declines in manufacturing jobs have contributed to increasing unemployment rates and an overall decline in men's earnings. At the same time, service jobs are on the rise, with a large share of jobs that are deskilled, nonunion, poorly paid, with little autonomy and job security. These jobs are typically filled by teenagers, women, and people of color.[1] As industrial jobs that previously afforded men a wage that could support a family become scarcer and women's earnings become more crucial to families, women have been increasingly pulled into the labor force.[2] Such changes in the sort of jobs that are available have not only affected two-parent families, however. Men's decreased earning power has also contributed to higher numbers of female-headed households due to a decline in the number of men who are viewed as suitable marriage partners.[3] These single-mothers often struggle to support their families on low-wage service jobs, contributing to the feminization of poverty,[4] an increase in the number of women and children living in poverty.

Rural areas have experienced a similar, yet slower decline in industry and increase in service jobs. These changes have been accompanied by a decline in agricultural jobs as farms become larger due to increased mechanization.[5] The distribution of jobs by sectors, however, varies greatly from one rural area to the next. Jobs in rural areas are more dispersed, with fewer employers in the local labor market and less variety of jobs than in urban areas.[6] The share of workers in jobs that are low-skilled and at the low end of the pay scale is well above the nation's in rural America.[7] An increasing number of African Americans, Latinos, and Asian Americans are being pulled into rural communities to fill low-wage jobs. Accordingly, farm workers have one of the lowest median weekly earnings by occupation with the

largest percentage of workers who belong to a minority group, most of whom are Hispanic.[8]

Services are now the source of slightly more than half of all rural jobs, compared to about two-thirds of urban jobs, providing 73 percent of rural women's total employment Within rural service sectors, women are relatively concentrated in retail trade, which has the lowest average pay of any major industry.[9] In their research on rural economies and families, Albrecht et al. found that when the proportion of the labor force working in the service sector increased, men were less likely to be employed, and, in turn, female-headed households were most prevalent. Although the rural poor are more likely to be married than those in central cities, the number of female-headed families is growing. Albrecht et al. argue that such changes are related to higher levels of rural poverty.[10]

Such transformations demonstrate the dynamic interchange between the realms of work and family. Accordingly, a growing body of scholarship[11] has developed to investigate the ways these two realms of life intersect and overlap at both macro levels, as in the economic transformations and trends addressed above, and micro levels, as individuals attempt to juggle, balance, and, more recently, weave[12] the competing and often contradictory demands of work and family life. Central to the study of work and family and the demystification of work and family as separate spheres[13] of life is the issue of child care. For working parents, managing child care around the demands of paid work can be a challenging endeavor. However, until recently much of the literature on work and family has focused on middle-class dual-earner families (with two employed parents), assessing changes in the division of labor in child care and housework as increasing numbers of women take on "second shifts"[14] at home after coming home from their first shift of paid work.[15]

In anticipation of and following welfare reform in 1996, research on low-income families has increased, largely in an effort to assess the impact of such policy changes on the well-being of children and families. Much of this and previous research on low-income families has focused on survival strategies, such as Edin and Lein's work on how low-income single-mothers "made ends meet" on low-wage work and/or welfare prior to welfare reform. Within this literature, child care is one of many needs that must be met through a number of creative strategies, along with transportation, food, shelter, and health care, to ensure family survival.[16] Survival strategy has been an important focus because it reveals and centers the material conditions and needs of families, while demonstrating the agency of parents in their attempts to deal with those conditions. Affordable quality child-care options are central needs, and low-income parents undertake many strategies to manage limited child-care options.[17]

Most research on low-income families has focused on urban contexts, leaving a dearth of knowledge about the particular effects of rural contexts.[18] Important questions requiring further investigation include: Do rural contexts necessitate a different array of material circumstances, and therefore, survival strategies? Do rural contexts necessitate different strategies for managing child care? Key to differentiating rural contexts from urban are the greater dispersion and limited availability of jobs, lack of public transportation, and greater dispersion and limitations of health care

and social services. Because of the limited resources in rural areas, parents are more likely to rely on informal child-care options through family and friends.[19]

By focusing on two groups of mothers in two different rural county contexts, this chapter builds on the work of others in promoting a better understanding of how rural contexts affect the lives of low-income families. Rather than add to the on-going list of survival strategies used by these mothers to meet their child-care needs, I take a different approach by focusing on the conditions of low-wage work, demonstrating how such conditions are pivotal in structuring the child-care options to which mothers have access and the amount of energies or labor mothers must expend to manage inconsistent child-care options with inflexible and inconsistent working conditions. I argue that the conditions of low-wage work to which these mothers have access actually create constant work for them in configuring and reconfiguring child-care arrangements. Such energies expended by mothers clearly have implications for child well-being and child poverty.

METHODS

To analyze mothers' efforts at coordinating low-wage jobs and managing child care, in-depth open-ended interviews were conducted in 2000 and 2001 with 33 Latina mothers, many of whom migrate to perform agricultural work in Harvest County, and in 2002 with 12 white mothers primarily employed in service sector jobs in Delta County. Both Harvest and Delta Counties are rural counties in Michigan.[20] This chapter draws from a larger research project focused on the invisible and taken for granted work necessary for these two groups of mothers to attain and sustain low-wage employment.[21]

In Harvest County, Latinas involved in agricultural labor with at least one child under 12 and incomes 200 percent of the poverty level or lower were targeted. Interviewers developed a sample by visiting labor camps, through their connections in their own community work and personal interactions, through the referrals of other community/human service workers, friends, friends of friends, and eventually through friends and acquaintances of other mothers interviewed. Thirty-three Latina mothers were interviewed in 2000 and again in 2001.[22]

The Delta County sample began with the informant list from a previous research project in the studied county,[23] contacts made through a community worker in the county, flyers posted at local businesses, and eventually through friends and acquaintances of other mothers interviewed. Twelve mothers with at least one child and incomes 200 percent of the poverty line or lower were interviewed in 2002.

Mothers interviewed in Harvest County all identified as Latina or Hispanic. Twenty-three mothers (70%) regularly migrated to work in Harvest County. Most considered Texas their home. The majority of women and their partners were employed in agricultural labor in Michigan, and a third of the women were laid off between crops, while 12 percent were unemployed at the time of the first interview. Over three-fourths of the women reported an education of high school or less and

over half reported an eighth grade education or less. The women were not asked about their English language skills, but over half chose to conduct the interview in Spanish. Of the 33 women from Harvest County only one reported no partner or husband. Seventy-nine percent of mothers had more than one child and 20 women had at least one child aged 5 or under in the household.

Delta County women self identified as white. Although all of the women reported previous work experience, half were not employed at the time of the interview. Seventy-five percent reported completing high school. Nine were living with or married to a partner. Three-fourths of the women had more than one child, and over half had at least one child aged 5 or under.

WORKING CONDITIONS AND CHILD-CARE OPTIONS

Although the women's circumstances differed in significant ways, the working conditions with which they contend and their struggles to manage child care illustrate some important parallels. The job contexts that both groups of mothers described mirror national trends for rural areas addressed previously: low-skill, low-pay, unfriendly-to-family jobs.[24] Such job contexts shape the working conditions to which mothers have access and, therefore, the amount of effort necessary for mothers to coordinate and manage child care.

Low Pay and the Costs of Child Care

The jobs to which mothers in both counties had access generated little income for them to support their families and secure child care for their children. Gail, who worked as a cashier at a local branch of a discount chain, compared her salary with those of other employees working at other branches of the chain across the country and found that "the lowest hourly wage, let's say in . . . South Carolina was $7.50 an hour . . . I was making five and a half an hour up here."[25]

Agricultural labor is characterized by particularly low pay. An oversupply of agricultural labor, shaped by immigration laws, helps explain why the low pay and poor working conditions make these workers one of the most disadvantaged groups in the United States.[26] Mothers interviewed in Harvest County were no exception.

Such low pay severely restricts child-care options, particularly formal child-care arrangements. Mothers in both counties struggled to manage the costs of paid child care on their low-wage jobs, as addressed by Liz, a Delta County mother, below:

> The money I shelled out on day care was ridiculous because you drop them off at 8 o'clock in the morning and you didn't pick em up until 7 o'clock at night because that's when proofs got done. Granted, the bank closed at 5 o'clock, but we still had two hours of checks to be processed and balanced to get out of there.

Extended workdays necessitated additional hours of child care, increasing the cost of that care. Such economic dilemmas about the costs of care were not limited to

single mothers, however. Ellie, a Delta County mother of three, expressed similar concerns about the cost of child care, given the income she derived from her employment:

> Two dollars an hour per kid. And it wasn't bad when [one child] was there, but if they had breaks for the schooling, the Christmas break, or anything like that where the kids were off, Suzy would be there, so it would be four dollars an hour and then with him [youngest son], it would be six, so I'd only be making, you know, fifty cents an hour and that wouldn't even pay for gas back and forth.

Ellie was not alone in noticing that the pay of low-wage work often did not cover the costs of care. Several mothers from both counties made similar comments, some noting times when they were unable to work because of the costs of care or because of other complications finding adequate child care. Celina, a Harvest County mother, explained below:

> Well, last year we paid two thousand dollars in one month to take care of the four children. . . . If I get a good job I don't qualify for the childcare [assistance] and there are four [children]; it already happened to me . . . the job didn't work out [because of the cost of] the baby sitter. Two thousand dollars in one month is a lot, and that's just part-time for the children.

Thus, formal (paid) child-care arrangements were cost prohibitive for many families and some were unable to work at times due to a deficit of care.

To deal with the exorbitant costs of child care, mothers from both counties turned to informal child-care arrangements with family members and friends and worked separate shifts from their partners.[27] Others relied on Head Start programs and other subsidized child-care arrangements through the state. Nevertheless, mothers (and their partners) often encountered problems qualifying for assistance for one or all their children. For example, Flavia reported that:

> For two children I have to pay because they don't qualify for the government to pay; for two of them they pay and for two they don't. . . . I had to pay a lot if I worked Saturday and Sunday, [yet] I had to work Saturday and Sunday to be able to pay [for child care].

Thus, Flavia and other parents found themselves in a Catch-22.

Though child-care subsidies helped offset the high costs of child care for some mothers, problems with waiting lists and regulations remained. A Delta County mother explained the dearth of child-care options common in rural areas, "I know that the state has programs for low-income [families], but then you have to have a licensed babysitter, and that's not easy [to find] around here either." Thus, negotiating quality care around the requirements and restrictions needed to subsidize costly child care presented mothers with difficult child-care dilemmas, as illustrated by Clara, a Delta County mother's, circumstances:

> The day care that I had for [my children] last year would not accept FIA payments, . . . but it was the best day care we could get. . . . And we just couldn't afford ninety dollars a kid each week. She didn't accept FIA [Family Independence Agency] because she said it's just too much time to wait for them because sometimes they don't send their checks out on time.

One Harvest County couple explained it well: "When the two of us work, how nice. . . . When there is someone to take care of [the children], both of us work." Their comment illustrates the additional hardships for families who migrate to Harvest County: the lack of support networks in finding and securing formal child-care arrangements.

Inconsistencies in Hours and Scheduling of Work

Not only was pay an issue for the mothers, but in some cases the work that Delta County mothers found was only part-time, temporary, and/or fewer hours than promised when they were hired. For example, one young, single mother, Brandy, needed more hours than she was getting at her gas station job. She said, "I was hired in, supposed to be full time and I was about 32 if I got lucky."

On the other hand, several Delta County mothers reported periods in which they were working 60–80 hour weeks, either at one job or at multiple jobs they took on for economic reasons. According to Erin, "I worked seventy-two hours in one week and never got paid over-time, never got anything. I was supposed to be a part-timer."

Women in Delta County also encountered temporary or seasonal jobs. For example, Liz, a school bus driver has to manage her finances carefully with her seasonal work: "When school's in, I work. So, basically I work on an average, maybe six months out of the year." Nancy, a young mother says her job is mostly "a summer kind of thing . . . so I only work Friday, Saturday, and Sunday."

Though seasonal work encountered by Delta County mothers offered some predictability in annual schedules, Harvest County mothers found less regularity in the scheduling of agricultural labor. Mothers and their partners contend with—and in some cases travel significant distances to contend with—unstable and inconsistent working conditions:

> You could say there were good times and bad times [during the year]. They stop us, they give us one or two weeks and then they come two or three days and now there isn't any [work] and that it how it is. (Yesenia, non-migrant agricultural laborer)

Women who live in Harvest County year round (approximately 30%), like Yesenia quoted above, are often employed as seasonal agricultural laborers. The work lasts only as long as a given crop. Moreover, agricultural workers did not work consistently throughout any given season. Temporary layoffs were common. Gitana reported: "Well, right now we're not working at all. . . . Sometimes we work forty hours per week; sometimes . . . up to eighty hours per week . . . sometimes . . . twelve hours a

day; sometimes ten . . . hours." The work available and the length of a season varied from year to year. Mothers (and their partners) could not predict the next year from the prior year. As Francisca explained: "Well, . . . last year we worked seven months. I do not know about this year."

The availability of work is also conditioned by the weather, including freezes or lack of rain as well as the whims of employers. Needless to say agricultural labor in Harvest County is characterized by feast or famine and the unstable work schedule makes formal child-care arrangements extremely challenging to negotiate.

Inconsistencies and Complications in Child-Care Arrangements

Not only did the accounts of mothers in both counties suggest that many encounter inconsistencies in scheduling and hours of work, but those conditions complicate child-care arrangements for some, particularly for those who rely on formal child care. When asked if anything made it more difficult for her to work, Tomasa, a Harvest County mother, responded:

> Most of it was day care, and that you have to leave too early [in the mornings and evenings] and the day care was still closed at those time[s]. . . . [At] 6:30[a.m.] I would drop [my daughter off], and . . . the day care close[d] also by 6:30[p.m.]. So, I would . . . be there just barely on time to get her. And then I would still have to take her for a couple of minutes more to the field until I finished [harvesting crops].

Low pay of such work affected the child care to which mothers had access, but so too did fluctuations in hours and scheduling. It meant a never-ending cycle. Thus, turnover in child-care arrangements was not uncommon, nor was instability in many mothers' employment circumstances. For example, Jenna, a single mother in Delta County, recounted a string of child-care arrangements that patched together formal and informal arrangements, such as a reliable friend who was unlicensed but trustworthy and a teenage daughter who watched her youngest on weekends. Arrangements seemed to fluctuate with her changes in employment and other circumstances.

Although the flexibility of informal care from family and friends often offset the inflexibility and inconsistencies of work schedules, this sort of care was not isolated from fluctuations and change. Jenna also spoke of using her older daughter as a babysitter until her daughter went to college. Similarly, changes in informal child-care arrangements among migrant workers in Harvest County were not unusual from one season to the next. Afra explained that her niece who had cared for her children during the previous season was no longer her child-care provider "because she wanted to work in the fields." Even though social services in the state of Michigan provides subsidies for informal child care by family or friends, the amount of the subsidy, less than a living wage, does not insure consistency of care providers. In addition, one might expect that others in the social networks of mothers in both counties would live in similarly tenuous economic circumstances, subject to frequent life fluctuations.[28]

Scheduling of formal child-care arrangements may also change,[29] particularly since even formal arrangements are often provided by mothers who care for their own and others' children from their homes. Brandy's account below illustrates the complications that fluctuations in day-care provider schedules can present:

> The day care provider told me that she does twenty-four hour care, but about a week later she told me that they wanted their family time after five o'clock so I had to switch my hours [at work], which was really hard because they didn't want to work with me on it.

Brandy's account reveals the feedback between fluctuating work and child-care schedules that leads to constant work for mothers to try to manage.

Inflexibility

Not only was inconsistency in hours and scheduling a problem for families, but mothers in both counties also encountered inflexible employers and/or working conditions. For example, Brandy, the single Delta County mother of two addressed above, found her job as a gas station attendant to be inflexible:

> There were a couple of days where I had to call in because the kids were sick or transportation didn't work out and they didn't like that at all. They didn't want to work with me . . . even though hiring in they knew that I was a single mother and had quite a few problems with stability because of transportation. . . .

Family emergencies created issues for many parents. For example, Candida, a Harvest County mother, noted that her workplace instituted a policy that says if an employee leaves early they cannot return to work the next day. Antonia said that:

> They told us that we could leave only if it is an emergency. And I said like if my daughter has the flu, I said I'd go to see how she is and take her to the hospital or the clinic. And they told me, "You can't ask for permission, only in the case of an emergency." And I said to them, "What is an emergency only if someone dies?" . . . I said, "No. An emergency is if someone gets sick"

Flavia reported that her boss did not tell her that her babysitter called to tell her that her daughter was sick. Engracia's husband was not even told about a death in his family until his shift was through. Such incidents illustrate the brittle and unyielding nature of their work conditions—truly a contested terrain for families.

THE "WORK" OF COORDINATING CHILD CARE AND LOW-WAGE WORK

As illustrated above, low pay and inconsistencies in employment structure the often fluctuating child-care options to which mothers have access. Such circumstances create

constant work for mothers (and their partners), as they attempt to piece together and reconfigure fluctuations in employment and child care. Managing affordable child care of acceptable quality around the schedules of low-wage and often inflexible employment involves stress and expending energy, a precious commodity. Mothers must manage getting children to child-care providers, often at unusual times, negotiate with formal and/or informal (friends and family) child-care providers, coordinate with the schedules of partners/fathers, manage the care of older children, and constantly worry that the house of cards does not collapse.

The Work of Getting Children to Day Care

Making sure children get to and from child-care providers also involved additional preparation and planning such as packing a bag ahead of time and getting children ready. Gail and Ellie, Delta County mothers who had to be at work at seven and six a.m. respectively, prepared a bag the night before to send with their children to the child-care provider with clothing and other things they would need:

> [I'd] usually come home and get [the bag] right then. Take the dirty stuff out and put it right by the door. . . . I had to be out of here at six because I had to start at seven. So, I was up, nine out of ten times the bag was packed. . . . [My daughter] went in her jammies, wrapped in a blanket, and then I had to talk . . . the day care provider into getting up early to take her, because she didn't start till seven, and I had to be at work at seven. (Gail)

With the odd hours required of low-wage service and agricultural labor, several mothers discussed having to wake their children at very early hours to transport them to formal or informal care arrangements. Celina, a Harvest County mother, explained the difficulties of transporting her children at the early hours necessitated by harvesting, "sometimes it is hard to wake up my children at five o'clock in the morning, and they do not sleep well." Celina's account provides a glimpse into the world of stress for children's lives as well as parents.

Negotiating with Child-Care Providers

Whether mothers relied on formal or informal child-care arrangements, Brandy's previous example and that of Gail above both demonstrate the need for them to negotiate with child-care providers (and employers) in order to try to accommodate the often inflexible and fluctuating hours of low-wage work. For example, so that a friend who she trusted but was not licensed could provide care for her children, Jenna, a Delta County mother negotiated an arrangement that would work for both parties. "She would watch [my children] after school. She would watch them when I worked nights at the bar. . . . And the pay off was, I helped take food down there. And I didn't' put her on my taxes or claim her at the end of the year or anything like that." Because of the dispersion of child-care options in rural areas, mothers are more likely to rely on informal care arrangements,[30] leaving more room for such

negotiations. Accordingly, as others have confirmed, child-care arrangements of low-income families often change.[31] Because work schedules and child-care arrangements are in a state of flux, such negotiations must happen again and again.

Bringing Children to Work

Because of cost prohibitions or other difficulties finding care, for a few mothers bringing children to work was at least part of the child-care arrangements they pieced together, as Ellie, a Delta County mother, explained:

> We didn't know anybody really around that area. My sister-in-law lived like fifteen miles away, and the paper route was going the opposite direction, you know. At eleven o'clock at night, it was hard to take them out there. . . . So, nine times out of ten, I just took them with me or had one of the neighbors come over and just sleep overnight and watch them there.

On such occasions, the children slept in the car while Ellie delivered papers.

Similarly, Tomasa, a Harvest County mother, talked about bringing her six-month-old child to the fields with her due to a deficit of care at later hours. "There was no day care for her. There was nobody I knew that [sic] could take care of her so I would take her to the fields." Such an arrangement required coordination and planning on her part:

> I would . . . fix it up for her and I'd put her there [in the fields] to sleep and sometimes my aunt would lend me her daughter. She was . . . eight years old and she would keep an eye on her. . . . We'd find a place that looked safe, you know, for them to stay there and we would take her, you know, formula and everything.

Tomasa reflects on her child-care strategy with great sadness, wondering if the time her daughter spent in the fields is related to the serious health problems she developed later in life: "I didn't want her in the fields 'cause I knew how hot it was and, you know, they would spray stuff and I didn't want to have her there in the fields." Nevertheless, faced with no other viable alternative, Tomasa negotiated this arrangement.

Coordinating with Partners' Schedules

Some mothers with partners managed child care through an arrangement in which both parents worked different shifts. Though such an arrangement allowed one parent to be present at all times, this strategy required a lot of coordination, as illustrated by Francisca, an agricultural worker who lives in Harvest County with her husband and three children year-round:

> I get up at four thirty in the morning, I make lunch for my husband, because he works at night and arrives at five in the morning or five thirty. . . . At six I get the children up and

> when he comes I have lunch, tortillas and everything. [In the evening, I get the children ready for school], and then in the morning I just get them up so that they stay awake and I go to my job. . . . [My husband] arrives, eats lunch, gets the children up and takes them to the bus and in the afternoon he picks them up and when I arrive, the children already ate dinner and they are just waiting for me to arrive to bathe them and everything.

Although Francisa points out that her children are never alone, such a strategy requires a lot of effort and coordination on her and her husband's part.

Managing Care with Older Children

To fill in deficits of care on weekends and at odd hours, some mothers relied on older children. Such an arrangement, however, requires monitoring and preparation of children for such responsibility. For example, when asked how she combines her work and family responsibilities, Columba, a Harvest County mother, explained: "I started, you know, with my kids teaching them a little bit of responsibility like throwing out trash, picking up their stuff. So they get the feel of responsibility and help me out."

Although older children were often assets in filling gaps in care, sometimes planning for the care of and coordinating the supervision of older children required as much effort, and, perhaps, more emotional work than coordinating care for younger children.[32] Mothers worried about their children's abilities to care for themselves and their siblings and to stay out of trouble. When Gail, a Delta County mother, was at work, for example, her children would "terrorize my house. . . . Yeah. The older they get, there's always more worries."

One common concern of mothers was ensuring that children got on the bus to school. This was a particular problem for mothers, like Laurel, who had to leave for work before their children's school bus arrived:

> I'd have to be at work at sometimes five, six o'clock in the morning. Well, then there was nobody here for my kids when they got on the bus, so. And teenagers you kind of like to pay attention to what they're wearing to school, . . . and make sure they're getting on that bus. Several times I was getting phone calls [at work]. . . . "Mom I missed the bus." Well, mom can't run all the way home now to get you. . . . They would miss school. Yeah, so that got frustrating.

To deal with this situation, Laurel and her husband, Jeff, would make plans:

> Well, you call home and make sure the kids are up. I'll call home right around bus time to make sure they're ready for the bus . . . But then there was times, you know, where you're at work, and you just can't take that time. You're busy at the time, and you can't get to the phone to check. And by the time you did get to the phone, they were all gone. And then you kind of sit there and wonder how their day started out.

Although mothers often planned ahead to the time when they could simplify their child-care needs as children became school age and/or able to take care of themselves

and/or their siblings, their accounts illuminate often overlooked labors involved in managing the care of older children around the schedules of work.

The Insatiable Need for Coordinating Child Care

These mother's circumstances and challenges might resonate with any parent. Indeed, many working parents recognize the taken for granted and often invisible backstage labors[33] they go through to coordinate child care around the schedules of their employment: the labors of worrying, checking in, coordinating with partners' schedules, and many other efforts they make. Increasingly, parents can make use of a growing body of literature (in the research community as well as within popular culture) that legitimizes these previously invisible efforts and struggles. Then what sets apart these two groups of mothers from every other parent? One of the key differences is the material with which parents have to work. The conditions of low-wage work necessitate constant coordination, as Brandy's circumstance from above illustrates:

> The day care provider told me that she does twenty-four hour care, but about a week later she told me that they wanted their family time after five o'clock so I had to switch my hours [at work], which was really hard because they didn't want to work with me on it. . . . But I ended up getting, I got off at like seven, which [the day care provider] worked with me on. . . . She decided that was okay. And then [my employer] gave me pretty much the hours that I needed for day care, but they put me on weekends, and I didn't have day care on weekends, so that was a hard spot.

Brandy's account reveals how the fluctuations and inconsistencies of low-wage work and child-care arrangements necessitate such coordination and reconfiguring happens over and over again. The schedules of low-wage work along with the child-care arrangements they afford both appear to be in a state of flux that requires constant reconfigurations for mothers. Garey has offered the metaphor of weaving to illustrate mothers' attempts to mesh their family and working lives.[34] However, these two groups of mothers appear to be working with constantly unraveling threads, attempting to piece together an improvisational patchwork of care.[35]

CONCLUSIONS AND IMPLICATIONS FOR CHILD POVERTY AND WELL-BEING

Based on these mothers' accounts, their common conditions of work (low pay and inconsistencies) are pivotal in creating the constant labors necessary to manage child-care arrangements. Such findings have important implications for child poverty and child well-being.

This chapter has focused on two important groups within a changing rural landscape.[36] Such a focus on the particular issues facing parents and children in rural areas is crucial since child poverty rates are higher in rural areas than in urban areas, and the gap between rural and urban poverty grew significantly during the later

1990s. Poverty is highly concentrated in rural counties. Of the 50 counties with the highest child poverty rates, 48 are located in rural areas. The employment conditions of parents seem to be crucial to child poverty rates. Many full-time jobs in rural areas cannot support a family. For example, 27 percent of children live in low-income working families in rural America versus 21 percent in metro areas. A growing number of female-headed households live in poverty (43% in rural areas vs. 34% in urban areas), contributing to a phenomenon known as the feminization of poverty.[37] Rural workers are more likely to be underemployed and less likely than their urban counterparts to receive cash public assistance to supplement or substitute for low wages. In addition, because of the low quality of jobs in rural areas and the likelihood of employment at smaller companies, rural children are more heavily dependant on health insurance from public sources versus benefits through their parents' employment. Such health care options are often of lower quality.[38]

The implications of parents' employment options on child poverty and well-being are clear. The amount of pay and benefits to which parents have access determine the material circumstances with which they live and whether a family falls above or below the poverty line. In addition to this more obvious connection, the mothers' accounts discussed in this chapter also suggest that the conditions of employment determine the array of child-care options available to mothers and, in turn, the amount of efforts and energies needed to manage the child-care options available to them. Not only does the quality of child-care options available have implications for child well-being, but the labors and reconfigurations in managing child care on the part of parents potentially sap them of time and energy they could be investing in their children. Therefore, if the goal is to address child well-being and child poverty, then one way to foster more consistent care for the children of low-wage parents is to improve the conditions of employment. For example, increasing the minimum wage could make formal child care more accessible to low-wage working parents. Since an increasing percentage of the poor consists of women and their children, addressing the gender wage gap that persists (women's average full-time earnings are still 76% of men's earnings) could have a significant impact on child poverty by affording single-mothers and dual-earner families alike greater earning power.

Improving the child-care options available to parents and children is another way to affect child well-being. Supplementing the cost of and creating more quality care could have significant positive impacts on children.[39] Parents also desperately need care that is flexible and available during unconventional hours (early mornings, evenings, and weekends). However, in reality, those with lower incomes appear to be saddled with the least flexible work and child-care options.[40] These mothers' accounts also suggest a need for care and/or supports of older children. Finally, special attention to the particular child-care needs and obstacles of rural parents is necessary. Because of the dispersion and deficit of formal child-care options in rural areas, supporting informal care from family and friends may be the best routes to improving child-care conditions.[41] More research focused on rural child-care issues is needed.

All these potential measures (improving working conditions and child-care options) could serve to lessen the amount of work that mothers need to undertake to

manage child-care arrangements. Although attention to the particular contexts and circumstances of low-income parents in rural areas is necessary, policies aimed at lessening the labors necessary to manage work and family could benefit all working parents and their children. All working parents labor to manage care for their children. Policies that make work more flexible for parents (such as paid family leave and flexibility in scheduling and hours) could benefit all parents and children. Thus, to tackle child poverty and the well-being of all children, we cannot overlook the work that parents do, both inside and outside the home.

NOTES

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20. County names are pseudonyms, as are all names of subjects. According to the 2003 Rural-urban Continuum Classification Coding system, "a classification scheme that distinguishes metropolitan counties by size and nonmetropolitan counties by degree of urbanization and proximity to metro areas . . . resulting in a 9-part county codification," Delta County is a nonmetro county with an urban population of 2,500–19,999, adjacent to a metro area. The same coding system designates Harvest County as a non–metro county completely rural or less than 2,500 urban population, adjacent to a metro area, U.S. Department of Agriculture (USDA), Economic Research Service (ERS), "Rural-urban Continuum Codes," www.ers.usda.gov/data/ruralurbancontinuumcodes, accessed on September 3, 2003; for a history of the coding system also see Margaret A. Butler, *Rural-Urban Continuum Codes for Metro and Non-metro Counties* (Washington, DC: U.S. Dept. of Agriculture, Economic Research Service, Agriculture and Rural Economy Division, 1990).

21. E. Brooke Kelly, Working for Work in Rural Michigan: A Study of How Low-Income Mothers Negotiate Paid Work, Ph.D. diss., Michigan State University, 2004.

22. These mothers were initially interviewed as part of a larger longitudinal study, formally identified as NC-1101 "Rural Low-Income Families: Tracking Their Well-Being and Functioning in the Context of Welfare Reform," (www.ruralfamilies.umn.edu). Though the larger project draws on data collected in several states, this chapter relies on interviews conducted in Harvest County, Michigan only. For additional information about data collection, samples, and/or analysis, see E. Brooke Kelly, *Working for Work in Rural Michigan*, or contact the author directly.

23. David R. Imig et al., "The Context of Rural Economic Stress in Families with Children," *Michigan Family Review* 2 (1997): 69–82; Barbara Wells, *Family Continuity and Change in a Restructured Economy: A Case Study from Rural Michigan*, Ph.D. diss., 1999, Michigan State University.

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25. The conditions of work in this section are further addressed for Delta County mothers in E. Brooke Kelly, "Leaving and Losing Jobs: Resistance of Rural Low-Income Mothers," *Journal of Poverty*, 9 (2005): 83–103.

26. René R. Rosenbaum, "Migrant and Seasonal Farmworkers in Michigan: From Dialogue to Action," *JSRI Working Paper* #39, The Julian Samora Research Institute, Michigan State University, East Lansing, Michigan, 2002.

27. For a discussion of child care strategies, see Kelly, *Working for Work in Rural Michigan*.

28. Stacey J. Oliker, "Work Commitment and Constraint Among Mothers on Workfare," *Journal of Contemporary Ethnography* 24 (1995): 165–194.

29. Other research has confirmed that low-income families use multiple child care arrangements and that changes in child care arrangements are common, Holloway et al., as cited in Ellen K. Scott, Andrew S. London, and Allison Hurst, "Instabilities in Patchworks of Child Care When Moving from Welfare to Work," *Journal of Marriage and Family* 67 (May 2005): 370–386.

30. Walker and Reschke, "Child-Care Issues Facing Contemporary Rural Families."

31. Holloway et al., "Instabilities in Patchworks of Child Care When Moving from Welfare to Work."

32. see Demie Kurz, "Caring for Teenage Children," *Journal of Family Issues* 23 (2002): 748–767.

33. Irving Goffman, *The Presentation of Self in Everyday Life.* New York: Doubleday, 1959; Kelly, *Working for Work in Rural Michigan*.

34. Garey, *Weaving Work and Motherhood.*

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36. However, rural America is diverse and the experiences of these two particular groups of mothers discussed in this paper should not be generalized to represent all rural mothers or even all white or all Latina rural mothers. Additional research is needed to gather more information about other groups, contexts, and circumstances in rural areas.

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40. Randy Albelda, "What's Wrong with Welfare-to-Work," in *Work, Welfare, and Politics: Confronting Poverty in the Wake of Welfare Reform*, ed. Frances F. Piven et al. (Eugene: University of Oregon Press, 2002); Sonya Michel, "The Politics of Child Care in America's Public/Private Welfare State," in *Families in the U.S.: Kinship and Domestic Politics*, ed. Karen. V. Hansen and Anita I. Garey (Philadelphia: Temple University Press, 1998); Scott, London, and Hurst, "Instabilities in Patchworks of Child Care When Moving from Welfare to Work."

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CHAPTER 8

Conflicts between Wage Work and Care Work: How Single-Parent Families of Children with Disabilities Manage to Juggle Competing Demands

Ellen K. Scott

In a system of privatized care such as the United States, the family, regardless of the number of adults present or the resources available, is fully responsible for all dependents—be they elderly, young, sick, or disabled. In the context of a capitalist economy, jobs are structured such that employees are expected to be able to negotiate the demands of wage work as if there were no competing demands of care work. To the extent that there are services and work supports available to enable families to manage care work and wage work, they are aimed at making more feasible this privatized system of care and more efficient the unencumbered worker. That there is a conflict between wage work and care work is not a new idea, nor is it news that single parents, particularly parents caring for children with special needs, face unique demands as they juggle the competing terrain of employment and care work. As indicated in the review below, the existing literature tells us something about patterns of care work and employment in families of children with disabilities, but we know less about the nuanced processes of decision making, the experiences of employment and care and how they do or do not conflict, and parents' emotional experiences as they negotiate these competing demands. In this paper, I look at a subset of parents, single parents, who are most likely to face conflicts between employment and care work in this system of privatized care and a capitalist economy.

For both single- and two-parent families, that balance between wage work and care work is shaped by a number of factors, including the financial resources available; structure of the employment, and the benefits such as health insurance, sick leave and vacation benefits; presence of an involved network of family and friends; severity of the child's condition; availability of alternative care; availability of other services, which can be beneficial to the child and thus potentially reduce disability-related disruptions to employment, but can also can require transportation and presence of

parents during work hours; and the parent's beliefs about, and approach to, wage work and care work. In families with more intense obligations of care, for example, in the case I examine here, single parents and disabled children, caregivers are forced to juggle competing obligations that often greatly exceed those in the families of typically developing children. In the context of a reigning ideology of individualism, a privatized and market-based system for the provision of care, and the absence of public means for aiding families in the provision of care for chronically ill or disabled members, parents find themselves largely on their own. If they have the economic means to purchase extra support, or if they have family members who are willing to help out, the provision of care may be spread to more than one person. But most often the care work for disabled children has been the responsibility of the parent, with occasional respite help from other family or network members, if they are lucky.

BACKGROUND

Estimates of the rate, and the number, of Americans under the age of 18 who experience limiting conditions due to illness and disability vary with definitions of disability, but indicate that between 6.5 and 15 percent of all children in the United State have a chronic condition.[1] However, rates of children with disabilities and chronic illnesses are disproportionately high in low-income families.[2] Researchers have found that those living below the poverty line are twice as likely to report that they have children with limitations or a disability as those living above the poverty line.[3] Children with limiting conditions also disproportionately live in single-parent families.[4]

Given the relationship between poverty, family structure, and rates of disability, it is not surprising to find the rate of disability is high among welfare-reliant families.[5] Loprest and Acs (1996) found that nationally 11–16 percent of families on AFDC had at least one child with some functional limitation, and Meyers, Lukemeyer, and Smeeding (1996; 1998) found that one-fifth of welfare-reliant families in four California counties reported having at least one child with chronic health problems or disability. Post-welfare reform data indicate that 20 percent or more families receiving welfare have a child with a health problem.[6] Further, researchers find that having a child with a disability is often an obstacle to leaving welfare.[7]

Families caring for children with disabilities face substantial challenges. Such children often require more frequent medical, psychological, or social service appointments; early intervention and special education programs; time-consuming and demanding routines for dressing, feeding, and minding, especially for those with mild to severe physical or emotional difficulties; more frequent school appointments; sometimes hospital trips and stays for urgent care; and time-consuming arrangement and management of alternative care when parents are employed and not able to provide the care themselves. Care for children with disabilities is more time consuming and more costly than caring for typically developing children.[8] Hence, parents often face difficult tradeoffs between providing this care informally within the family or working outside the home and coordinating formal care for their children.

The decision to reduce or stop work in order to provide necessary care is contingent on a host of factors, including: the severity of the child's disability or illness; the child's age and the presence of other children in the family; the presence of more than one child with special health care needs; the presence of another potential income-earner in the household; access to alternative sources of care; and the family's financial resources.[9] Cultural norms dictate that in both single- and two-parent families, the primary caretakers are the mothers in the vast majority of the cases. Therefore, the consequences for employment of care work for children with disabilities have been born primarily by mothers.[10] Compared to mothers of children without disabling conditions, mothers of children with disabling conditions have lower labor force participation rates.[11]

Effects of a child with special health care needs on employment vary by race/ethnicity, income/poverty status, and family structure.[12] Mothers in white, two-parent families with a disabled child have a significantly lower probability of work compared to similar families without a disabled child, but income is a crucial variable in this story. In high-income families, parents have more resources with which to purchase alternative care and the rates of maternal employment are similar to those families without disabled children. Work reduction is significantly greater in low-income families than it is in middle- and upper-income families. In two-parent families with a stable worker earning at least a moderate income, the costs of alternative care discourage maternal labor force participation and encourage maternal caregiving for the disabled child. However, in white single-parent families and all non-white families, the reduction in maternal work is *not* significant compared to similar families without a disabled child, perhaps because in very low-income and/or single-parent families, parents have less freedom to reduce work hours or leave the labor force altogether.[13]

Historically, some very low-income single-parent families have relied on cash welfare to support their care for disabled children.[14] However, extended reliance on cash welfare to provide this care is no longer possible. In 1996, the federal Personal Responsibility and Work Opportunity Reconciliation Act, or PRWORA, replaced Aid to Families with Dependent Children with Temporary Assistance to Needy Families. Among other changes, states were required to implement mandatory work requirements and establish time limits to cash benefit programs for poor families with children. These changes prevent low-income families of disabled children from relying on cash assistance and providing direct care until their child turns 18 years of age. Therefore, those families not included in state exemptions from these regulations have had to find a way to provide the care and do the wage work necessary to support their families financially.

Employment rates are affected by the challenge of finding reliable child care, which can be quite difficult.[15] Nonetheless, some mothers do manage to work when their children are in school, and others are able to arrange alternate center-based and relative care. While some studies find that mothers who have children with special health care needs are employed at the same rate as mothers in the general population, mothers of children with special health care needs often work part-time rather than full-time.[16] Such part-time work may be the result of work reductions to provide care.

The existing literature tells us something about patterns of care work and employment in families of children with disabilities. Much of it focuses on two-parent families. We know little about the processes of decision-making, the experiences of employment and how they conflict (or not) with care work, and the emotions single parents experience as they negotiate these competing demands. In a longer paper entitled "In this Labor of Love We Are Up Against the World," I drew on open-ended interviews with 20 families to examine how single- and two-parent families navigated the conflicts between wage work and care work when also caring for children with disabilities. Here I present the data from the interviews with 11 single parents, who were the most impoverished members of my sample and who faced the biggest challenges in juggling work and care and providing for their families. Their stories reveal the difficulties of privatized care in a nation committed to resisting any notion of communal responsibility for our young, our elderly, and our disabled or chronically ill. In these stories, the contradictions inherent in a philosophy of individualism as the grounding ideology in a society could not be more apparent. I look at how parents' attempts to juggle employment and care work reveal the untenable nature of our system of privatized care.

METHODS AND SAMPLE

During spring and summer of 2005 I conducted 20 pilot interviews with families recruited primarily through two service organizations in Eugene, Oregon, and with a few families I knew personally or had met in the course of doing this project. As this was intended to be a pilot project in which I began to explore the issues families caring for children with disabilities face, I did not restrict the sample in any manner. That is, I did not define the sample by disability type, age of child, family structure, family income, or any other potential criteria. My intention was to use the opportunity to interview diverse families in order to deepen my sense of the issues they face, the strategies they use to negotiate the competing demands in their lives, and the potential differences between social/emotional/behavioral disorders and motor or other kinds of physical disabilities, or differences across income and family structure.

The majority of the families (14/20) in the study had children with social/emotional/behavioral disorders (including the autism spectrum, ADHD, bipolar disorder, and developmental delays) and some had more than one child with a disability. The disabilities in the group of 6 families I label "other medical" include Usher syndrome (involving hearing and sight impairment), Down's syndrome, cerebral palsy, and congenital diaphragmatic hernia. There were more single-parent families (11) than two-parent families (9). Nine of the single-parent families and 5 two-parent families had children with emotional/behavioral disorders. Two single-parent families and 4 two-parent families had children with other medical problems. Eleven families in my sample were low-income (9 of these single-parent families).

My current sample doesn't allow me to investigate some of the other issues which I plan to consider in the future when I expand my sample, for example, the different issues that rural families face when they are far from services and especially if they lack

transportation, and the issues that immigrant and sometimes non-English speaking families and Native American families face in negotiating the demands of caring for children with disabilities, particularly given the cultural and linguistic barriers to the services available to them.

THE JUGGLE OF CARE WORK AND WAGE WORK FOR SINGLE PARENTS

Most of the single parents in my sample had children with emotional/behavioral disorders (9 of 11); two single-parent families had children with other medical problems, in both instances cerebral palsy. All of these families were headed by women. Five single parents did not work outside the home and six did. All five women who were not employed had children with emotional/behavioral disorders. Two of these five women were also disabled themselves, and one had serious health problems. Of the women who were employed, two had health problems.

Single Unemployed Parents

For three of the single unemployed parents with whom I spoke, the demands of the care work for their disabled children constituted merely one of a myriad of problems which prevented them from sustaining employment. They described their struggles with serious mental and/or physical health problems, histories of involvement with men who were substance abusers and violent, and other serious challenges besides their children's disabilities. They relied (intermittently) on cash benefits from TANF and sometimes SSI to support their families, often in combination with food stamps and the Oregon Health Plan (the state Medicaid program). Linda's story illustrates:

Linda had three boys, the youngest diagnosed with autism. She was severely disabled from a back injury sustained about 15 years ago. She left her husband, the father of her three children, many years ago due to his drug use. She worried that perhaps his drug use had something to do with her youngest child's autism and her oldest child's defiant conduct disorder. The chronic pain she suffered required almost heroic efforts on her part to continue the daily tasks of raising three boys, regardless of their disabilities. Despite her pain and immobility, she spent enormous time and energy managing her children's problems, advocating for them, arranging appropriate services through the schools, struggling to find summer programs that would take them, and often searching for appropriate school settings for each of her two troubled boys. In reflecting on what it has taken to manage her own pain and her children's needs, she said: "I was beginning to wonder if I could be a mom anymore, that they were going to have to go somewhere else. That the pain was getting me down so much I can't always keep the house clean, I just don't feel like I can do the things a mom needs to do [crying] and I love them so much."

The other two single unemployed parents do not face additional severe obstacles to employment. In one instance, the sole reason she is not currently employed is the

care work demanded because of her son's autism. I include her story below in the discussion of employment and care work.

Single Parents' Struggles to Sustain Employment and Care for their Kids

The single parents with whom I spoke all told stories of the extraordinary difficulties they had managing their paid work and their care work. Their stories included tales of jobs lost due to the conflicts between the job and the work of managing their child's illness. Those who were currently employed told stories of unusual employers who were willing to create as much job flexibility as they needed to manage their paid work and care work without conflict. Their stories make clear: their children always come first. Parents' accounts reveal that they see themselves as the experts in managing their child's illness ("no one knows my child the way that I do"), and in their opinion, there is no one else who can do the job as well as they can.

Their care work involved a range of activities from arranging for services provided by others to learning how to provide necessary therapeutic interventions at home to advocating on the child's behalf in the school system. There was little or no respite care available to them, either for the occasional break parents needed to preserve their mental health, or on an ongoing basis, for example, after school. Thus, the obstacles to their employment were many, including the hours needed to manage and provide the care their child needs, the appointments that often disrupted a work day, the lack of alternative care necessary to free the parents to work a full day, and finally the sheer exhaustion from doing not just a typical second shift but care work that far exceeds the demands of a typically developing child.

Losing Jobs

A number of parents lost jobs due to the difficulties of managing their children with social/emotional/behavioral disorders. Vivian, who was not employed when I interviewed her, talked about the steady decline in her employment situation culminating in her unemployment and reliance on SSI and child support in order to get by while she was managing her child's treatment for autism.

Vivian had been employed as a paramedic for years. She left this job when her husband became abusive and ultimately she could not trust him at home with the children, nor did she trust him with her children's caretaker. She quit her job in order to care for her family. Initially, she tried to run a day care out of her home, but she said:

> The abuse was horrible. The women's shelter came and rescued us and the police removed him. Because the police were involved, I lost my child care license. Ever since then, it's been down hill.

After leaving the shelter, getting situated in a new home, she found employment in a large national chain retail store. Around the time her son turned 3, she, the Head Start teachers, and doctors began to suspect he had some problems and when he was

in first grade he was diagnosed with autism. Vivian felt that there "were no resources for him [in that town]," hence the difficulty finding the diagnosis.

During those years, Vivian had a very difficult time juggling paid work and care work. She said:

> [My son's] needs became more and more, him needing me. He failed in child care, failed in school, the school called me: "Come get him, he's out of control, he's hurting himself, or he's not being safe, or he's running [away]." [My employer] finally said, "We have to put you on FMLA (Family Medical Leave Act) . . . ." The problem was that there were no physicians, no counselors, no one who was trained in [autism], that had any clue what to do for [my son], what meds he should be on. . . . So we were just getting no where. We were just spinning our wheels, and I was losing my job because I couldn't go to work. Every single day the school was calling me, and I couldn't find child care because the providers were quitting on me.

After her employer suggested she take family medical leave for a while, she "begged" for a transfer to the Eugene store because Eugene had "rave reviews for autism resources." Desperate for help, Vivian chose to uproot her entire family from their home and move them to a new place. Her employer agreed to the transfer: "They made a slot for me because I had done so well. I mean I really was a valuable employee, a good worker; I was head of their marketing department, despite everything that was going on. So they went ahead and transferred me."

She managed to find a school she liked for her autistic son and the child care she needed for the additional hours when she was at work, but she soon found herself unable to work. Her abusive ex-husband found them and seeing him caused her son to regress severely. Once again, Vivian found herself overwhelmed by his needs. The child care provider quit because he was throwing tantrums and was unmanageable; the school began calling her every day again. She again used family medical leave to try to sort out the problems, but with only a few weeks left of FMLA, she was ultimately terminated from her job. She continued to be involved daily with his care—at school, staying home so that she was available when he was kicked out of school, developing an IEP, finding a new school for him, getting the therapy he needed, etc. She briefly tried to work for a construction company, but again could not find the after school care she needed. Furthermore, she needed to keep her income low so that she still qualified to have his medical care covered by SSI. "His pills alone cost $3000 per month. That's just his meds. That doesn't include the weekly doctor's visits, counselors, etc." When we spoke, Vivian felt stuck. Her 9-year-old son's care needs were too demanding and she needed to keep her earnings down in order remain eligible for the health insurance she needed desperately.

As Vivien told this story, she did not describe a sense of despair, but rather was fairly matter-of-fact about the situation. Her son had been doing better of late and that gave her optimism that they might be turning a corner. Not so the story of Karen, who expressed considerable distress over the ways in which she found her life unmanageable due to her son's emotional-behavioral problems. Karen's 8-year-old son was diagnosed with a number of problems: oppositional defiant disorder,

obsessive-compulsive disorder, ADHD, and possible Asperger's. Karen had recently lost a job as a medical transcriptionist at a hospital as a result of her inability to juggle her son's needs and her work. She said:

> The reason I lost my job is that I couldn't get there on time [because of the struggles in the morning with my son]. The interesting thing about that is that I'm such a responsible person. In my life, I've been very responsible and on time and worked for powerful people, and there has never been a problem about being late. In the last few years, with the stress of [my son] and the divorce, I could not get there on time . . . and I pretty much lost my job because I couldn't get there on time.

Karen's days were consumed with advocacy for her son at school, working with teachers to develop systems that would achieve results with her son. She had found that positive reinforcement was the key with her son; some teachers were willing to participate and others were not. She was considering home schooling for him after two very frustrating years trying to establish a program that worked for him in the public schools. As I discuss below, Karen was arranging her employment to accommodate the demands of caring for her son, but she also felt enormously frustrated by the limitations in her own life as a consequence of caring for him.

Other single parents with children with emotional/behavioral disorders also reported that they had lost jobs when the demands of care work conflicted with their employment obligations. The most typical scenario was that they needed to be available to go into school at a moment's notice because their children were having a bad day. Without a job that could or would allow for such flexibility, they were either fired or had to quit because they needed to leave work on repeated occasions to be with their children. Such unpredictable care work obligations were not issues the parents of children with other medical problems talked about. Emotional/behavioral disorders were particularly demanding in this regard.

Jobs that Work, Employers Who Care

Most crucial in the employment of the single parents caring for children with disabilities is job flexibility: the ability to leave when called to care for their child, work different times to make up hours, take days off when necessary for doctor and therapeutic appointments, and in some instances the ability to work part-time or split shifts. Among the women with whom I spoke, this was available in the context of small companies in which employers or supervisors explicitly understood and supported parents' obligations to care. Sometimes mothers worked in organizations that provided services to families with children or adults with disabilities and there they found tremendous empathy for their plight. In each instance, the women had jobs that worked, and employers who cared.

Karen, whose story is introduced above, had tried to get a graduate degree in counseling but caring for her son had prevented her finishing her degree. After her divorce, she had resorted to medical transcription, a skill she'd acquired in the military,

although she hated the work. She did it for the flexibility if afforded her. This was the job from which she was fired the year before I interviewed her. It was to this work that she was just returning when we spoke:

> [After being fired and taking a break from work], I had to find a job. I've been really kind of looking at my options. I said I would never transcribe again. So I'm compromising now going back to transcription only because it gives me the flexibility that is required for [my son]. I can't have, I can't do the 9–5, it's just not possible. Unless we had an assistant, unless we hired someone to come and be here. And there goes my whole income, and my ex just refuses [to pay for care].

Despite loathing the work, Karen found a company that would hire her to do transcription, but allow her to work at home doing a split shift, 4 hours in the morning and 4 hours in the evening. With this schedule, Karen thought that she could manage the dual demands of her care work and her wage work.

Sarah, the mother of two boys aged 7 and 4, had an associate's degree in accounting and worked full time for a company that manages data. Her older son had multiple diagnoses: ADHD, pervasive developmental disorder, and potentially bipolar disorder. She said it was possible for her to be employed full time at this small company because her employer understood her situation and is willing to accommodate her needs. When she was arriving late for work after driving both her children to school because the older child had missed the bus, her employer offered her a flexible schedule. He said, "Why don't you just work 8:30 to 5:30 instead, or if you make it in by 8:15 then work until 5:15. It's okay." Further, she said,

> I can take a full day off if I have to, or a half-day off, and it's not a problem. I don't have to make up the work on the weekend or anything. School calls and says, "Hey, your kid can't ride the bus because he's not being safe, he won't put his seat belt on," and my boss will say, "Okay, go get your kid. I got it. It's okay." . . . He himself has told me family's first. "Take care of your kids."

Having lost at least one job because she was being called into school frequently, Sarah was amazed by and deeply appreciative of her boss's attitude. However, this flexibility was a product of his generosity, and Sarah could not rely on it. She had only been in the job for 6 months when I spoke with her. Hopefully, her employer's patience did not wear thin.

Diane, the mother of an 8-year-old son with autism, said that job flexibility was the most critical asset for her. Receiving $650/month child support, Diane made do in a job paying $12/hour with no benefits (her son was covered by the Oregon Health Plan, but she had no health insurance). She said, "I have no benefits. I just have the flexibility and that in itself is a benefit and their support. I could not ask for a better place to work." She worked 20 hours/week and was able to take time off when she or her son got sick, or during the summer when her son was out of school and she could find no alternative care. Recounting a time when she missed work for weeks,

she remarked: "Where I work, they are very supportive and understanding. I was worried, am I going to lose my job, but they like me so they are very flexible."

The company, where she worked as a research assistant, created educational materials for people who have developmental disabilities. Therefore, perhaps they had greater understanding of her situation than other workplaces might have. For Diane, it was also very important that she work part-time so that she could be present for the demands of her son's care work: "The reason I work part-time is that I fit my schedule into [my son's] needs so that I can be present with him after he's out of school. I can do his homework with him, like if he had OT or any other needs, I'm there. . . . Keeping the routine, keeping [my son] on task, making sure his health is okay, all those things that come up with kids with autism—the cycling, the behaviors, all those issues." His schedule was crucial, she explained: "You have to be on it every day. You cannot let up."

It was financially feasible for Diane to manage because she had some child support income and she lived in low-income housing. Her priority was the care work for her son. For her, the job was perfect, and greater income from full-time work could not compensate for the time she would lose with her son. Further, she like most of the parents I interviewed, could not find regular alternative care that would allow her to work full-time or during the summers if she wanted to. But Diane's story was another story of a small company with a compassionate employer. It is hard to imagine how she would be able to provide the care she does for her son in more typical, less flexible work situations.

Other parents found similarly flexible employment situations and/or worked part-time, but not everyone was so lucky. Anna, for example, worked for a large timber company, and had a 14-year-old son with ADHD, depression, and a possible bipolar diagnosis. She could not leave work if she was called in to his school. Therefore, she worried a lot about whether she would be sanctioned for missing work, or whether she would ever risk losing her job. After years of cycling from welfare to low-wage work, this stable job with decent pay and benefits was well worth holding on to, so Anna did everything she could to be the reliable employee she knew her company expected. Although things were better by the time I interviewed her, Anna had gone through periods of having to contend with her son's disruptions at school. During those periods, she relied on the one friend she could call for help. "I'm being called once a week at least [before when he was in middle school]. . . . Sometimes he'd get suspended for 3 days at a time. And it was frequent enough that work was telling me that, you know, you have to try to make a plan because this can't happen all the time." Sometimes, if she couldn't leave work and her friend was unavailable, Anna would let him walk home when he was kicked out. Other times she would bring him home and go back to work and stay late. Her employer had not yet actually threatened to fire her, but she worried about it a lot.

CONCLUSION

These single-parent families reflected the national population of single parent families in a number of respects: compared to the two-parent families in my sample, they were more likely to have incomes below 200 percent of poverty, the parent was

more likely to also endure a chronic illness or disability, and they were more likely to have more than one child with a disability. With only one adult in the household, their struggles to manage the competing demands of caring for a child with a disability and sustaining employment were extreme.

Those, like Vivian, who could not find work that was sufficiently flexible and that had the additional work and health care benefits necessary to enable them to meet their child's predictable and unpredictable needs, eventually opted out of the workforce, at least for a period of time. Others suffered from their own disabilities and could not manage to work and provide care for their children.

These single unemployed parents relied on combinations of multiple sources of financial and material support—TANF, SSI, child support, Food Stamps, and housing assistance, if available. But these sources were often unreliable. Families receive child support when fathers have an income and they are willing to provide it or the child support division is capable of enforcing their parental obligations. Receipt of Supplemental Security Income is contingent on children fitting into ever-narrowing definitions of qualified disabilities. The process of applying for SSI is long and cumbersome and many parents do not pursue it, because they assume that their child will not be eligible for benefits. Waiting lists for housing assistance are long, and it is often difficult to find landlords who accept subsidies. In order to rely on TANF to provide care, parents of children with disabilities must be exempt from work requirements (something that varies with case workers and state policy). In most states, they eventually face time limits which prevent them from relying on this source of income for an extended period. In Oregon, until summer of 2005 the state was given a federal waiver from the implementation of time limits. As long as a recipient participated in employment activities, there was no 5-year time limit imposed. As of summer 2005, the state was no longer exempt from time limits and DHS was required to begin cutting anyone who received cash benefits for 36 months continuously between summer 2003 and 2006.

Public sources of income available to support a family caring for a child with a disability are inadequate and/or short-term. Without private resources to rely on, single parents find it virtually impossible to care for their children without working. Those parents who are not employed often sacrifice the family's financial well-being in order to provide care. Those who do work, struggle to find inadequate, expensive alternative care, which is often unavailable at all, and they are often forced to compromise the care their children receive

The single parents in this sample who were employed told stories of losing jobs, having to rely on the kindness of employers for the kind of flexibility they needed, and working part-time in order to have adequate time to care for their children. They had difficulty finding alternative care either to allow them to work more, or to provide them with the occasional respite they desperately needed. Typically, work schedules were entirely organized around their children's care needs. In the one case in which the parent (Anna) worked full time in a relatively inflexible job, her child was a young teen and she had to rely occasionally on him to care for himself. She was not comfortable with this solution, but she saw no other option. After years of relying on welfare to support herself and her child, she was determined not to lose this relatively good job.

These stories reveal the conundrum of the privatized provision of care and jobs structured by a liberal, free-market economy. They reveal the extraordinary struggle of single-parent families to manage the needs of their children and the demands of their jobs, in the absence of other sources of financial support or alternative care for their kids. Families are isolated. There are few public resources to assist with care needs. The labor market is organized such that employers are entitled to ignore completely the care demands of an employee; they have no social or economic obligation to accommodate the conflicts between the wage labor and the caring labor. Single parents manage to provide financially for their families and provide the care work that is needed through creative and often lucky solutions, given this unforgiving and seemingly untenable context. They manage on little money; they rarely take a break from work or care; they find employers who provide the flexibility they need; they are resilient when they lose jobs and must begin again.

In the context of a society which presumes parents, usually mothers, can and ought to be fully responsible for the care of their children with few public resources to assist them, parents demonstrate an extraordinary capacity to accommodate this double bind structured by work and care. They do more than simply manage their circumstances: they face the demands with dedication, resilience, and often the creativity necessary to make it all work. Despite the constraints on their lives and the lack of public resources to assist them, most parents expressed a sense of optimism about, and commitment to, their child's well-being, born of the deep and enduring love they felt for their child. Their resilience was staggering, especially in the single-parent households. This was reflected in children who were doing relatively well, considering the scarcity of resources. Mixed with this, however, was a sense of fear and despair as parents looked to the future, with no end to their care work in sight and no apparent resources available to help ease the load.

As the parents endure by paying an enormous personal and economic cost to give their kids the best life they can manage, perhaps we should ask how much better off parents and children might be if we considered this labor a social good, a community service, as is now being debated among TANF reformers? As community service, we might provide this work the public support it deserves? The Americans with Disabilities Act demands that as a society we commit to creating the conditions under which people with disabilities have equal opportunities to thrive. This begins in childhood and it begins in the home. Providing parents with the financial resources necessary for them to care for their special needs children directly or to purchase care, and investing in training and building the public infrastructure of services necessary to adequately care for children with disabilities, are first necessary steps toward this goal of equality of opportunity.

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CHAPTER 9

Children's Exposure to Neighborhood Poverty and Affluence in the United States, 1990–2000*

Jeffrey M. Timberlake and Joseph Michael

American social scientists have long been interested in the effects of poverty on children's physical, psychological, and social development. This scholarly focus issues from at least two sources: first, the United States exhibits the highest child poverty rates in the Western industrialized world.[1] In the year 2000, the U.S. child poverty rate stood at 22 percent, compared to 15 percent in Canada, Australia, and the United Kingdom, 10 percent in Austria, Germany, and the Netherlands, and less than 5 percent in Denmark, Finland, Norway, and Sweden.[2] Of the 30 member nations in the Organization for Economic Cooperation and Development, only Mexico suffers a higher child poverty rate than the United States (27% in 2000).[3]

Second, research has demonstrated that family poverty is strongly associated with indicators of child well-being.[4] According to national-level estimates from the late 1980s and early 1990s, children aged 5 to 7 from poor families (incomes in the lowest quintile) score an average of one-half to four-fifths of a standard deviation lower on standardized reading and math tests and two-fifths of a standard deviation higher on an index of behavioral problems, compared to children reared in affluent families (incomes in the upper quintile). By the teen years, girls from poor families are over eight times more likely to become a teen mother than girls from affluent families, and the high school dropout rate is more than five times higher for poor children relative to children from affluent families.[5]

Thus, the combination of high rates and strong associations with measures of child well-being has led scholars to focus on family poverty in understanding outcomes for American children. And, given that family poverty rates have historically been at least two to three times higher for blacks and Hispanics than for whites and Asians,[6] much scholarly attention has been paid to understanding the influence of exposure to family poverty on racial and ethnic inequality in children's well-being.

Complementing this well deserved focus on family poverty, scholars have increasingly added a focus on *neighborhood* poverty in attempting to understand variation in outcomes for children, particularly variation by race/ethnicity and social class. Although sociological inquiry into the effects of neighborhood characteristics on the behavior and life chances of individuals spans nearly the entire history of the discipline, William Julius Wilson is frequently credited with rekindling sociologists' concern with "neighborhood effects" on children.[7] In *The Truly Disadvantaged*, Wilson argues that a combination of urban deindustrialization and the migration of middle-class blacks out of inner city neighborhoods in the 1970s resulted in sharp increases in the concentration of poverty in urban black neighborhoods. According to Wilson, these trends have had catastrophic effects on the capacity of inner city parents to socialize children successfully.[8] Wilson's work triggered an avalanche of inquiry into the effects of neighborhood context on child well-being.[9] Scholars have tended to focus on childhood because there are sound theoretical reasons to suspect that neighborhoods have powerful influences on children's life chances. Early childhood and adolescence are crucial periods in which life trajectories are shaped via the influences of peer relationships, schooling, and initial labor market experiences, and children are overwhelmingly exposed to these influences in their local neighborhood.

Among the many outcomes that have been studied recently are school achievement,[10] teenage sexual behavior,[11] and delinquency.[12] Taken as a whole, the findings of this research have been mixed;[13] however, the bulk of the evidence indicates that neighborhoods exert small to moderate independent effects on children. Prior research has also shown that black and Hispanic families are much more likely than statistically equivalent white families to live in poor neighborhoods,[14] and that the concentration of neighborhood poverty soared in the 1970s and 1980s, and then declined somewhat in the 1990s.[15] However, with rare exceptions,[16] prior studies have not explicitly focused on children's exposure to neighborhood poverty, and virtually no research examines children's exposure to neighborhood affluence.

The purpose of this chapter, therefore, is to provide a detailed picture of the context of poverty and affluence in which children live in the contemporary United States, and an assessment of what has changed for better and for worse in the decade between the last two decennial censuses. Specifically, we present data on children's exposure to neighborhood poverty and affluence (1) across racial/ethnic and poverty status groupings; (2) by region and urban area type (i.e., nonmetropolitan and metropolitan areas, comprising central cities and suburban rings); and (3) over time, by examining changes in the distributions in (1) and (2) from 1990 to 2000. We believe this exercise is useful for at least two reasons. First, if the notion of "neighborhood effects" on children is to be taken seriously, then it is important to get a basic sense of the conditions under which American children have been living over the past several decades. Perhaps surprisingly, we are aware of no other research that presents the data shown in this chapter in as comprehensive and easily interpretable a format. Due in part to this dearth of such descriptive research, we also suspect that many

scholars, policy makers, and interested lay persons are unaware of the massive levels of inequality in children's neighborhood contexts demonstrated in the following pages. We hope that this chapter will spur these audiences to pay more attention to the effects of neighborhood poverty and affluence on children's lives. To this end, we conclude the chapter by briefly discussing some implications of our findings for public policy efforts aimed at improving the lives of America's children.

DATA AND MEASURES

Data

Our data come from the 1990 and 2000 U.S. Decennial Censuses, concatenated in the Neighborhood Change Database (NCDB). The NCDB was developed by the Urban Institute in conjunction with GeoLytics, Inc.[17] The units of analysis are census tracts, which serve as a proxy for the neighborhoods in which children live.[18] A unique feature of the NCDB is that all tracts are matched to consistent 2000 boundaries. This means that comparisons of geographic units over time are not hampered by systematically changing boundaries of those units. We analyze metropolitan area, central city, and suburban census tracts separately, and include a residual "nonmetropolitan area" category to capture children's exposure to neighborhood poverty and affluence in small towns and rural areas.[19]

Measures

Dependent Variable

We measured neighborhood poverty and affluence by adapting a typology widely used in urban sociological and demographic research. Paul Jargowsky and Mary Jo Bane developed a categorical measure of neighborhood poverty by defining neighborhoods with poverty rates of less than 20 percent as "nonpoor," 20 percent to 40 percent as "poor," and greater than 40 percent as "extremely poor." The authors and local census officials confirmed the validity of these categories by visiting neighborhoods in several cities, finding that neighborhoods in poorer categories appeared more distressed on several subjective indicators.[20]

We follow Jargowsky and Bane by defining "high poverty" neighborhoods as those with between 20 percent and 40 percent of their residents in poverty, and "extreme poverty" neighborhoods as those with poverty rates in excess of 40 percent. We also extend their typology by disaggregating the "nonpoor" neighborhood type into three components: "affluent" neighborhoods have 3 percent or less of their residents in poverty,[21] "low poverty" neighborhoods are those with poverty rates of between 3 percent and 10 percent, and "moderate poverty" neighborhoods are defined as having poverty rates of 10 percent to 20 percent. This extension obviously yields more detailed information on inequality in children's exposure to neighborhood poverty and affluence; however, we find that our extended typology also reveals substantively important findings. This is because there are much higher levels of inequality at the

upper end of the distribution than in the middle, inequality that an aggregated "less than 20 percent" category would obscure.

Independent Variables

Our geographic independent variables are census region (Northeast, Midwest, South, and West) and urban area type, including nonmetropolitan and metropolitan areas, the latter comprising central cities and suburban rings. At the child and family level, we assess the effects of race/ethnicity on exposure to neighborhood poverty and affluence by defining five mutually exclusive (though not exhaustive) racial/ethnic groups: non-Hispanic white, Asian, black, and American Indian, and Hispanic of all census racial categories. We also compute distributions for poor and nonpoor children, based on the Census Bureau's family poverty designation. Finally, because the NCDB does not provide child poverty status by race or ethnicity, we use a proxy measure—poor and nonpoor families with children.[22]

Table 9.1 presents the 2000 distributions of children and families with children by race/ethnicity and poverty status, by region and urban area type. We present these data for two reasons: first, they give an overall picture of the racial/ethnic and poverty status demography of America's children, plus an initial glimpse of variation in their distribution by geographic and urban area type. Table 9.1 also enables interested readers to calculate the absolute and relative magnitudes of the percentages presented in Figures 9.2 through 9.13. For example, Figure 9.10 shows that in 2000 about 16 percent of black children in central cities lived in extremely poor neighborhoods. Combining this figure with data from Table 9.1 yields the percentage (8.6%) and absolute number (about 927,000) of black children living in poor central city neighborhoods in 2000.[23]

FINDINGS

Neighborhood Poverty and Neighborhood Context

In the first stage of our analysis we demonstrate why, on average, neighborhood poverty is likely to be harmful for children and why neighborhood affluence is likely to be beneficial. To do this, we present tract-level averages from 2000 census data of six frequently analyzed indicators of neighborhood socioeconomic status (SES) across our five neighborhood types. This analysis also validates our use of neighborhood poverty rates as a single indicator of neighborhood SES.

Figure 9.1 below presents averages across the neighborhood types of median family income (in 1999 thousands of dollars). At the neighborhood level, family income is, among other things, an indicator of purchasing power in a neighborhood,[24] which has effects on the ability of a neighborhood to support a thriving commercial sector. In addition to their instrumental and symbolic functions, local businesses are an important source of adolescents' early labor market experiences. Second, we examine the percentage of neighborhood residents with a college degree or more, an indicator of the human capital available to a neighborhood. This indicator likely

Table 9.1
2000 Distributions of Children and Families with Children by Race/Ethnicity and Poverty Status, by Region and Urban Area Type

	Total[a]		Region (%)				Urban Area Type (%)			
								Metropolitan Areas		
	n (000)	%	Northeast	Midwest	South	West	Nonmetro Areas	Total	Central Cities	Suburbs
Children										
By race/ethnicity										
White	49,547	68.7	18.9	26.3	33.9	21.0	23.1	76.9	21.3	55.6
Asian	2,554	3.5	20.2	12.6	18.5	48.7	4.9	95.1	41.0	54.1
Black	10,750	14.9	17.0	19.5	55.0	8.5	13.8	86.2	53.1	33.0
Hispanic	12,264	17.0	13.7	9.3	30.8	46.1	9.8	90.2	45.8	44.4
American Indian	814	1.1	5.9	17.4	27.3	49.4	49.1	50.9	22.4	28.5
By poverty status										
Poor	11,747	16.6	16.6	18.5	40.2	24.7	23.1	76.9	43.4	33.5
Nonpoor	59,178	83.4	18.3	23.9	34.5	23.2	19.2	80.8	26.7	54.1
Families with children										
By race/ethnicity and poverty status										
White	25,788	73.2	18.9	26.1	34.5	20.4	22.8	77.2	21.5	55.7
Poor	2,574	10.0	16.6	21.1	39.8	22.4	31.4	68.6	29.1	39.6
Nonpoor	23,214	90.0	19.2	26.7	33.9	20.2	21.9	78.1	20.7	57.5
Asian	1,343	3.8	20.8	11.7	19.6	47.8	4.3	95.7	39.7	55.9
Poor	169	12.6	23.8	10.3	17.0	48.9	5.4	94.6	56.9	37.8
Nonpoor	1,174	87.4	20.4	11.9	20.0	47.7	4.2	95.8	37.3	58.5
Black	4,668	13.2	16.8	18.7	55.7	8.8	13.2	86.8	51.9	34.9
Poor	1,494	32.0	16.2	19.6	56.9	7.3	17.8	82.2	59.6	22.6
Nonpoor	3,174	68.0	17.0	18.2	55.1	9.6	11.1	88.9	48.2	40.7
Hispanic	4,905	13.9	15.0	8.8	32.9	43.3	9.3	90.7	46.3	44.4
Poor	1,296	26.4	18.5	6.6	32.9	42.0	10.8	89.2	54.5	34.7
Nonpoor	3,609	73.6	13.8	9.6	32.9	43.8	8.7	91.3	43.3	47.9
American Indian	333	0.9	6.4	17.4	29.9	46.3	44.2	55.8	24.7	31.1
Poor	103	30.8	6.3	18.0	24.5	51.2	53.6	46.4	24.0	22.4
Nonpoor	230	69.2	6.5	17.1	32.3	44.2	40.1	59.9	25.0	35.0

[a] "*n* (000)" column does not include a small residual "other race/ethnicity" category (included in the calculations for the "%" column).
Source: Authors' calculations from 2000 U.S. Census data.

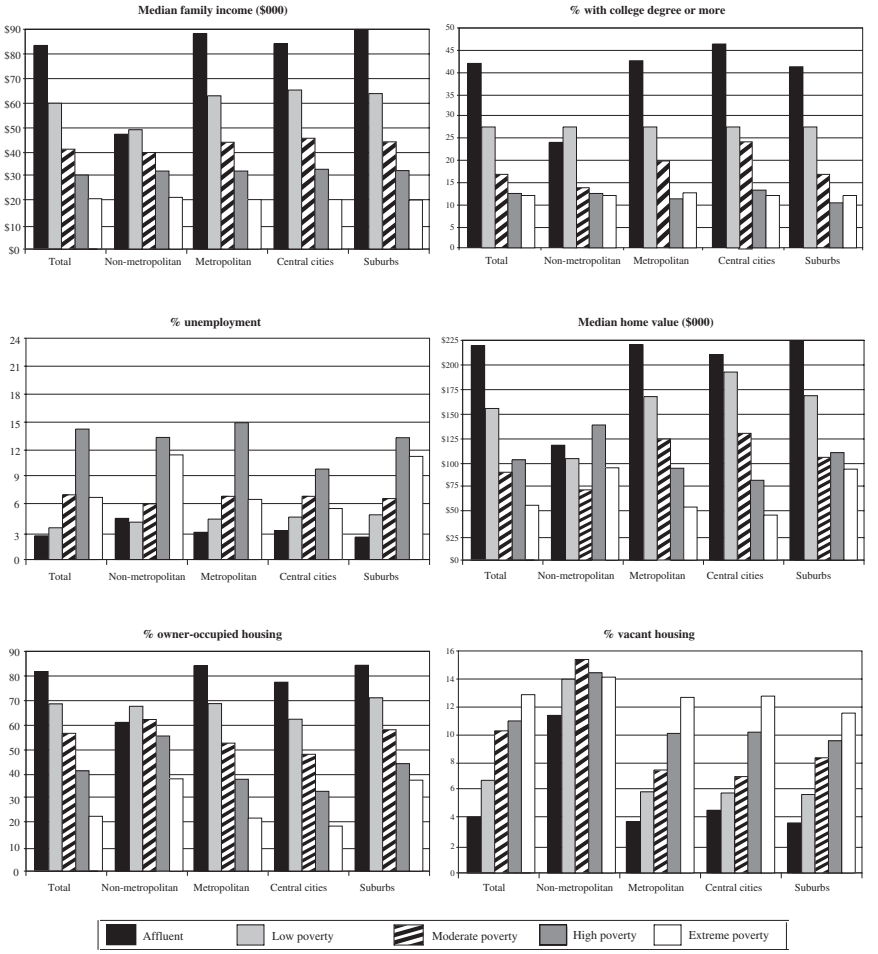

Figure 9.1
Selected Population and Housing Characteristics, by Neighborhood and Urban Area Type, 2000. *Source:* Authors' calculations from 2000 U.S. Census data.

captures the quality of social networks embedded in neighborhoods, networks which enable or retard the ability of youths to find out about employment and educational opportunities. Third, we measure the unemployment rate, which, among other things, has effects on the culture of work to which children are exposed in a neighborhood.[25] We also measure three housing characteristics: median home value and percent owner-occupied housing, which indicate the stake that residents have in their neighborhoods, and the percentage of vacant units, which is correlated with neighbors' and landlords' willingness to invest in the upkeep of property.[26] Each of these measures of housing quality is related to residential stability and the willingness of residents to form social ties and maintain public order.[27]

Figure 9.1 demonstrates that poor neighborhoods on average provide more disadvantaged contexts for children's development. As of 2000, the average affluent neighborhood boasts a median family income of about $82,000, compared to less than $20,000 for the poorest neighborhood type. Affluent neighborhoods have an average of 42 percent of their residents with a college degree or more, against 12 percent for extremely poor neighborhoods. Unemployment rates are shockingly high in extremely poor neighborhoods, averaging about 20 percent. High poverty neighborhoods have an average of 11 percent unemployment rates, while these rates average 6 percent or less in the three "nonpoor" neighborhood types. Children growing up in affluent neighborhoods are surrounded by homes with an average median value of nearly $220,000, compared to just over $70,000 for homes in the poorest type. Fully 82 percent of households in affluent neighborhoods own their own homes, while this percentage drops to an average of 23 percent in extremely poor neighborhoods. Finally, vacancy rates average about 4 percent in affluent neighborhoods, against 13 percent in the poorest neighborhood type.

Figure 9.1 also reveals substantial variation by urban area type in these indicators. Family incomes, levels of human capital, and median home values are appreciably higher on average in metropolitan areas versus nonmetropolitan areas, while vacancy rates are higher in nonmetropolitan areas than in urban areas. Unemployment rates are essentially identical across the urban/nonurban divide. Percent owner-occupied housing presents a unique pattern among the indicators we analyze here. Note that the most affluent tracts in metropolitan areas have dramatically higher rates of homeownership than in the equivalent nonmetropolitan tracts, while the reverse is true for high and extreme poverty neighborhoods. In low and moderate poverty neighborhoods, there is little difference between metropolitan and nonmetropolitan areas on this indicator.

2000 Distributions of Neighborhood Types

We turn next to an analysis of the geographic distribution of neighborhood types as of 2000. Figures 2 and 3 present these distributions, first by region and then by urban area type. We present all remaining data in the form of bar graphs, for ease of visual inspection. A full set of tables upon which the figures are based is available upon request.

Region

The distributions for the Northeast and Midwest are strikingly similar, likely reflecting a relatively common industrial past. Cities in the Northeast were founded and developed earlier than in the Midwest; however, by 1900, industrialization was in full swing in both regions. Owing to its poorer, more rural past, the South has appreciably fewer affluent and low poverty neighborhoods compared to the Northeast and Midwest (about 40% versus about 60%). A plurality of southern census tracts is moderately poor (34.2%), while the South contains the largest percentage of high poverty (22.1%) and extreme poverty (4.4%) neighborhoods of the four census

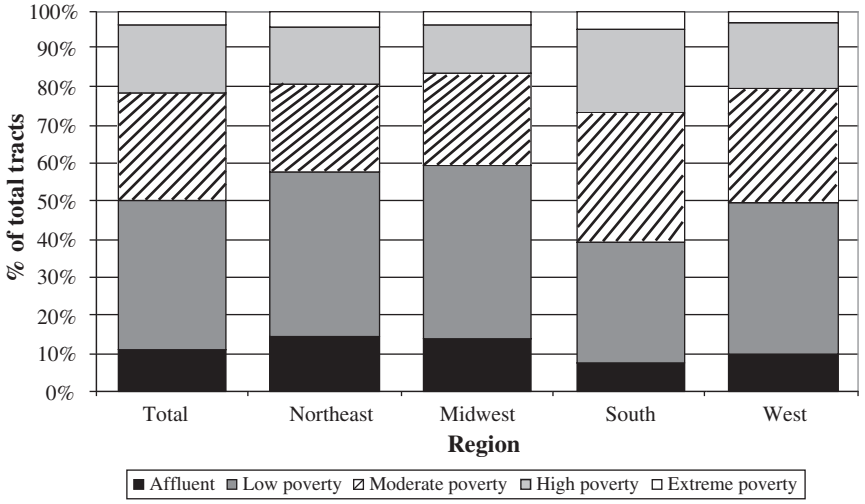

Figure 9.2
Distribution of Neighborhood Types, by Region, 2000. *Source:* Authors' calculations from 2000 U.S. Census data.

regions. The West represents an intermediate case, with a greater percentage of affluent and low poverty tracts, and a lower percentage of the two poorest neighborhood types than the South.

Urban Area Type

Figure 9.3 shows much more variation in the distribution of neighborhood types than did Figure 9.2. Although the total percentages of "nonpoor" (0 to 20% poor) and "poor" (greater than 20% poor) tracts are virtually identical in nonmetropolitan and metropolitan areas (about a 4:1 ratio for each), the tails of the distribution are much smaller in nonmetropolitan than in metropolitan areas. Small towns and rural areas contain very few of the poorest and richest neighborhood types, with a large plurality (45.7%) of tracts falling in the "moderate poverty" type (rates of 10% to 20%). By contrast, only about 24 percent of metropolitan area tracts are moderately poor. This difference is distributed into a much higher percentage of affluent (13.6% vs. 1.9%), and to a lesser extent, low poverty (41.4% vs. 30.7%), and extremely poor (4.3% vs. 2.4%) tracts.

Within metropolitan areas, we are not surprised to observe dramatic differences in the percentage of affluent and extremely poor neighborhoods. Central cities have nearly 12 times the percentage of the poorest neighborhoods compared to suburbs (9.0% vs. 0.8%), and suburbs have nearly 4 times the percentage of affluent tracts (19.8% vs. 5.4%). Fully 92 percent of all suburban tracts fall in the "nonpoor" aggregate category, against 60 percent for central cities. Within this aggregate grouping,

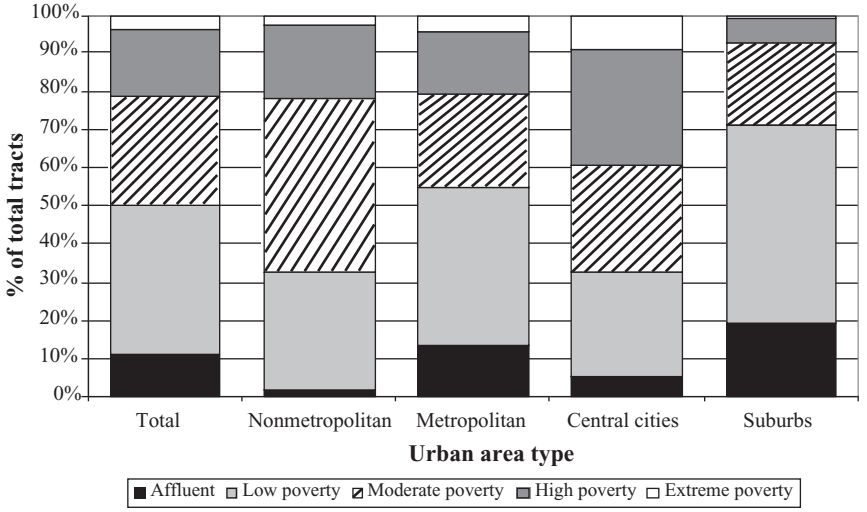

Figure 9.3
Distribution of Neighborhood Types, by Urban Area Type, 2000. *Source:* Authors' calculations from 2000 U.S. Census data.

about 52 percent of suburban tracts are in the "low poverty" category, compared to about 28 percent for central cities.

1990 to 2000 Change in the Distribution of Neighborhood Types

We now analyze relative percent changes ([%2000 − %1990] %1990 × 100) in the distribution of neighborhood types, first by region (Figure 9.4) and then by urban area type (Figure 9.5). Figure 9.4 shows that the 1990s were a decade of shrinking tails in the distribution of neighborhood types. Note that the total percentage of affluent neighborhoods declined by about 9 percent from 1990 to 2000, while the percentage of extremely poor neighborhoods declined nearly 25 percent in relative terms. This latter finding was observed by Jargowsky,[28] and likely reflects the long and robust economic recovery during the Clinton administrations. The three intermediate neighborhood types all showed small growth, indicating that the richest and poorest neighborhoods were redistributed somewhat into these three categories.

Region

These changes were not shared equally across regions, however. The Northeast saw sharp declines in the percentage of affluent tracts (from 19.3 percent in 1990 to 14.6 percent in 2000, yielding a relative decline of almost one-quarter), while the percentage of affluent tracts changed little in the three remaining regions. The 1990s appeared to benefit the Midwest the most, as the percentage of low poverty tracts

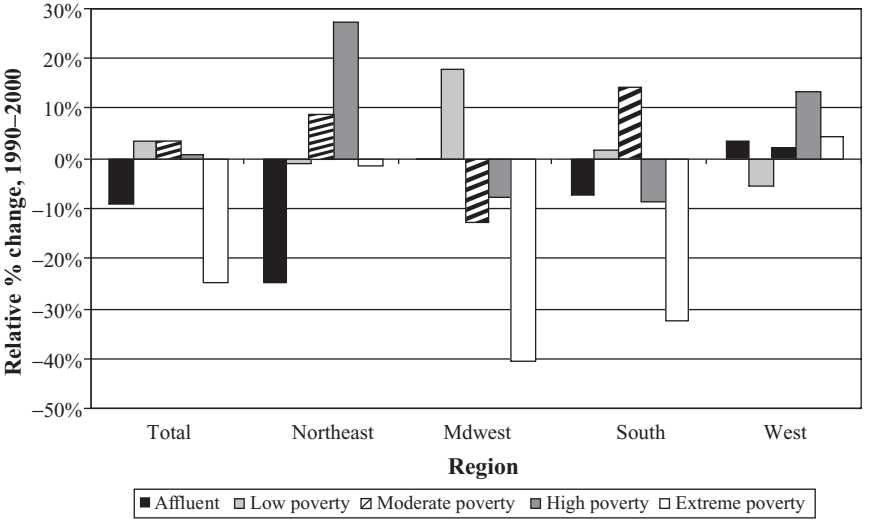

Figure 9.4
Relative Percent Change (1990–2000) in the Distribution of Neighborhood Types, by Region. ***Source:*** **Authors' calculations from 1990 to 2000 U.S. Census data.**

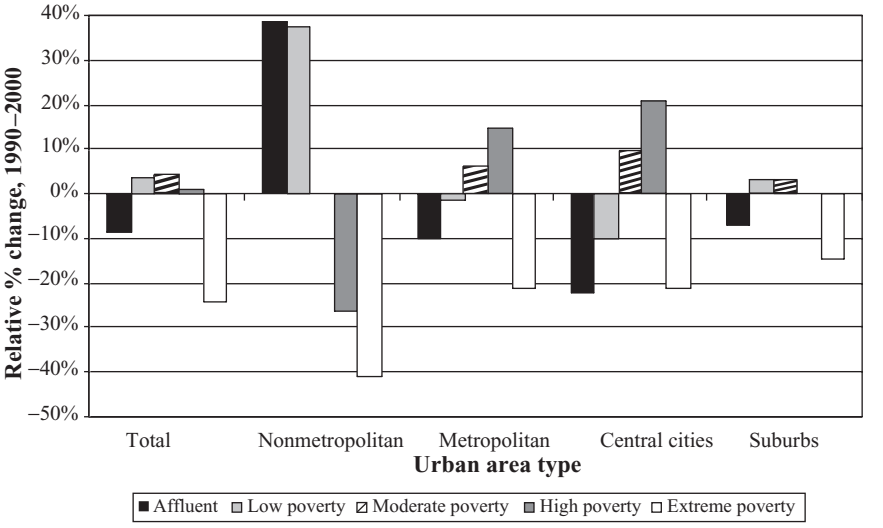

Figure 9.5
Relative Percent Change (1990–2000) in the Distribution of Neighborhood Types, by Urban Area Type. ***Source:*** **Authors' calculations from 1990 to 2000 U.S. Census data.**

increased about 19 percent and the percentage of extremely poor tracts declined by over 40 percent. The South experienced a redistribution of the most affluent and the two poorest neighborhood types into the low and especially moderate poverty types, while the West saw increases in the percentage of all neighborhood types except for the low poverty category.

Urban Area type

Figure 9.5 presents percentage changes in the distribution of neighborhood types across nonmetropolitan and metropolitan areas. Nonmetropolitan areas enjoyed an increase in the proportion of affluent and low poverty tracts and a decline in the percentage of the two poorest neighborhood types. Our data do not permit us to account definitively for these changes, but we suspect that the 1990s benefited nonmetropolitan areas via the continuing tendency of industry to locate in those areas and the resulting attraction of the nonpoor population to these areas. Metropolitan areas and their constituent central cities and suburbs display patterns similar to the overall picture. This is not surprising, given that about 88 percent of all tracts were located in metropolitan areas in 2000. A comparison of central cities and suburbs reveals that the 1990s were a mixed blessing for the former. Central cities experienced sharper relative declines in the proportion of affluent and nonpoor tracts than suburbs, though the percentage of the poorest neighborhood type also declined more in central cities than in the suburbs.

Distributions of Children across Neighborhood Types

The third stage in our analysis concerns the distribution of children (less than age 18) across neighborhood types. We first examine these distributions by race/ethnicity and poverty status, and these two variables by region and urban area type.

Race and Ethnicity

Figure 9.6 presents the distribution of all children, and children from five major racial/ethnic groups. As of 2000, about 80 percent of all children live in the three "nonpoor" neighborhood types. Of these, 12 percent live in affluent, 40 percent are in low poverty, and 28 percent are in moderately poor neighborhoods. Children in poor neighborhoods are distributed into high poverty (17%) and extremely poor neighborhoods (about 3%).

Prior research on racial and ethnic inequality in neighborhood context would predict dramatic levels of variation in these distributions across the five racial/ethnic categories. Indeed, our research bears out these predictions. Whereas about 83 percent of Asian and 89 percent of white children live in the three nonpoor neighborhood types, those percentages are about 52 percent for black, 59 percent for Hispanic, and 55 percent for American Indian children. Within the nonpoor category, white and Asian children live in affluent neighborhoods at about five times the rate of the three other groups, about 15 percent compared to 3 or 4 percent. At the other end of the distribution, rates of exposure to extremely poor neighborhoods average 12 percent

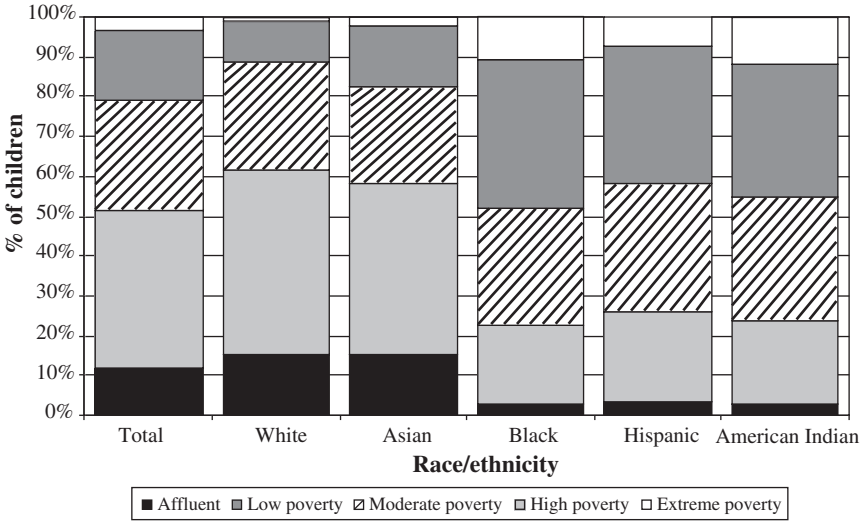

Figure 9.6
Distribution of Children in Neighborhood Types, by Race/Ethnicity, 2000. ***Source:*** **Authors' calculations from 2000 U.S. Census data.**

for American Indian, 10 percent for black, 7 percent for Hispanic, 2 percent for Asian, and 1 percent for white children. Over 40 percent of black, American Indian, and Hispanic children can be found in neighborhoods with poverty rates in excess of 20 percent in 2000, against only 11 percent of white and 17 percent of Asian children.

Thus, at least on the dimension of children's exposure to neighborhood poverty and affluence, by 2000 the American racial/ethnic hierarchy has effectively become bifurcated into a white/Asian component and a black/Hispanic/American Indian component. Indeed, the graphical method of presenting results employed in this chapter drives this point home visually. Note that the white and Asian distributions collectively look starkly different from those of the three remaining groups, which in turn look remarkably similar.

Counterbalancing this rather gloomy snapshot is Figure 9.7, which shows overall changes in the distribution of children in neighborhood types, and presents findings broken down by race and ethnicity. Overall, children's exposure to the poorest neighborhood type declined substantially in the 1990s, from 5.0 percent of all children in 1990 to 3.2 percent in 2000. These improvements were experienced most dramatically by black children, whose representation in extremely poor neighborhoods declined 44 percent, from a 1990 rate of 18.3 percent to 10.3 percent in 2000. American Indian and Hispanic children's exposure to the poorest neighborhood type declined by about 38 percent, while Asian and white children experienced less dramatic relative declines (32 percent and 29 percent, respectively), from an already very low 1990 baseline.

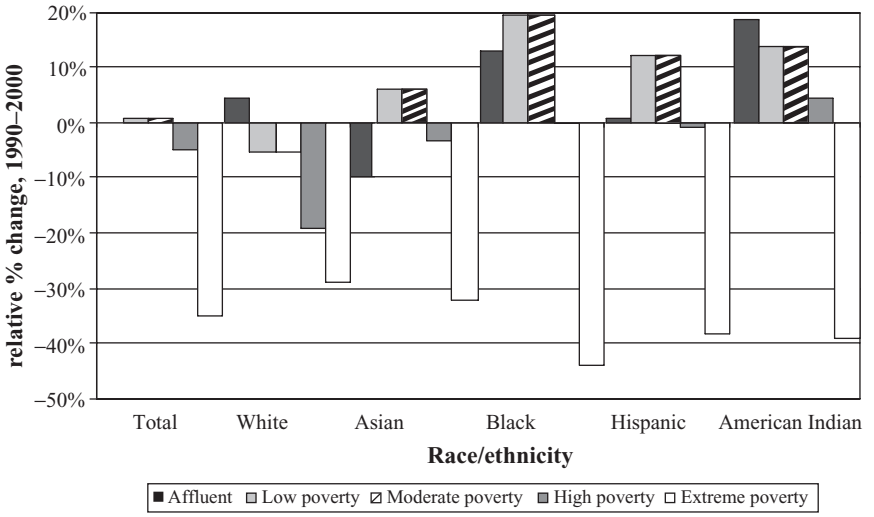

Figure 9.7
Percent Change (1990–2000) in the Distribution of Children in Neighborhood Types, by Race/Ethnicity. *Source:* Authors' calculations from 1990 to 2000 U.S. Census data.

Overall, it appears as though the 1990s were quite beneficial for children from the three most disadvantaged racial and ethnic groups. In addition to the findings regarding changes in exposure to extremely poor neighborhoods already reported, black and American Indian children experienced substantial increases in their exposure to the three nonpoor neighborhood types, and Hispanic children experienced increases in exposure to two of the three. In comparison, Asian children experienced a decline in exposure to the most affluent neighborhood type, and white children experienced increasing exposure to neighborhood affluence and declining exposure to the four other neighborhood types.

Poverty Status

Figure 9.8 presents the 2000 distributions of poor and nonpoor children in the five neighborhood types, and the relative percent change in those distributions from 1990 to 2000. The left-hand section of the figure shows dramatic differences in the neighborhood contexts to which poor and nonpoor children are exposed. As of 2000, nearly 50 percent of poor children live in neighborhoods with poverty rates of at least 20 percent, compared to only 12 percent of their nonpoor counterparts. At the other end of the distribution, about 59 percent of nonpoor children live in the two least poor neighborhoods, of which 14.4 percent live in neighborhoods we categorize as "affluent." The equivalent percentages for poor children are 19 percent and 1.3 percent, respectively. The right-hand section of Figure 9.8 shows marked improvements in poor children's exposure to neighborhood poverty and affluence. The percentage of poor children living in the three "nonpoor" neighborhood types all increased

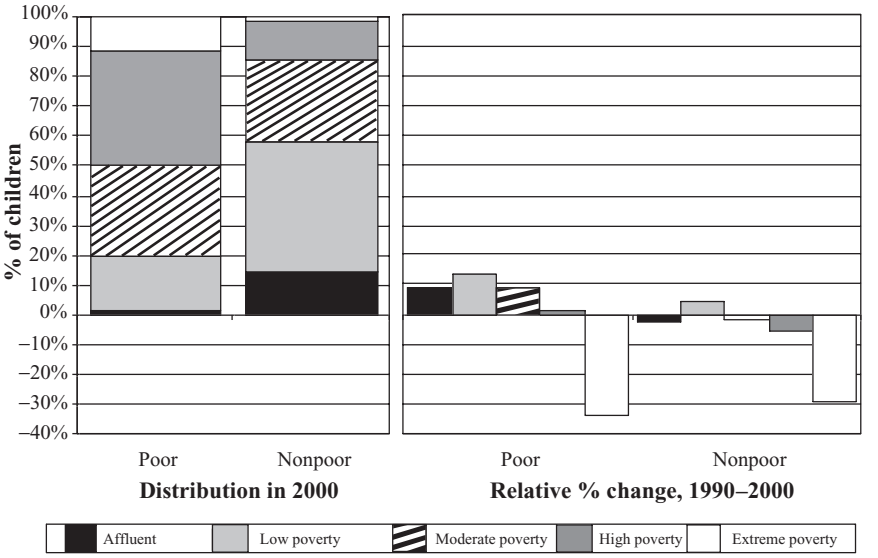

Figure 9.8
Distribution of Children in Neighborhood Types, by Poverty Status, 2000 and Relative Percent Change, 1990–2000. ***Source:*** **Authors' calculations from 1990 to 2000 U.S. Census data.**

during the 1990s, and the percentage exposed to extremely poor neighborhoods declined by about one-third, from a 1990 level of 17 percent to about 11 percent in 2000. Nonpoor children experienced almost no change in their neighborhood poverty distributions—the large bar associated with extremely poor neighborhoods represents a small absolute decline in exposure, from 2.2 percent in 1990 to 1.6 percent in 2000.

Race/Ethnicity and Region

Figure 9.9 presents distributions of children in the five neighborhood types by race/ethnicity and region. In general, the findings in Figure 9.9 conform to those in Figure 9.6; however, several noteworthy regional differences are apparent. First, white children in the Northeast and Midwest are much more likely to live in the most affluent neighborhoods than their southern and western counterparts. About 72 percent of white children from the first two regions live in neighborhoods with less than 10 percent, compared to only 51 percent in the South and 57 percent in the West. White children are about twice as likely to live in the most affluent type in the former compared to the latter two regions (about 20% vs. about 10%). black children, by contrast, experience the lowest exposure to extremely poor neighborhoods in the West—about 7 percent in 2000—compared to the Northeast and Midwest (about 14% and 12%, respectively).

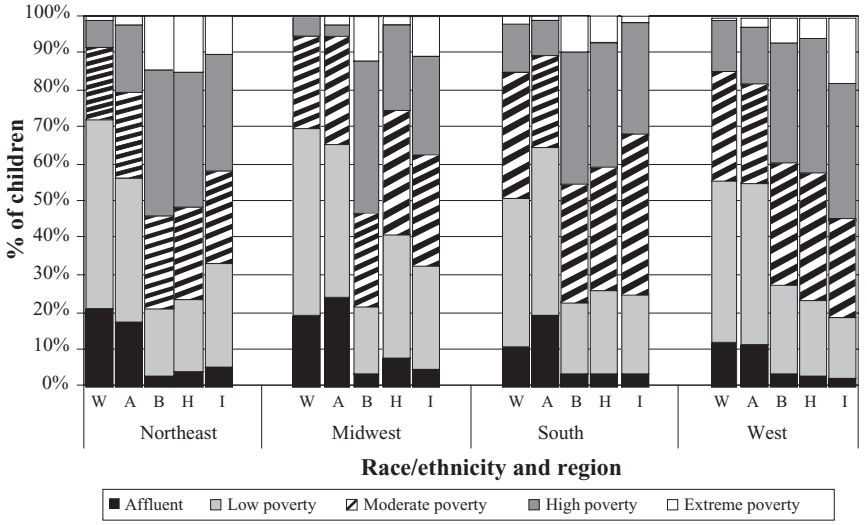

Figure 9.9
Distribution of Children in Neighborhood Types, by Race/Ethnicity and Region, 2000.
Source: **Authors' calculations from 2000 U.S. Census data.**

Hispanic children in the Midwest experience much more advantaged neighborhood contexts compared to their co-ethnics from other regions. Over 40 percent of midwestern Hispanic children live in the two most affluent neighborhood types, compared to about 25 percent in the Northeast, South, and West. At the other end of the distribution, about 25 percent of midwestern Hispanic children live in the two poorest neighborhood types, including only 2 percent in extremely poor neighborhoods. This latter figure declined from 7 percent in 1990, representing a relative decrease of about 72 percent (data not shown). In contrast, exposure to the two poorest neighborhood types combined averages 52 percent in the Northeast (of which 15% are in extremely poor neighborhoods), 41 percent in the South, and 43 percent in the West.

Asian children in the Midwest are twice as likely to live in affluent neighborhoods than their western counterparts (24% vs. 12%) and southern Asian children are substantially less likely to live in the two poor neighborhood types compared to Asian children in the Northeast and West (11% versus 21% and 19%, respectively). Finally, about 56 percent of western American Indian children live in the two poorest neighborhood types, of which about 18 percent live in tracts with greater than 40 percent poverty rates. This represents the largest single race/ethnicity by region concentration we observed in 2000. Only 2 percent of western American Indian children live in affluent neighborhoods, one-half to one-third the rate of American Indian children in the three other regions.

What accounts for the regional variation we observe? We suspect it is largely due to class-selective internal migration, at least for the four non-White groups. Note

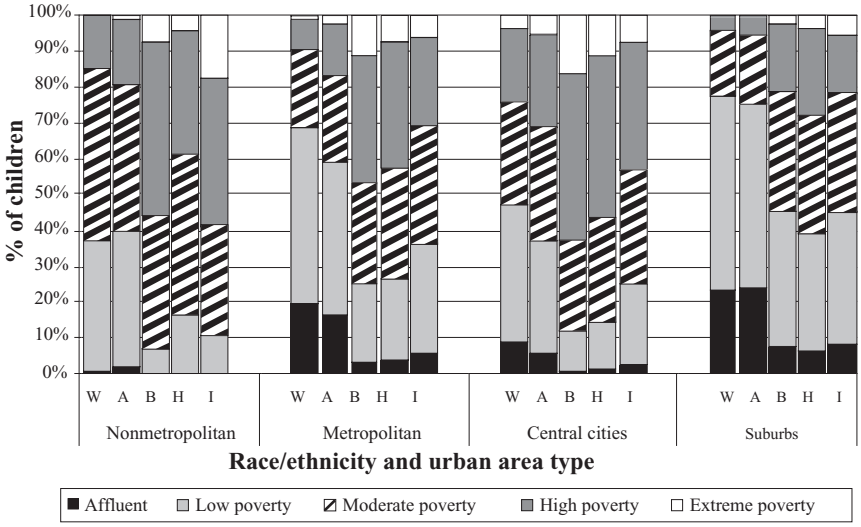

Figure 9.10
Distribution of Children in Neighborhood Types, by Race/Ethnicity and Urban Area Type, 2000. *Source:* Authors' calculations from 2000 U.S. Census data.

that in each case outlined above, children experienced their most advantaged contexts in regions that have historically been destinations for internal migrants. For blacks, historically concentrated in the South, and following the Great Migration in the Northeast and Midwest, children experience the least neighborhood disadvantage in the West, a more recent destination for black migrants. For Hispanic children, the largest ports of entry for immigrants are in the South (including Florida and Texas), the West (including Arizona and California), and the Northeast (including New York and New Jersey). Thus, midwestern Hispanic children are likely to be children of internal migrants, who may be selected for income, education, or other class factors. Asian immigrants largely enter the United States through gateway cities in the West and Northeast; hence, children in the South and West are likely also children of more advantaged internal migrants. Therefore, regional variation in children's exposure to neighborhood poverty and affluence may have less to do with variation in the treatment of different racial/ethnic groups than with the class composition of members of those groups.

Race/Ethnicity and Urban Area Type

Figure 9.10 presents distributions of children in the five neighborhood types by race/ethnicity and urban area type. Figure 9.10 shows that children in small towns and rural areas tend to experience much poorer neighborhood contexts than their urban counterparts. Whereas 70 percent of white and 60 percent of Asian children in metropolitan areas live in neighborhoods with poverty rates of less than 10 percent, the equivalent figures for nonmetropolitan areas are 38 percent and 40 percent.

black and American Indian children are much more likely to live in these two types of neighborhoods in metropolitan areas (25% and 37%, respectively) than in rural areas and small towns (8% and 11%, respectively). At the other end of the distribution, 56 percent of black children live in the two poorest neighborhood types in nonmetropolitan areas. In metropolitan areas this figure is about 47 percent, although urban black children are more likely than rural and small town children to live in the poorest neighborhood type (11% vs. 7%, respectively). American Indian children are nearly twice as likely to live in the two combined poor neighborhoods in nonmetropolitan relative to metropolitan areas (59% vs. 31%, respectively), and almost three times more likely to live in the poorest neighborhood type in rural areas and small towns relative to urban areas (17% vs. 6%). Hispanic children are a somewhat anomalous case, experiencing less exposure to neighborhood affluence and about the same exposure to neighborhood poverty in metropolitan relative to nonmetropolitan areas.

Within metropolitan areas, we observe substantial variation in the distributions of children between central cities and suburbs, and substantial racial/ethnic variation within each of these components. This is not surprising, given that a vast literature details the increasing concentration of poverty in central city neighborhoods in the 1970s and 1980s,[29] as well as racial/ethnic inequality in both the propensity of groups to reside in the suburbs and the attainment of high-SES neighborhoods within suburbs.[30]

Indeed, the two right-hand sets of bars in Figure 9.10 reveal that central city children experience far more disadvantaged neighborhood contexts than suburban children, and that, as shown in Figure 9.6, there are essentially two racial/ethnic patterns: one for whites and Asians, and one for blacks, Hispanics and American Indians. The one exception to this latter rule is that American Indian children in central cities evince substantially more exposure to nonpoor neighborhoods—especially the low poverty type—and substantially less exposure to neighborhood poverty than either blacks or Hispanics. Note also the similarity between the central city distributions for white and Asian children and the suburban distributions for black, Hispanic, and American Indian children. If neighborhood conditions are one source of mobilization for political coalitions that cross-racial and ethnic lines,[31] the findings in Figure 9.10 suggest that central city whites and Asians and suburban blacks, Hispanics, and American Indians would be natural allies. However, given the separation between these groups by physical distance and municipal boundaries, such a coalition would seem unlikely to form or persist over time.

Poverty Status, Region, and Urban Area Type

Figure 9.11 presents distributions of children in the five neighborhood types by poverty status, region (the left-hand section), and urban area type (the right-hand section). For poor children, about half live in each of the aggregated nonpoor and poor categories, and within those types there are nearly identical distributions of children in the disaggregated neighborhood types. In the Northeast, a slightly larger percentage of children live in the low poverty and extreme poverty types than in the South and West.

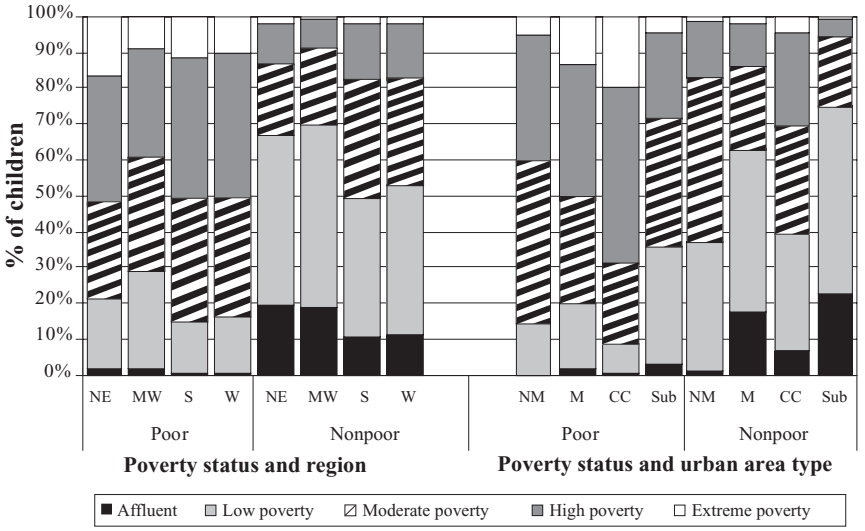

Figure 9.11
Distribution of Children in Neighborhood Types, by Poverty Status, Region, and Urban Area Type, 2000. *Source*: Authors' calculations from 2000 U.S. Census data.

In the Midwest, children are twice as likely to live in low poverty neighborhoods as in the South and West (about 30% vs. about 15%, respectively), with the distributions in each of the other four neighborhood types being about equal in these three regions. For nonpoor children, there is a split between the distributions in the Northeast and Midwest, and in the South and West. These differences are driven primarily by larger representations of children in the most affluent neighborhood type and smaller percentages of children in high poverty neighborhoods in the former relative to the latter two regions.

With respect to variation across urban area types, the most striking finding concerns the distribution of poor children in central cities. As of 2000, nearly 70 percent of poor central city children live in the two poorest neighborhood types, of which fully 20 percent live in extremely poor neighborhoods. As shown in Figure 9.1, these are neighborhoods with low median incomes, percentages of residents with a college degree, median home values, and percentages of owner-occupied housing, and extremely high rates of unemployment and vacant housing. If growing up in such neighborhood contexts has deleterious effects on children, then it is clear from Figure 9.11 that a great majority of poor urban children are at a disadvantage relative to their poor nonmetropolitan and suburban counterparts. Indeed, poor children in suburbs experienced about two-fifths the rate of exposure to high and extreme poverty neighborhoods as poor children in central cities. Finally, to take the most extreme cross-group comparison, note that less than *6 percent* of nonpoor suburban children live in the two poorest neighborhood types (compared to the previously reported

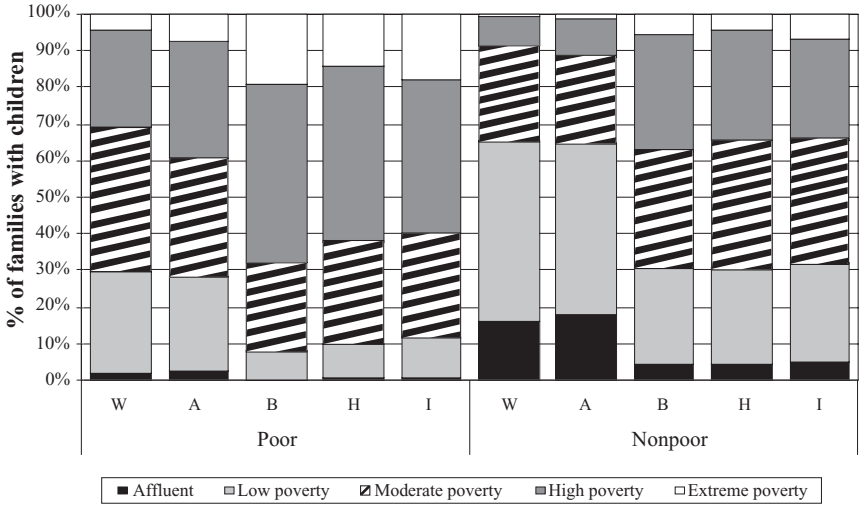

Figure 9.12
Distribution of Families with Children in Neighborhood Types, by Poverty Status and Race/Ethnicity, 2000. *Source:* Authors' calculations from 2000 U.S. Census data.

70%), and nearly a quarter live in the most affluent type, compared to four-tenths of 1 percent among poor central city children.

Distributions of Families with Children Across Neighborhood Types

As noted previously, the NCDB does not provide breakdowns of children by race/ethnicity and poverty status; hence, we use a proxy measure—poor and nonpoor families with children.

Race/Ethnicity and Poverty Status

Figure 9.12 presents the 2000 distributions of families with children in the five neighborhood poverty types, by race/ethnicity and poverty status. As with Figure 9.6, note the remarkable similarity in the distributions of white and Asian families versus black, Hispanic, and American Indian families, a finding that holds for both poor and nonpoor families alike. Among the poor, nearly 70 percent of white families with children live in the three nonpoor neighborhood types, while about 60 percent of poor Hispanic and American Indian families and nearly 70 percent of black families with children live in the two poorest neighborhood types. Nearly half of black poor families live in high poverty neighborhoods, with the remaining 20 percent living in extremely poor neighborhoods. The equivalent percentages for poor white families are 25 percent and 5 percent. Poor Asian families experience about the same exposure to nonpoor neighborhoods as whites, but are more heavily represented in high poverty neighborhoods than are whites. Among the nonpoor, nearly 90 percent of white and Asian families live in nonpoor neighborhoods, compared to about 65 percent of families from the three other groups. As in Figure 9.10, note that the distributions

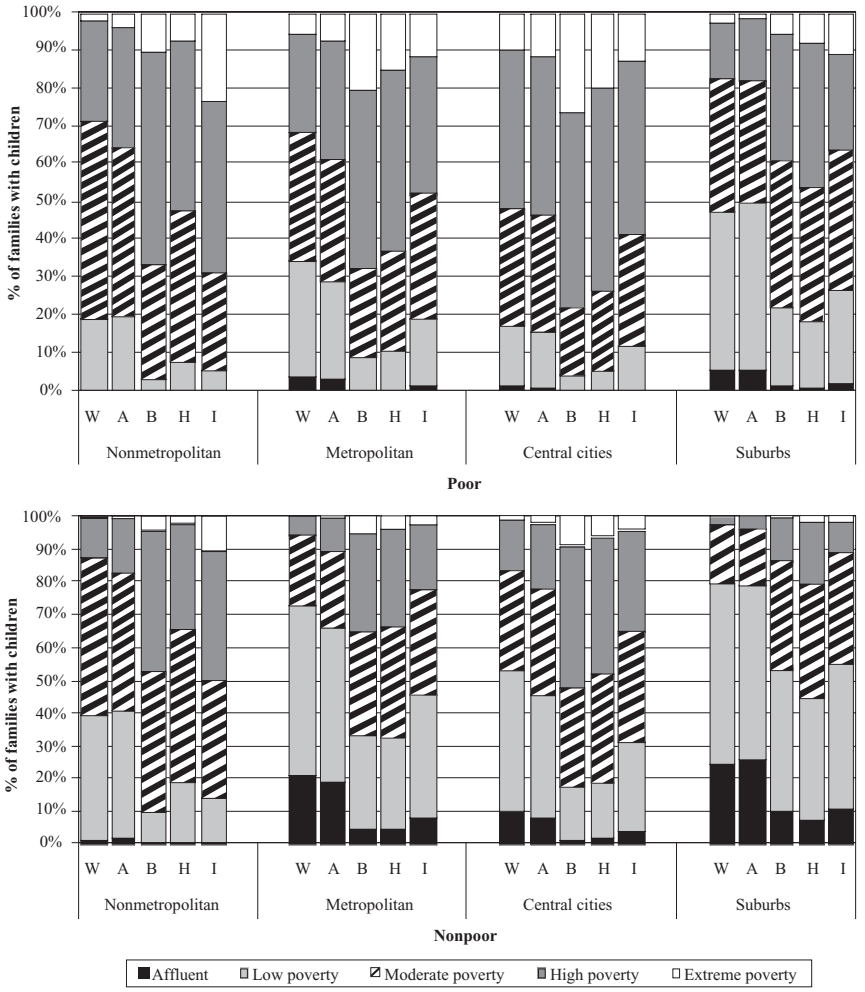

Figure 9.13
Distribution of Families with Children in Neighborhood Types, by Poverty Status, Race/Ethnicity, and Urban Area Type, 2000. ***Source:*** **Authors' calculations from 2000 U.S. Census data.**

of nonpoor black, Hispanic, and American Indian families look virtually identical to the distributions for poor white and Asian families. Thus, in terms of exposure to neighborhood poverty and affluence in the United States, poverty for whites and Asians is more or less equivalent to nonpoverty for the three other racial/ethnic groups.

Race/Ethnicity, Poverty Status, and Urban Area Type

Figure 9.13 presents the neighborhood poverty distributions for poor and nonpoor families, by race/ethnicity and urban area type. This three-way cross-classification

of independent variables produce a large number of data points, so we focus our discussion on poor central city black and Hispanic families—the "truly disadvantaged" families on whom much scholarly attention has been focused over the past two decades—and on nonpoor suburban white and Asian families with children. This latter set of groups is sometimes thought to be the American "mainstream"—groups that face little discrimination in the labor market and who have achieved both nonpoor economic status and residence in American suburbs.

Figure 9.13 shows that as of 2000, nearly 80 percent of poor central city black families live in neighborhoods with poverty rates of at least 20 percent. About 27 percent of black poor central city families reside in the poorest neighborhood type, those with poverty rates in excess of 40 percent. The corresponding figures for Hispanic families are 74 percent and 20 percent. These figures correspond to about 237,000 poor black families (5.1% of all black families) and 138,000 poor Hispanic families (2.8% of all Hispanic families) living in the poorest central city neighborhoods. In contrast, between 50 percent and 60 percent of poor central city families from the three other groups live in the two poorest neighborhood types, of which 10 percent to 12 percent live in the poorest type. For whites, only about 75,000 poor families live in extremely poor central city neighborhoods, about 0.3 percent of all white families. Thus, in proportionate terms, there are 17.3 times as many poor black central city families living in the poorest neighborhoods as equivalent white families ($0.051 \; 0.003 = 17.3$). As astounding as these levels of inequality are, they represent some improvement from 1990 to 2000. The share of poor black and Hispanic central city families in the poorest neighborhood type declined by about one-third during this decade, compared to about one-quarter for white families (data not shown).

At the other end of the distribution, nearly every nonpoor suburban white and Asian family (96%) lived in one of the three "nonpoor" neighborhood types. These rates for the three other groups were 85 percent for black, 78 percent for Hispanic, and 86 percent for American Indian families. However, here is another instance where disaggregating the nonpoor category reveals more inequality than would otherwise be observed—about 25 percent of white and Asian nonpoor suburban families lived in "affluent" neighborhoods, compared to only 10 percent, 8 percent, and 11 percent for black, Hispanic, and American Indian families, respectively. Note finally from Figure 9.13 that the "moderate poverty" bars are much larger for the latter three groups compared to whites and Asians. This indicates that a substantial fraction of nonpoor suburban black, Hispanic, and American Indian families are living in neighborhoods with 10 percent to 20 percent of their residents in poverty. In short, even when they are nonpoor, and even when they are suburbanized, black, Hispanic, and American Indian families with children face much greater exposure to neighborhood poverty than their white and Asian counterparts.

We find that about 46 percent of all nonpoor white and Asian families live in the two most affluent neighborhood types in the suburbs. These figures correspond to about 40 percent of all white and Asian families. This datum deserves special emphasis: *about 40* percent *of all white and Asian families are* nonpoor *and reside in* suburban *neighborhoods with poverty rates of* 10 percent or less. The corresponding figures for black, Hispanic, and American Indian families are 15 percent, 16 percent, and

13 percent, respectively. Returning to our analysis of exposure to central city neighborhood poverty, 15 percent of all black families and 11 percent of all Hispanic families are poor and reside in central city neighborhoods with poverty rates of 20 percent or more. The corresponding figures for whites and Asians are 2 percent and 4 percent. Irrespective of poverty status and central city/suburban residence, fully 39 percent of black and 38 percent of Hispanic urban families with children live in the two poorest neighborhood types, compared to 7 percent for white and 14 percent for Asian families.

CONCLUSIONS

Our goal in this chapter was to present descriptive data on the levels of and changes in the exposure of children from five major racial and ethnic groups to neighborhoods with drastically different socioeconomic profiles. We showed that many important indicators of neighborhood SES vary dramatically across neighborhood poverty types, and that in general nonmetropolitan areas are less well off on the six indicators analyzed than metropolitan areas. We then presented changes in the geographic distribution of poor and nonpoor neighborhoods, finding scant variation by region and much more substantial variation by urban area type. We argued that although American Indian, black, and Hispanic children continue to suffer much higher rates of exposure to neighborhood poverty than their white and Asian counterparts, the 1990s was also a decade of hopeful improvements in the neighborhood conditions of children from the more disadvantaged groups. Finally, we demonstrated that although poor and nonpoor children and families with children from the five racial/ethnic groups may nominally share residential space in metropolitan areas, black, Hispanic, and American Indian children continue to be exposed to dramatically higher rates of neighborhood poverty than their white and Asian counterparts.

Over a decade ago, Douglas Massey and Nancy Denton demonstrated that the spatial segregation of a racial or ethnic group with high poverty rates has the mathematical effect of concentrating poverty in the neighborhoods of that group.[32] In subsequent work, Massey and Mary Fischer noted that just as segregation and increasing poverty interact to generate ever-growing poverty concentrations, the reverse occurs if either segregation or the poverty rate of a segregated group declines.[33] For at least 30 years, blacks and Hispanics have been both residentially segregated and suffered dramatically higher rates of poverty than their white counterparts. And, *ipso facto*, for at least 30 years, poverty has been highly concentrated in black and Hispanic neighborhoods. However, during the 1990s segregation declined appreciably for African Americans, and the U.S. economy showed nearly unprecedented levels of economic growth and prosperity. We believe we have detected at least one of the effects of these changes; namely, black, Hispanic, and American Indian children's exposure to neighborhood poverty declined appreciably in the 1990s.

The results of this analysis, along with those of Jargowsky,[34] suggest that neighborhood conditions for children, at least along various socioeconomic dimensions, are dramatically affected by the health of the national, regional, state, and local economies. As such, the findings of this analysis would prescribe prolonged and robust economic development for improving the neighborhood conditions of America's

children. Of course, such development is not always subject to the whims of policy makers, given normal business cycle fluctuations over time. What is more under the control of policy makers are antipoverty policies, specifically job growth policies, that would target residents of poor neighborhoods. Finally, although residential desegregation policies have rarely been given serious consideration, it is clear that dispersing poor and minority group members throughout American metropolitan would serve to reduce the stark levels of inequality in exposure to neighborhood poverty and affluence observed in this chapter.

NOTES

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1. Lee Rainwater and Timothy M. Smeeding, *Poor Kids in a Rich Country: America's Children in Comparative Perspective* (New York: Russell Sage Foundation, 2003).

2. Luxembourg Income Study [LIS], "Key Figures," accessed April 24, 2006, http://www.lisproject.org/keyfigures.htm. Data from Census 2000 estimates the U.S. rate to be 16.6 percent (See Table 1). This discrepancy is due to variation in the definition of poverty status. See LIS for details on measurement.

3. Ibid.

4. Mary Corcoran, "Rags to Rags: Poverty and Mobility in the United States," *Annual Review of Sociology* 21 (1995); Robert Haveman and Barbara Wolfe, "The Determinants of Children's Attainments: A Review of Methods and Findings," *Journal of Economic Literature* 33 (1995); Greg J. Duncan, W. Jean Yeung, Jeanne Brooks-Gunn, and Judith R. Smith, "How Much Does Childhood Poverty Affect the Life Chances of Children?" *American Sociological Review* 63(1997); Susan E. Mayer, *What Money Can't Buy: Family Income and Children's Life Chances* (Cambridge, MA: Harvard University Press, 1997).

5. Ibid, 42.

6. In 1960 the black poverty rate was about 55 percent compared to only about 18 percent for whites. Black poverty rates declined dramatically in the 1960s, reaching about 32 percent in 1970, compared to about 10 percent for whites. For most of the 1970 to 2000 period, Black poverty rates have averaged about 30 percent, compared to about 10 percent for whites, 25 percent for Hispanics, and 12 percent for Asians. See U.S. Bureau of the Census, "Historical Poverty Tables," accessed May 10, 2006, http://www.census.gov/hhes/www/poverty/histpov/hstpov2.html. In 2003, poverty rates for blacks, Hispanics, whites, and Asians were estimated to be 24 percent, 23 percent, 8 percent, and 12 percent, respectively. See U.S. Bureau of the Census, "Income Stable, Poverty Up, Numbers of Americans With and Without Health Insurance Rise, Census Bureau Reports," accessed April 21, 2006, http://www.census.gov/Press-Release/www/releases/archives/income_wealth/002484.html>.

7. Christopher Jencks and Susan E. Mayer, "The Social Consequences of Growing up in a Poor Neighborhood," in *Inner-City Poverty in the United States*, ed. Laurence E. Lynn, Jr. and Michael G. H. McGeary (Washington, DC: National Academy Press, 1990): 111; Robert J. Sampson, Jeffrey D. Morenoff, and Thomas Gannon-Rowley, "Assessing 'Neighborhood Effects:' Social Processes and New Directions in Research," *Annual Review of Sociology* 28(2002): 446.

8. William J. Wilson, *The Truly Disadvantaged: The Inner City, the Underclass, and Public Policy* (Chicago: The University of Chicago Press, 1987), 57.

9. Sampson, Morenoff, and Gannon-Rowley, "Assessing 'Neighborhood Effects:' Social Processes and New Directions in Research."

10. James P. Connell and Bonnie L. Halpern-Felsher, "How Neighborhoods Affect Educational Outcomes in Middle Childhood and Adolescence: Conceptual Issues and an Empirical Example," in *Neighborhood Poverty Volume I: Context and Consequences for Children*, ed. Jeanne Brooks-Gunn, Greg J. Duncan, and J. Lawrence Aber (New York: Russell Sage Foundation, 1997); David J. Harding, "Counterfactual Models of Neighborhood Effects: The Effect of Neighborhood Poverty on Dropping Out and Teenage Pregnancy," *American Journal of Sociology* 109 (2003).

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12. Greg J. Duncan, Johanne Boisjoly, and Kathleen Mullan Harris, "Sibling, Peer, Neighbor, and Schoolmate Correlations as Indicators of the Importance of Context for Adolescent Development," *Demography* 38 (2001); Bruce H. Rankin and James M. Quane, "Social Contexts and Urban Adolescent Outcomes: The Interrelated Effects of Neighborhoods, Families, and Peers on African American Youth," *Social Problems* 49 (2002).

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14. See, e.g., Richard D. Alba and John R. Logan, "Variations on Two Themes: Racial and Ethnic Patterns in the Attainment of Suburban Residence," *Demography* 28 (1991); Emily Rosenbaum and Samantha Friedman, "Differences in the Locational Attainment of Immigrant and Native-Born Households with Children in New York City," *Demography* 38 (2001); Craig St. John and Shana M.B. Miller, "The Exposure of Black and Hispanic Children to Urban Ghettos: Evidence from Chicago and the Southwest," *Social Science Quarterly* 76 (1995).

15. Paul A. Jargowsky, *Poverty and Place: Ghettoes, Barrios, and the American City* (New York: Russell Sage Foundation, 1997); Paul A. Jargowsky, "Stunning Progress, Hidden Problems: The Dramatic Decline of Neighborhood Poverty in the 1990s," Living Cities Census Series Report, Center on Urban and Metropolitan Policy (Washington, DC: The Brookings Institution, 2003).

16. St. John and Miller, "The Exposure of Black and Hispanic Children to Urban Ghettos."

17. GeoLytics, Inc., "Census CD Neighborhood Change Database 1970–2000 Tract Data," Machine-readable data file (East Brunswick, NJ, 2003).

18. The Census Bureau defines census tracts as "small, relatively permanent statistical subdivisions of a county . . . [with] between 2,500 and 8,000 persons and, when first delineated, are designed to be homogeneous with respect to population characteristics, economic status, and living conditions" (U.S. Bureau of the Census, *Census of Population and Housing, 1990 United States: Summary Tape File 3A, Technical Documentation, Appendix A*, (Washington, DC: U.S. Department of Commerce, Bureau of the Census, 1992). While tracts may not perfectly replicate the subjective definitions citizens have of their "neighborhoods," many researchers have used tracts as the best available proxy.

19. Because the sociological concept of "neighborhood" generally requires at least a moderate degree of propinquity among residents, it isn't evident that rural or small town census tracts

have sociologically meaningful levels of "neighborhood" poverty. Nevertheless, because the distribution of neighborhood types and racial/ethnic groups in those types differs dramatically in nonmetropolitan relative to metropolitan areas, we include nonmetropolitan areas in the analysis for comparison's sake.

20. Paul A. Jargowsky and Mary Jo Bane, "Ghetto Poverty in the United States, 1970-1980," in *The Urban Underclass*, ed. Christopher Jencks and Paul Peterson (Washington, DC: The Brookings Institution, 1991).

21. This neighborhood type might be more precisely labeled "extremely nonpoor," since it is not necessarily true that neighborhoods with low poverty rates are affluent in other respects. Our analysis of 2000 census data reveals that the average 1999 median family income in "affluent" neighborhoods fell between the 91st and 92nd percentiles of the entire family income distribution. Although there is obviously variation around that average (i.e., not all "extremely nonpoor" neighborhoods also have high median family incomes), this fact, combined with the findings we present in Figure 9.1, suggest that this neighborhood type corresponds well to a reasonable definition of "affluent."

22. The findings presented using this proxy measure are conservative estimates of the true level of racial and ethnic inequality, because the average black or Hispanic family has more children than the average white or Asian family (about 1.31 and 1.64 versus 0.88 and 1.05 children per family, respectively [authors' calculations from U.S. Census data, 2000]).

23. $8.6\% = 0.16$ (proportion of Black central city children in extremely poor neighborhoods from Figure 10) $\times$ 0.53 (proportion of black children in central cities from Table 9.1) $\times$ 100, and 0.086×10.75 million Black children $\approx$ 927,000 black children.

24. Douglas S. Massey and Nancy A. Denton, *American Apartheid: Segregation and the Making of the Underclass* (Cambridge, MA: Harvard University Press, 1993), 135.

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27. Robert J. Sampson, Jeffrey D. Morenoff, and Felton Earls, "Beyond Social Capital: Spatial Dynamics of Collective Efficacy for Children," *American Sociological Review* 64 (1999).

28. Jargowsky, "Stunning Progress."

29. Wilson, *Truly Disadvantaged*; Jargowsky, *Poverty and Place*.

30. Alba and Logan; Scott J. South, and Kyle D. Crowder, "Residential Mobility between Cities and Suburbs: Race, Suburbanization, and Back-to-the-city Moves," *Demography* 34 (1997).

31. John R. Logan and Harvey L. Molotch, *Urban Fortunes: The Political Economy of Place* (Berkeley, CA: University of California Press, 1987).

32. Massey and Denton, *American Apartheid*.

33. Douglas S. Massey and Mary J. Fischer, "How Segregation Concentrates Poverty," *Ethnic and Racial Studies* 23 (2000).

34. Jargowsky, "Stunning Progress."

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CHAPTER 10

CHILDREN AND THE CHANGING SOCIAL ECOLOGY OF ECONOMIC DISADVANTAGE IN URBAN AMERICA

Robert L. Wagmiller, Jr.

Children living in high-poverty neighborhoods, regardless of their own family economic circumstances, face challenges that children residing in more affluent neighborhoods do not. They experience poorer home environments, less maternal warmth, and less cognitive stimulation from their mothers.[1] They encounter greater social and physical disorder and lower levels of child-centered control in their neighborhoods.[2] They see fewer stably employed men and women in their neighborhoods and their parents have fewer friends who are stably employed or college graduates and more friends and neighbors who are on public assistance.[3] A culture of despair that further impedes achievement and fosters delinquency oftentimes arises in their neighborhoods.[4]

Consequently, children in these neighborhoods typically fare worse than similarly situated children in more affluent neighborhoods.[5] They score lower on IQ and educational achievement tests.[6] They have higher rates of behavior problems.[7] They are more likely to experience depression, anxiety, oppositional defiant disorder, and conduct disorder.[8] They are more likely to drop out of high school.[9] They engage in riskier sexual behavior, resulting in higher teenage pregnancy rates.[10] They commit more delinquent acts and more serious delinquent acts.[11]

Although exposure to extreme levels of neighborhood poverty has many harmful consequences for children, no study has comprehensively examined children's exposure to extreme levels of neighborhood poverty. Previous studies have documented trends for the entire population,[12] but no study has reported trends for children separately. There are, however, several reasons to believe that levels of exposure and trends for children may differ from those for adults and the population as a whole. First, poverty rates for families with children are much higher than for families without children, which may make it more difficult for families with children to escape high-poverty neighborhoods.[13] Second, growing segregation by life course cycle in the

metropolis, with childless individuals and couples increasingly inhabiting city neighborhoods, may lead to greater racial and ethnic disparities in exposure to concentrated disadvantage for children because of the overrepresentation of poor, minority children in those families that remain in the city.[14] Third, while segregation by race and ethnicity declined for adults between 1990 and 2000, it increased for children.[15] Consequently, the exposure of minority children to extreme levels of neighborhood poverty may not have declined as dramatically in the 1990s as did overall levels of exposure for minority group members.[16] Jargowsky, in the only study that has examined children's levels of exposure to high-poverty neighborhoods, reports that in 1990 poor children and black and Hispanic children were more likely to live in high-poverty neighborhoods than poor adults and black and Hispanic adults.[17]

This chapter makes several contributions to the growing literature on neighborhood poverty. First, it develops a comprehensive, multidimensional framework for assessing the social ecology of children's economic disadvantage. Second, it uses this framework to investigate racial and ethnic group disparities in children's exposure to economic disadvantage in urban America. Levels and trends in children's exposure to neighborhood poverty, presented separately by race and ethnicity, are reported for all U.S. metropolitan areas over the last 30 years using aggregate data from the U. S. Census of Population and Housing.

THE CHANGING SOCIAL ECOLOGY OF DISADVANTAGE IN URBAN AMERICA AND CHILDREN'S EXPOSURE TO NEIGHBORHOOD POVERTY

The social ecology of disadvantage in urban America has changed dramatically over the last three decades, "creating a social milieu significantly different from the environment that existed in these communities [low-income neighborhoods] several decades ago."[18] In his now classic study of the predominately African American neighborhoods on the south side of Chicago, Wilson first noted that the geography of urban poverty was changing. Industrial restructuring, suburbanization of population and employment, and the migration of middle-class African Americans out of traditionally black neighborhoods, Wilson argued, was causing poverty and other forms of social and economic disadvantage to become increasingly concentrated in a small but growing number of intensely disadvantaged and progressively more isolated inner-city neighborhoods.

While Wilson's explanations for this new geography of urban poverty continue to be debated,[19] many studies have documented an increasing geographic concentration of poverty in U.S. metropolitan areas.[20] Jargowsky, for example, reports that during the 1970s the number of high-poverty neighborhoods[21] in American metropolitan areas increased 50.1 percent and the population of high-poverty neighborhoods rose 24.7 percent.[22] During the 1980s, the geographic concentration of poverty increased even more sharply, with the number of high-poverty neighborhoods increasing 54.3 percent and the population of these neighborhoods rising by 54.1 percent. By

1990, there were 2,726 high-poverty neighborhoods with a population of nearly 8 million people.

As the number and population of high-poverty neighborhoods rose dramatically in the 1970s and 1980s, the racial and ethnic composition of these neighborhoods also began to change.[23] While the absolute number of blacks living in high-poverty neighborhoods increased sharply during this period and a much higher percentage of blacks than whites or Hispanics continued to live in these deeply disadvantaged neighborhoods, the number of Hispanics and whites living in high-poverty neighborhoods rose more sharply than did the number of blacks. As a result, blacks represented a declining proportion of the population of high-poverty neighborhoods during the 1970s and 1980s. By 1990, 17.4 percent of blacks, 10.5 percent of Hispanics, and 1.4 percent of whites resided in high-poverty neighborhoods.

Recent studies by Jargowsky, and Kingsley and Pettit indicate that during the 1990s this ecological shift in the geographic distribution of poverty unexpectedly reversed.[24] The number of high-poverty neighborhoods declined by 20 percent and the total population of these neighborhoods fell by 23 percent.[25] As the number and population of high-poverty neighborhoods declined dramatically in the 1990s, the proportion of the population of high-poverty neighborhoods that is African American continued to fall and the proportion that is Hispanic continued to rise.[26] By 2000, less than 40 percent of the population of high-poverty neighborhoods was black, 29 percent was Hispanic, and 24 percent was white.

While recent studies have extensively documented levels and trends in exposure to high-poverty neighborhoods for the population and specific racial and ethnic subgroups, little is known about how levels and trends for children may differ from those for the population or subgroup as a whole. There are, however, several reasons to believe that levels of exposure and trends for children, particularly racial and ethnic minority children, may differ from those for the population or subgroup as a whole. First, poverty rates for children, especially young children, are much higher than for adults and a much higher percentage of children live in families experiencing extreme poverty (<50% of federal poverty threshold).[27] As a result, children, particularly young children, may be more likely to live in high-poverty neighborhoods. Second, racial and ethnic group disparities in levels of exposure to high-poverty neighborhoods may be greater for children than for the group as a whole because minority children experience greater residential segregation than do adult group members.[28] Third, trends for children, particularly for children from racial and ethnic minority groups, may diverge from overall trends both because of growing residential segregation by life course stage[29] and diverging patterns of racial residential segregation for adults and children.[30]

A MULTIDIMENSIONAL FRAMEWORK FOR ASSESSING CHILDREN'S EXPOSURE TO NEIGHBORHOOD POVERTY

Children's exposure to neighborhood poverty varies across multiple analytic dimensions. Children can live in neighborhoods in which many residents are poor (*resident*

high-poverty neighborhoods). They can reside in neighborhoods in which many group members are poor (*group high-poverty neighborhoods*). They can live in communities in which many children are poor (*child high-poverty neighborhoods*). Each of these dimensions can have different and independent effects on children's experiences, opportunities, and outcomes. Resident poverty, for example, can drain from a community the resources necessary to sustain local organizations and institutions and reduce the number of mainstream role models available in a community.[31] Because even in integrated environments social interactions tend to be highly segregated,[32] group poverty can limit children's access to social capital and race-specific role models. Child poverty can foster the development of a youth subculture that impedes achievement and nurtures delinquency.[33] When multiple dimensions overlap, children in a neighborhood or racial and ethnic subgroup confront even greater challenges.

Children's exposure to poverty in their community environment is examined across three dimensions:

Resident Poverty Rate: The percentage of children in a geographic unit (county, region, metropolitan area, etc.) that live in neighborhoods in which more than 40 percent of persons are poor.

Group Poverty Rate: The percentage of children in a racial or ethnicsubgroup in a geographic unit (county, region, metropolitan area, etc.) that live in neighborhoods in which more than 40 percent of subgroup members are poor.

Child Poverty Rate: The percentage of children in a geographic unit (county, region, metropolitan area, etc.) that live in neighborhoods in which more than 40 percent of children are poor.

Neighborhoods are defined as high-poverty neighborhoods when 40 percent or more of residents are poor. Previous studies have shown that this threshold most closely matches local individuals' perceptions of the neighborhoods in their city that are most deeply disadvantaged. Ethnographic observation has confirmed that these neighborhoods "look and feel" like underclass neighborhoods (i.e., they are characterized by dilapidated housing, vacant units with broken and boarded-up windows, abandoned and burned-out cars, young men loitering, etc.).[34]

DATA AND METHODS

Sample and Data

Children's exposure to extreme levels of neighborhood poverty as well as racial and ethnic disparities in exposure is investigated using tract-level Census data for U.S. metropolitan areas between 1970 and 2000. Census tracts are employed because they represent the closest approximation to neighborhoods available in official statistics, with populations typically ranging between 2,500 and 8,000 inhabitants and boundaries initially drawn to construct geographic units with relatively homogenous population characteristics, economic status, and living conditions. The sample

employed in this study includes all tracts in the 204 metropolitan areas defined by the U.S. Bureau of the Census in 1970.[35] Data were drawn from the Neighborhood Change Database (NCDB), which integrates information on population and housing characteristics from the 1970, 1980, 1990, and 2000 Decennial Census of Population and Housing into a single database. All 42,178 tracts in the counties and towns comprising the 204 metropolitan areas selected for inclusion in this sample are employed in the analyses to follow.

Tract and metropolitan area boundaries are periodically redrawn in response to population shifts, making geographic comparability an important concern in any longitudinal study of neighborhoods. Tract boundaries are redrawn in order to maintain their size and geographic integrity and new tracts are added as the population of a metropolitan area migrates into previously untracted areas. Relatively few tracts maintain stable boundaries over the entire 1970–2000 time span.[36] Because the principal focus of this study is change in children's exposure to high-poverty neighborhoods, it is important that temporally consistent geographic units are used. Otherwise, it is impossible to determine whether apparent changes in children's exposure to concentrated poverty are attributable to changes in the spatial distribution of children and poverty or to changes in the geographic boundaries of spatial units. To avoid this problem, this study computes measures of children's exposure to high levels of neighborhood poverty using census tract data normalized to Census 2000 tract boundaries.

The boundaries of metropolitan areas also change over time. Much as tract boundaries are redrawn as population distributions shift, metropolitan area boundaries shift as the size, distribution, and social and economic integration of core and outlying areas change. Because changes in metropolitan area boundaries reflect the spatial expansion or contraction of the metropolis, some researchers prefer to use contemporaneous boundaries.[37] However, researchers whose primary interest is change in the geographic distribution of the population often prefer to use temporally consistent metropolitan area definitions that avoid confounding distribution and boundary changes.[38] For this reason, this study applies 1970 metropolitan area boundaries to the 1980, 1990, and 2000 data to create temporally consistent metropolitan area definitions.

Although the creation of temporally consistent tract and metropolitan area boundaries greatly reduces the possibility that arbitrary changes in geographic boundaries distort conclusions about changes in the social ecology of child poverty, the use of these boundaries is not without its drawbacks. The application of 2000 tract definitions to earlier census years results in the creation of a few tracts with unusually small populations and a few tracts with unusually large populations.[39] More problematically, the application of 1970 metropolitan area boundaries to subsequent decades ignores the spatial expansion or contraction of the metropolis since 1970. Regrettably, this is unavoidable if temporally consistent geographic boundaries are to be used.[40] Because few high-poverty neighborhoods are located in these mainly outlying regions of the metropolis, the exclusion of these neighborhoods has a negligible effect on the trends discussed in this chapter.

RESULTS

Overall trends in children's exposure to extreme levels of neighborhood poverty are presented for each dimension in order to provide a comprehensive picture of the changing social ecology of child poverty in the United States. To gain a better understanding of racial and ethnic group disparities in children's exposure, measures are reported separately by race and ethnicity. Racial and ethnic group differences in the extent of overlap between dimensions are also discussed at the conclusion of this section.

Resident Poverty

Table 10.1 presents for each census year resident poverty rates—the percentage of persons who live in neighborhoods in which 40 percent or more of persons are poor (*resident high-poverty neighborhoods)*—by age, poverty status, and race and ethnicity. Percentage change between 1970 and 1990 and 1990 and 2000 are also reported. Data for Hispanics, Native Americans, and Asians, Native Hawaiians, and Pacific Islanders are unavailable for 1970. Data on children's poverty statuses are unavailable for 1970 and 1980.

Overall levels and trends in children's exposure to resident high-poverty neighborhoods parallel those previously reported for the entire population.[41] Children's exposure rose sharply in the 1970s and 1980s and fell dramatically in the 1990s. Between 1970 and 1990, resident poverty rates for children increased by 80 percent to 90 percent, which is comparable to the rate of increase for working-age adults and moderately higher than the rate of increase for the elderly population. In the 1990s, resident poverty rates for children fell by 30–35 percent, which again parallels the experiences of working-age and older adults. Resident poverty rates decline with age, with the youngest children experiencing the highest rates of exposure to resident high-poverty neighborhoods. One notable exception to this general pattern is the high rate of exposure for young adults, which increased more sharply in the 1970s and 1980s and declined less sharply in the 1990s than did exposure rates for other age groups, even young children. On average, children's rates of exposure to resident high-poverty neighborhoods are 50 to 70 percent higher than those for working-age and elderly adults, but nonetheless remain relatively low (3–6%).

While overall age differences in exposure to resident high-poverty neighborhoods are modest, racial and ethnic disparities in children's exposure are quite large. Only 1 to 2 percent of white children in any given year reside in resident high-poverty neighborhoods. Moreover, resident poverty rates for white children are nearly identical to those for working-age whites. Resident poverty rates for black children, by comparison, are 10 to 16 times higher than those for white children, with rates ranging from 13 to 27 percent, and are noticeably higher for black children (particularly young black children) than for black adults. Resident poverty rates for children from other racial and ethnic minority groups are generally higher than for

Table 10.1
Resident Poverty Rates by Year and Age, 1970–2000: All U.S. Metropolitan Areas

	1970	1980	1990	2000	Percent Change 1970–1990	Percent Change 1990–2000
Age						
0–4 years	3.60	4.88	6.80	4.63	88.81	−31.94
5–9 years	3.58	4.60	6.46	4.60	80.33	−28.80
10–14 years	3.40	4.39	6.37	4.14	87.17	−34.95
15–17 years	3.27	4.39	6.28	4.00	92.08	−36.24
18–24 years	2.60	5.22	8.84	8.10	239.36	−8.39
25–64 years	2.15	2.76	4.04	2.81	88.19	−30.50
65 years or older	2.61	3.21	4.26	2.53	63.22	−40.57
Children by poverty status						
Poor Children	–	–	21.65	14.65	–	−32.33
Nonpoor Children	–	–	2.66	2.04	–	−23.41
Children by race						
White						
0–5 years	1.55	1.28	2.02	1.80	30.43	−10.83
6–14 years	1.40	1.12	1.95	1.56	39.43	−19.91
15–64 years	1.06	1.27	2.20	1.93	108.64	−12.55
65+ years	1.26	1.24	1.87	1.12	48.31	−40.06
Black						
0–5 years	16.72	20.42	26.85	14.14	60.65	−47.34
6–14 years	17.17	18.97	24.61	12.99	43.30	−47.23
15–64 years	13.69	16.07	19.52	10.52	42.63	−46.13
65+ years	20.85	24.36	29.53	13.86	41.64	−53.08
Hispanic						
0–5 years	–	10.32	12.86	8.26	–	−35.80
6–14 years	–	11.39	13.62	8.53	–	−37.36
15–64 years	–	9.07	11.24	7.37	–	−34.44
65+ years	–	11.24	15.26	8.45	–	−44.62
Native American						
0–5 years	–	7.02	9.81	7.31	–	−25.48
6–14 years	–	6.74	8.98	6.70	–	−25.42
15–64 years	–	5.55	7.24	5.35	–	−26.02
65+ years	–	7.35	8.52	6.35	–	−25.47
Asian, Native Hawaiian, and Pacific Islander						
0–5 years	–	1.70	4.46	2.34	–	−47.42
6–14 years	–	1.56	3.72	2.71	–	−26.95
15–64 years	–	1.72	3.32	2.87	–	−13.51
65+ years	–	1.99	2.73	2.37	–	−13.04

white children, but are universally much lower than for black children, highlighting the exceptional nature of black poverty.[42] For Hispanic children, resident poverty rates for this period range from 8 percent to 14 percent. For Native American children, they range from 7 percent to 10 percent. For Asian, Native Hawaiian, and Pacific Islander children, they range from 1.5 percent to 4.5 percent.

Not only are racial and ethnic disparities in children's exposure to extreme levels of neighborhood poverty great, but they have expanded significantly over the last three decades. Between 1970 and 1990, the percentage of black children between the ages of birth and 5 years old living in resident high-poverty neighborhoods increased from 16.7 percent to 26.9 percent and the percentage of black children between the ages of 6 and 14 years old living in resident high-poverty neighborhoods increased from 17.2 percent to 24.6 percent. Over this same period, the percentages of white children between the ages of birth and 5 years old and 6 and 14 years old living in resident high-poverty neighborhoods increased only from, respectively, 1.5 percent to 2.0 percent and 1.4 percent to 2.2 percent. During the 1980s, Hispanic, Native American, and Asian children experienced similarly modest increases. As a result, black children represented a slightly increasing proportion of the population of children in resident high-poverty neighborhoods in the 1970s and 1980s and white children represented a rapidly declining proportion of residents in these neighborhoods. In sharp contrast, black adults represented a persistently declining proportion of the population of resident high-poverty neighborhoods during this period and the proportion of white adults in these neighborhoods remained stable.

While the increase in the number of resident high-poverty neighborhoods in the 1970s and 1980s disproportionately disadvantaged black children, the dramatic and unexpected decline in the number of high-poverty neighborhoods in the 1990s disproportionately benefited black children. Between 1990 and 2000, the percentage of young black children living in resident high-poverty neighborhoods fell from 26.9 percent to 14.1 percent and the percentage of older black children living in these neighborhoods fell from 24.6 percent to 13.0 percent. By contrast, the percentage of young white children living in resident high-poverty neighborhoods fell only from 2.0 percent to 1.8 percent and the percentage of older white children living in these neighborhoods fell from 2.0 percent to 1.6 percent. Hispanic, Native American, and Asian children also experienced more modest declines during this period than did black children. As a result, the proportion of the child population of resident high-poverty neighborhoods that is black fell sharply in the 1990s, declining from 59.1 percent to 49.5 percent. Meanwhile, the proportion of the child population that is white increased for the first time, rising from 22.0 percent to 23.4 percent. In the 1970s and 1980s, the changing social ecology of economic disadvantage disproportionately disadvantaged black children, particularly young black children, greatly increasing their exposure to extreme levels of neighborhood poverty. In the 1990s, the unexpected reversal of these trends largely benefited black children, greatly reducing their exposure to resident high-poverty neighborhoods and moderating their overrepresentation in these deeply disadvantaged neighborhoods.

Table 10.2
Group Poverty Rates bv Year and Age. 1970–2000: All U.S. Metropolitan Areas

	1970	1980	1990	2000	Percent Change 1970–1990	Percent Change 1990–2000
White						
0–5 years	1.39	1.06	1.50	1.70	8.45	13.25
6–14 years	1.23	0.92	1.48	1.45	20.22	−2.09
15–64 years	0.87	1.05	1.65	1.68	89.87	1.72
65+ years	0.95	0.86	1.17	0.86	23.26	−26.61
Black						
0–5 years	30.19	29.64	40.29	22.37	33.44	−44.48
6–14 years	31.14	26.90	36.34	20.08	16.70	−44.74
15–64 years	24.46	22.38	27.82	16.02	13.72	−42.41
65+ years	27.47	24.52	27.74	15.49	0.96	−44.16
Hispanic						
0–5 years	–	16.72	18.43	11.53	–	−37.44
Poor children	–	17.34	18.75	11.54	–	−38.49
Nonpoor children	–	14.41	15.81	10.19	–	−35.51
65+ years	–	15.20	18.09	10.42	–	−42.42
Native American						
0–5 years	–	28.77	34.07	25.34	–	−25.63
6–14 years	–	25.69	29.53	23.60	–	−20.09
15–64 years	–	20.86	22.84	19.00	–	−16.81
65+ years	–	22.95	23.45	19.03	–	−18.84
Asian, Native Hawaiian, and Pacific Islander						
0–5 years	–	8.66	11.79	6.06	–	−48.64
6–14 years	–	8.11	10.55	6.76	–	−35.90
15–64 years	–	6.83	8.67	6.35	–	−26.72
65+ years	–	4.51	5.81	4.32	–	−25.65

Group Poverty Rates

Resident poverty rates reveal the distinctive nature of black children's exposure to high-poverty neighborhoods. However, as stark as racial disparities in children's exposure to extreme levels of neighborhood poverty are, resident poverty rates alone understate the distinctive disadvantage experienced by black children. For racial and ethnic group disparities in group poverty rates, which indicate the percentage of persons who live in neighborhoods in which 40 percent or more of their group members are poor (*group high-poverty neighborhoods*), are even greater. Group poverty rates for white, black, Hispanic, Native American, and Asian children and adults are reported in Table 10.2.

Group poverty rates for white children are universally low, ranging from less than 1.0 percent to 1.7 percent, and have changed very little over the past 30 years. Very few white children live in neighborhoods in which 40 percent or more of whites are poor.

Even when white children live in resident high-poverty neighborhoods, their neighborhoods frequently are not group high-poverty neighborhoods. Typically between 20 percent and 30 percent of white children in resident high-poverty neighborhoods reside in neighborhoods in which less than 40 percent of whites are poor.

Nearly all black children who reside in high-poverty neighborhoods, by contrast, live in neighborhoods in which 40 percent or more of the black population is poor. Even when black children escape living in a resident high-poverty neighborhood, there is a 1 in 10 chance that their neighborhood is a group high-poverty neighborhood for them. Consequently, group poverty rates for black children are exceptionally high, ranging from 20 percent to 40 percent over this period.

Group poverty rates for black children follow a somewhat different trajectory over the 1970-2000 time period than did resident poverty rates for these children. In the 1970s, while resident poverty rates for black children were generally rising, group poverty rates were declining. In the 1980s, both resident poverty rates and group poverty rates for black children increased sharply. In the 1990s, both resident poverty rates and group poverty rates for black children decreased dramatically. This pattern suggests that the increase in black children's exposure to resident high-poverty neighborhoods in the 1970s was either a reflection of these children's non-black neighbors becoming poorer or moving out of their neighborhoods in large numbers, while in the 1980s the increase in their exposure was largely a consequence of their black neighbors becoming poorer. In the 1990s, the dramatic decline in their exposure was primarily a reflection of their black neighbors becoming less poor.

Group poverty rates for the other racial and ethnic minority groups highlight the exceptionally disadvantaged ecological niche that black children occupy relative to other children. Not only are Hispanic and Asian children much less likely than black children to live in resident high-poverty neighborhoods, they are also much less likely to live in neighborhoods in which a large proportion of their group members are poor. Group poverty rates for Native American children are comparable to those for black children, but they are much less likely to reside in resident high-poverty neighborhoods. Only black children are likely to live in neighborhoods in which both high levels of poverty drain community social and economic resources and high levels of subgroup poverty limit access to group-specific social capital and role models.

Child Poverty Rates

Table 10.3 presents child poverty rates—which represent the percentage of persons who live in neighborhoods in which 40 percent or more of children are poor (*child high-poverty neighborhoods*)—by age, poverty status, and race and ethnicity. Because poverty status is only available by age after 1990, child poverty rates can only be computed for 1990 and 2000.

Poor children are more geographically concentrated than poor adults. Consequently, children are much more likely to live in communities in which many children are poor than they are to live in neighborhoods in which many residents are poor.

Table 10.3
Child Poverty Rates by Year and Age, 1990-2000: All U.S. Metropolitan Areas

	1990	2000	Percent change 1990–2000
Age			
0–4 years	14.09	11.26	−20.09
5–9 years	13.44	11.24	−16.33
10–14 years	13.23	10.32	−22.00
15–17 years	13.04	9.91	−24.04
18–24 years	13.49	11.72	−13.15
25–64 years	9.51	7.58	−20.21
65 years or older	10.22	7.28	−28.79
Children by Poverty Status			
Poor children	41.1	32.7	−20.60
Nonpoor children	7.38	6.27	−15.07
Children by Race			
White			
0–5 years	5.77	5.09	−11.82
6–14 years	5.35	4.44	−17.00
15–64 years	5.16	4.18	−19.00
65+ years	6.01	3.95	−34.32
Black			
0–5 years	40.07	28.63	−28.56
6–14 years	38.13	27.66	−27.45
15–64 years	33.14	23.43	−29.31
65+ years	44.78	30.99	−30.80
Hispanic			
0–5 years	26.44	19.55	−26.06
6–14 years	26.79	19.66	−26.63
15–64 years	23.21	17.52	−24.53
65+ years	27.29	19.45	−28.74
Native American			
0–5 years	21.53	15.34	−28.74
6–14 years	18.83	14.82	−21.31
15–64 years	14.97	13.59	−9.26
65+ years	21.39	13.93	−34.89
Asian, Native Hawaiian, and Pacific Islander			
0–5 years	11.06	6.52	−41.08
6–14 years	9.82	7.35	−25.13
15–64 years	7.40	5.95	−19.54
65+ years	8.55	7.25	−15.28

While only 4.0 percent to 6.8 percent of children reside in resident high-poverty neighborhoods, 11.2–14.1 percent of children reside in child high-poverty neighborhoods. As a result, a significant proportion of children live in communities in which many of the children they will encounter and befriend are likely to be poor.

As black children are much more likely than other children to reside in resident and group high-poverty neighborhoods, they are also much more likely to reside in child high-poverty neighborhoods. In 1990, 40 percent of black children resided in a neighborhood in which in at least 40 percent of children were poor. By comparison, only 5 percent of white children, 26 percent of Hispanic children, 20 percent of Native American children, and 10 percent of Asian children lived in such neighborhoods. The shifting social ecology of urban poverty in the 1990s, which dramatically decreased children's, particularly black children's, exposure to resident and group high-poverty neighborhoods also sharply reduced children's exposure to child high-poverty neighborhoods. By 2000, child poverty rates for black children had dropped by a quarter, to 28.6 percent. Child poverty rates for other racial and ethnic minority children also dropped dramatically in the 1990s, with rates for Hispanic children falling to 20 percent, rates for Native American children falling to 15 percent, and rates for Asian children declining to 7 percent. Child poverty rates for white children fell moderately, from 5.8 percent in 1990 to 5.1 percent in 2000. As a consequence, the proportion of the child population in child high-poverty neighborhoods that is black declined and the proportion that is white increased in the 1990s.

Overlap between Dimensions

Racial and ethnic disparities in children's exposure to different forms of neighborhood poverty are even more evident when the overlap between dimensions is examined. Table 10.4 presents the percentage of children by racial and ethnic group that live in neighborhoods that are classified as high-poverty on all three dimensions and no dimensions.

Black children are both much more likely than children from other racial and ethnic subgroups to reside in neighborhoods that are simultaneously classified as resident, group, and child high-poverty neighborhoods and are much less likely to reside in neighborhoods that are neither classified as resident, group, nor child high-poverty neighborhoods. By 1990, nearly 1 in every 5 black children lived in a neighborhood that was classified as high-poverty on all three dimensions, while only slightly more than half of black children resided in a neighborhood that was not classified as high poverty on any of the dimensions. The sharp decline in neighborhood poverty rates in the 1990s both dramatically decreased the share of black children residing in neighborhoods classified as high-poverty on all three dimensions (10–11%) and sharply increased the share of black children residing in neighborhoods not classified as high poverty on any of the three dimensions (68–70%).

Nearly all white children (94%) reside in neighborhoods that are not classified as high-poverty on any dimension and very few white children live in neighborhoods that are classified as high-poverty on all three dimensions (1%). Asian children are almost as unlikely as white children to reside in a neighborhood that is classified as

Table 10.4
Percentage Living in Neighborhoods That Are High and Low on All Three Dimensions, by Race, Age, and Year

	% in Neighborhoods High on All Three Dimensions			% in Neighborhoods Low on All Three Dimensions	
	1990	**2000**		**1990**	**2000**
White			White		
0–5 years	1.24	1.21	0–5 years	94.12	94.75
6–14 years	1.24	1.05	6–14 years	94.56	95.43
Black			Black		
0–5 years	19.91	11.32	0–5 years	56.21	68.19
6–14 years	18.54	10.42	6–14 years	58.46	69.54
Hispanic			Hispanic		
0–5 years	10.69	6.83	0–5 years	71.18	78.63
6–14 years	11.29	7.10	6–14 years	71.04	78.78
Native American			Native American		
0–5 years	7.28	4.90	0–5 years	59.72	68.25
6–14 years	6.84	4.70	6–14 years	65.34	70.18
Asian, Native Hawaiian, and Pacific Islander			Asian, Native Hawaiian, and Pacific Islander		
0–5 years	3.31	1.49	0–5 years	84.35	90.37
6–14 years	2.86	1.95	6–14 years	85.98	89.63

high-poverty on all three dimensions (3%), but are noticeably more likely to live in a neighborhood that is classified as high-poverty on at least one-dimension (10–15%). Native American children are almost as likely as black children to reside in a neighborhood that is classified as high-poverty on at least one dimension (30–40%), but as much less likely to live in a neighborhood that is classified as high-poverty on all three dimensions (5–7%). Hispanic children's exposure to neighborhood poverty falls between the extremes of black children on one hand and white and Asian children on the other hand. A relatively high percentage of Hispanic children live in neighborhoods that are classified as high-poverty on all three dimensions (7–11%), but a relatively high percentage also lives in neighborhoods that are not classified as high-poverty on any dimension (70–80%).

Black children occupy a uniquely disadvantaged ecological niche in the metropolis. They are more likely than children in other racial and ethnic subgroups to reside in neighborhoods in which large shares of residents, group members, and children are poor. They are much more likely to live in neighborhoods in which the three dimensions of neighborhood poverty overlap. They are much less likely to live in neighborhoods that are not classified as high-poverty on any dimension. At the other extreme, white children, and to somewhat lesser extent Asian children, occupy a distinctively advantaged ecological niche in which they tend to experience relatively

little exposure to neighborhood poverty. Hispanic and Native American children neither experience the ecological disadvantages that black children experience nor enjoy the ecological advantages that white and Asian children enjoy.

CONCLUSION

On a diverse set of indicators African American children and adolescents fare worse than other children and adolescents. They exhibit more behavioral and cognitive problems and score lower on academic achievement tests.[43] They are less likely to graduate high school[44] and enroll in college.[45] They are more likely to be unemployed or drop out of the labor force after leaving school.[46] When employed, they tend to work fewer hours and earn less.[47] They are more likely to be arrested and incarcerated.[48] They engage in riskier sexual behavior at earlier ages, resulting in higher teenage pregnancy rates.[49]

One reason that black children are worse off than other children is that they occupy a uniquely disadvantaged ecological niche in the metropolis. They are much more likely than children from other racial and ethnic subgroups to reside in neighborhoods in which large numbers of residents, group members, and children are poor. Moreover, they are more likely to live in neighborhoods in which the different dimensions of neighborhood poverty overlap and much less likely to live in neighborhoods that are not classified as disadvantaged on any dimension. Children from no other racial and ethnic group experience this multidimensional layering of ecological disadvantage.

Given the well-known harmful effects of residence in economically disadvantaged neighborhoods it is not surprising that black children fare worse than other children.[50] Yet, the findings presented in this chapter suggest some cause for optimism. After decades of deterioration, the ecological position of black children unexpectedly and dramatically improved in the 1990s. By 2000, a smaller percentage of black children resided in neighborhoods in which a large share of their neighbors, group members, and children were poor than at any time since the early 1970s. Though black children continue to be much more exposed to neighborhood poverty than children from other racial and ethnic groups, a much smaller proportion of black children today reside in these deeply disadvantaged neighborhoods than did at their zenith in the early 1990s. If, as a growing body of research documents, residence in high-poverty neighborhoods negatively affects child outcomes, racial and ethnic disparities in children's outcomes may at long last begin to decline as the shifting social ecology of urban poverty lessens black children's exposure to geographically concentrated disadvantage.

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CHAPTER 11

CHILDHOOD VICTIMIZATION AS A PRECURSOR TO VIOLENCE AMONG ADULT HOMELESS WOMEN*

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THE FOUR-CITY FLORIDA SURVEY

Prior to the Florida Four-City Survey analyzed here, studies with samples of homeless women and samples of victims of domestic violence existed, but no study evaluating homeless women's experience with violence, including domestic violence *and* using a large sample has ever been conducted. The Florida Four-City Survey, therefore, marks the first study to examine victimization among homeless women using standardized measurements to make comparisons with other research using samples of housed women possible. In addition, the study was designed to gain a more complete picture of what these women lived through prior to becoming homeless.

Development of the Florida study began in 2002 with a focus group involving six homeless women. From this focus group and a review of the literature, a questionnaire was developed to obtain detailed information about the experience of violence in the lives of homeless women. The questionnaire was designed to help us understand more fully the lifetime experiences of homeless women. We conducted survey interviews with about 200 women at shelters in each of four cities (Tampa, Orlando, Jacksonville, and Miami), for a total sample size just under 800. The scale and geographic range of the study design meant that we would need multiple individuals to conduct the interviews over the course of at least 6 months. Consequently, interviewers in each site were recruited from among existing shelter staff—case managers, intake workers, counselors, etc. All our interviewers were highly experienced in dealing with homeless women and their problems, and all took on their interviewing jobs as a supplement to their normal work roles. Our interviewers were largely case managers, who came into contact with issues of victimization on a daily basis. As such, they were already screened, trained, and provided with resources to deal appropriately with participants.

In addition to the survey, more qualitative in-depth interviews were conducted with about 20 homeless women in Orlando. Women who took part in the qualitative study were recruited by case managers at the Orlando Coalition for the Homeless who had participated in interviewer training. They were asked to identify women at the center who experienced some form of violence. The first 20 women who fit this criterion and agreed to participate were the interviewees for this part of the study. Interviews were arranged by case managers, who set up mutually convenient meetings between one of the study coprincipals and the participant in a private conference or sitting room on site at the homeless shelter.

Altogether, 737 women were surveyed. In Orlando, 199 women were interviewed at the Coalition for the Homeless of Central Florida. In Tampa, 200 women were surveyed at the Metropolitan Ministries facilities. At the I.M. Sulzbacher Center for the Homeless in Jacksonville, 146 women were surveyed and in Miami 192 women were surveyed at the Community Partnership for Homeless Inc. Each of the four facilities provides shelter and other services to some hundreds of homeless people daily, men and women alike. All of the shelters where respondents were solicited are general-purpose homeless facilities, not battered-women's facilities and not special-purpose facilities devoted exclusively to teens, to the addicted, or to the mentally ill.

Existing literature about violence and homelessness is a hodge-podge of results. One reason for this is the general avoidance of standardized, validated measuring instruments in favor of various *ad hoc* measures. Our strategy was to use standardized instrumentation wherever possible, modified as necessary and appropriate given our population and hypotheses:

The *Conflict Tactics Scale (CTS)*[1], as modified by Tjaden and Thoennes,[2,3] was used to measure the occurrence of "major violence" episodes among homeless women (and a parallel sample of about a hundred homeless men). The modifications of the scale by Tjaden and Thoennes make it equally useful in measuring violence committed by intimates or strangers (i.e., both domestic and street violence perpetrated against these women). The modified scale also asks about violence experienced both as child and as adult, inquires about the consequences of each episode, and records details on the reporting of each episode and what happened after the event was reported.

In essence, these modifications transform the CTS into a survey instrument similar to that used in the National Victimization Surveys. These modifications not only make the scale more useful in investigating our study hypotheses but also allow comparisons to a national sample of women.[2] One small modification of the Tjaden-Thoennes victimization items was necessary, namely, follow-ups for the most recent "major violence" episode (or episodes) that ask about mood or behavioral changes in the weeks and months immediately subsequent to the victimization, which allows us to test hypotheses about the consequences of violence in the lives of these women. The CTS has demonstrated reliability and validity.[4,5]

The *Personal History Form (PHF)* is a standardized instrument widely used in studies of homeless people to record family and background characteristics, housing and homelessness histories, recent residential information, lifetime homeless episodes,

most recent homeless episode, and the like. The only significant modifications required for present purposes, other than the deletion of some irrelevant items, were (1) to substitute the Tjaden-Thoennes childhood abuse sequence for the one contained in the PHF (the former is far more detailed and informative); and (2) to expand the allowable responses to the questions about "the reasons people have for leaving their residences" (in all the sequences about why the respondent is homeless) to specifically include intimate partner violence as one possible reason.

The *Addiction Severity Index (ASI)*[6] is a widely used instrument that obtains detailed information on respondent's medical status, employment and support, drug and alcohol use, legal status, family history and conflict, and psychiatric status. Again, we have extensive experience administering the ASI and have published on its methodological properties in research on homeless substance abusers.[7] Much of the ASI is redundant with items from the PHF and modified CTS and any redundant items were eliminated. Also, not all sections of the ASI are equally relevant to the aims of this research. From the legal status sequence, for example, our only interest is in the items asking about prior convictions (to test the hypothesis that homeless women with criminal records experience more violence than those without). Very little from the medical status sequence is relevant; moreover, most of the items in the section on employment and support that deal with "survival strategies" needed to be supplemented with additional items. (Note: the modifications to the ASI that we implemented make it impossible to compute so-called "ASI Scores" for our respondents.)

WHO WERE THE WOMEN THAT TOOK PART IN THE FLORIDA FOUR-CITY STUDY?

Virtually every study of homeless people undertaken in the past three decades has reported that the homeless are "surprisingly" well educated, and our study is no exception. Nearly two-thirds of the women in the sample had at least a high school degree (or better) and more than a third had some education beyond high school. And while these numbers lag behind the Florida population as a whole (among whom in the 2000 Census 79.9 percent had a high school degree or better and 51.2 percent had some education beyond high school), the level of educational attainment is still "surprisingly" high considering the level of impoverishment characteristic of the group.

Almost half of the sample of homeless women identified themselves as African American, with white women comprising one-third of the sample, followed by Hispanic-Latina (14.5%). Please note: In our (and most other) studies, respondents can identify as white, black, or Hispanic; in the US Census, Hispanics can be of any race (i.e., race and Hispanic status are asked as separate questions). Thus, precise comparisons between our results and those of the Census cannot be made. In the 2000 Census, however, only 14.6 percent of Floridians were identified as African American so that group is heavily over-represented in our sample of homeless women, as, indeed, they are in nearly every other study of homelessness ever undertaken.[8–10]

Lack of familial ties and profound estrangement from kith and kin are widely understood to be among the distinguishing marks of homeless people and a principal reason why people become homeless in the first place.[11] Consistent with this understanding, most of the women in our study (79%) had either never married (43%) or were currently divorced or separated from their spouses (36%). Only about one in six was married or cohabiting at the time of the interview. By way of contrast, in 2003, only 24.4 percent of the U.S. adult population had never married; 58.8 percent were currently married, and only 10.2 percent were separated or divorced. So stable, on-going marital relationships are far less common among homeless women than in the population at large.

HOMELESS HISTORIES

The events that led to being homeless were of particular interest to us . To gain a more complete picture we asked a variety of questions about the women's history of homelessness. The women we interviewed became homeless, for the most part, in their early thirties and had been homeless for an average of 1.6 years by the time we surveyed them. When asked about the longest single period in which they had been homeless, the average was a little over a year. A majority of the women (53%) indicated they were homeless by themselves with the next highest proportion indicating they were homeless with children (24%). This is particularly interesting as only one out of five women indicated they did not have any children. Just over 10 percent were homeless with their partners.

The Association between Violence and Homelessness

We asked each of the women if they were currently homeless because of violence or abuse committed against them by an adult partner in their last residence. Just about three-quarters of the women told us that violence was not a factor in their homelessness. The remaining quarter indicated that violence was either the main reason (14%) or at least one of the reasons why they were homeless (12%). These findings are generally consistent with the empirical literature, which converges on about one in four or five as the fraction of homeless women who are homeless because of violence. However, these findings are far lower than the one out of two often cited[12–14] with little, if any, empirical evidence to support it. It is obvious that at least *some* women are homeless because they are fleeing abusive domestic situations and that many homeless women were domestic violence victims prior to becoming homeless. Less obvious is whether prior experience with domestic violence is a *major* direct cause of homelessness among women, something that has been asserted far more frequently than it has been researched.

Although many of the women in our study did not identify violence as the primary reason they became homeless, it is clear from their depictions of their childhood that many of these women experienced a variety of negative childhood events, including violence, that certainly have shaped their adult lives in some way. At a minimum these

Table 11.1
Childhood Experiences Among Homeless Women ($N = 737$)

	Total Sample
% experienced childhood psychological aggression	66.7
% experienced minor childhood violence	49.8
% experienced severe childhood violence	49.8
% experienced any childhood violence	59.4
% parents ever married	75.3
% parents ever divorced, separated, or widowed	64.5
Mean number of times parents divorced, SD in ( )	1.55 (2.05)
% adults yelled at each other	62.2
% adults hit each other	39.7
% very unhappy childhood	14.2
% unhappy childhood	9.9
% so-so childhood	30.7
% happy childhood	26.4
% very happy childhood	18.8

women experienced some family instability, as over two-thirds told us that at some point their families were not intact. Witnessing adults engaging in violent behavior was also common. Most of the women we interviewed told us that the adults in their household yelled at each other and more than one out of three reported that they also hit each other. Perhaps even more telling is that their experiences with violence were not limited only to witnessing adult violence, but also to experiencing violence. More than two-thirds of the women told us that they were victims of childhood psychological aggression including being insulted, sworn at, humiliated, and embarrassed. Even more troubling, however, is that half of the women experienced minor violence (push, shove, grab, pull hair) and half experienced severe violence (threaten to kill, choke, beat up). Even with these negative and sometimes brutal experiences, however, almost half had positive recollections of their childhood. At the same time, half of the women remembered a less than happy childhood.

When we compared the reports of childhood happiness with the women's recollection of negative childhood events (e.g., violence), not surprisingly, we found that women who had experienced any of the negative childhood events (ranging from adults yelling at each other to severe child abuse) were much more likely to report an unhappy to very unhappy childhood. The data follow:

Given the extent of negative childhood experiences, it is not surprising that those experiences influenced these women as adults. For the women in our study, childhood violence was significantly related to their experience of homelessness. Women who experienced childhood minor or severe violence were on average 3 years younger when they first become homeless, and they were homeless more frequently and for longer periods of time. It is apparent that violence did play some role in the experiences of homelessness for these women, even though most did not identify childhood

Table 11.2
Associations between Childhood Happiness and Negative Childhood Events

	Yes	No
Adults in HH yelled at each other		
% Unhappy or very unhappy	33.9	8.3
Adults in HH hit each other		
% Unhappy or very unhappy	42.7	12.2
Experienced childhood psychological aggression		
% Unhappy or very unhappy	33.5	24.4
Experienced childhood minor violence		
% Unhappy or very unhappy	41.1	7.3
Experienced childhood severe violence		
% Unhappy or very unhappy	40.8	7.9
Experienced any childhood violence (minor or severe)		
% Unhappy or very unhappy	36.8	5.9

Note: All differences were significant p .001. To clarify the table: Among women who recalled that the adults in their childhood home yelled at one another, 33.9% said that their childhoods had been "unhappy" or "very unhappy." In contrast, among those who did not recall adults yelling at one another, only 8.3% reported unhappy or very unhappy childhoods.

experiences with violence as one of the reasons they were homeless. This information comes primarily from an open-ended question in the survey instrument where we asked the women to tell us some of the reasons they left home the first time they became homeless. Women who experienced childhood violence were also one and a half times more likely to use alcohol and almost twice as likely to use drugs as adults than women who did not experience such violence.

Childhood experiences were also important as they shaped the worldview of these women. In-depth interviews with the women revealed that experiences in childhood provided certain messages about women's sexuality, relationships, men, and violence. These messages had real effects as the women matured into adulthood. For the women interviewed in the qualitative study, childhood and adulthood experiences of violence and abuse played a major role in their development of low self-esteem; many actually used this phrase verbatim. Dee, for instance, said that the result of her child abuse was "low self-esteem. It took me a while to let my husband touch me." Diane, who was called "worthless and no good" and told she would "never amount to anything" by her father, now says, "It's taken me like that last few years to get my self-esteem back." Mo recalls, "I absolutely hated myself." She felt her mother did not want her, and her father continually "threw that up in my face." From childhood, Natalie felt she was "ugly and unloved." Marion says she had "no self value."

As children, many saw women brutalized, abused, and degraded. Often, the women experiencing this violence were our respondents' mothers. In addition to the trauma of witnessing and enduring abuse, seeing women mistreated in these ways relayed powerful meanings. Tamara succinctly states, "All my life I have seen men beat women." Similarly, Eliza recalls, "I thought that's the way life was. Because in the

neighborhood I grew up in, it was nothing to see a woman dragged, knocked down, stomped and beat . . . So many women, including my mother—they stood there and they took it . . . So I took on that generational trait. You were just supposed to take it."

This normalization of violence was gender-specific; the women almost always described seeing violence perpetrated by men against women. This was mapped onto their concept of adult relationships. Ruby describes, "All my relationships I had were very abusive and that's what I thought love was about. I didn't know no better. Any time they would beat me up and—they would beat me up bad and they would tell me later on they loved me. And I'd say, ok. And keep going and going and going that way. And that's like I learned it."

Another component to the messages about relationships and men was specific to sex. From both mothers and fathers, the women recalled hearing about how women were only good for one thing, and that one thing did not count for very much. Eliza's father told her she should have been a boy, saying, "You're gonna grow up and be a whore and have a belly full of babies. And you're not gonna be any good."

Both Ruby and Mo learned that men only wanted women for sex, and that women should therefore use their sexuality to their advantage. Mo remembers seeing her mother with many different men, and reflects on a conversation when her mother told her, "Oh, if you ever want to get a guy's attention, wear this kind of stuff, act this way, do this." Likewise, according to Ruby, "[My mother] taught me to lay up with the mens to get what I want. I was supposed to go to bed with all these different mens to get what I want. I didn't know no better. That's what we were supposed to do. My mom always said we had a money maker." Ruby recalls her mother visiting men, working as a de facto prostitute. She says, "I knew she had a lot of different mens. We was well-known as we was growing up as kids." Through messages like this, the women learned that degrading, exploitive, and abusive treatment was simply their lot in life.

Women in the quantitative part of the study had similar experiences. Childhood violence was one mechanism providing entry into sexually exploitative work. For example, women who experienced minor or severe childhood violence were more than twice as likely to work as prostitutes or strippers, professions that likely increased their risk for violence and further solidified their ideas about men, women, and sexuality.

In the qualitative component of this study, the average age that the women left home for good was about 18. Although it seems reasonable, this number belies the amount of shuffling in and out of residences, the early pregnancies and marriages, and the abuse the women experienced while young. Furthermore, the place they lived as children was often not a "home" in the sense that it provided support, survival, or protection. They often lived in an environment characterized by abuse and violence, poverty, loss and dislocation, parental drug and alcohol use, and illness. These factors led to transience and displacement beginning at a relatively young age.

By the age of 19, Amelia had already been shuttled between numerous "caretakers." She lived with her father until the age of 9, when he died. She then moved in with her brother for a year and a half, and then her grandmother from ages 11–15, who then also died. Amelia finally moved in with her mother, only to be kicked out at age 18 by a new stepfather. It took her less than a year to become homeless. Fully 16

of the 20 women we interviewed recounted some sort of physical or sexual abuse as children, with nearly all identifying emotional abuse or neglect.

Eliza lived with her mother, father, and siblings until she was 7. Because of violence and drinking between her parents, she lived with her uncle for a year. After returning to her parents at age 8, she was removed by the state and sent to a children's home. After a year or two, she was sent back home, where she was molested by her father and physically, verbally, and emotionally abused. She was beaten by her mother when she tried to confide her father's abuse. The parental neglect led her to wander the streets at night looking for food and a little bit of care. The first older man she met at age 13 or 14 who fed her when she was hungry became the father of her first two children. He was both a drug addict and abusive.

The sense one gets from the qualitative interviews is that these early abuse experiences left permanent scars on these women and profoundly warped their sense of what is normal and acceptable in adult relationships with men, and this in turn leads to a hypothesis that women who experience the most abuse as children will continue to be abused in later life. These results were mirrored by the quantitative portion of the study as many of the women who reported childhood victimization also reported adult victimization. Specifically, 86 percent of the women who experienced physical violence as a child also experienced physical victimization as an adult ($P < .001$). By comparison 52 percent of the women who did not experience childhood physical violence experienced adult physical victimization. Women who were victimized as children also experienced on average four more victimizations compared to women who were not victimized.

The effects of early experiences with violence linger into adulthood and adult relationships. We asked the women in our study a series of questions about their current or most recent partner to gain a sense of the quality of their intimate relationships. These questions asked about the controlling, isolating, and abusive behaviors of their intimate partners. Women who were childhood victims of violence identified more negative behaviors in their partners than did women who were not victimized. In addition, they also indicated that these negative behaviors occurred more frequently. Although our cross-sectional data do not allow us to presume causality, it is obvious that childhood experiences do influence adult relationships.

One of the mechanisms through which childhood victimization may increase the risk for entering into unhealthy adult relationships is its relationship to self-esteem and depression. In our study, childhood victimization was not significantly associated with adult self-esteem. It was, however, associated with depression. Women who were victims of childhood abuse were more than twice as likely as women who reported no abuse to feel that the term depressed described them very well. Furthermore, depression was significantly associated with adult victimization (stalking, sexual, or physical assault). It is important to note that the measure of depression in these analyses is a subjective assessment by the women themselves rather than a clinical diagnosis. Again, although causal ordering cannot be conclusively established, the association between childhood negative events, depression, and adult victimization cannot be ignored.

Childhood victimization was also significantly related to other types of victimization as well. Women who had experienced minor or severe abuse as children were more likely to be robbed, pick-pocketed, have things stolen from them, have been seriously beat up, stabbed or cut with a knife, and shot at with a gun.

Although there have been many suppositions about the relationship between homelessness and violence, there is only limited empirical evidence looking at factors that may increase the risk for victimization among this vulnerable population. Furthermore, much of this evidence only tackles one aspect of this complex relationship at a time. The Florida Four-City Study was able to provide, for the first time, a more complete picture of the myriad of risk factors that influence victimization using a large multisite sample.

In the Florida Four-City Study, we combined all types of victimization into one dependent variable that represented any adult victimization and find several factors that did emerge as important risk markers for this type of victimization. A common theme throughout the discussion of the results of this study is the impact of childhood experiences on a plethora of behaviors and attitudes. The results of the multivariate analysis indicated that childhood violence significantly increased the risk for adult victimization net of all other factors in the model. In addition, current alcohol use, being divorced or separated, and a greater number of children also increased victimization risk. Women from Miami were at less of a risk of victimization compared to the reference group of women in Orlando. The only characteristic of homelessness, per se, that was significantly associated with victimization was number of times homeless. Women who were homeless more frequently were at a greater risk for victimization. Finally, women who described themselves as depressed were more likely to be victims.

What these analyses tell us is that homeless women are a vulnerable population with childhood violence at the crux of this vulnerability. Minor and severe violence experienced as a child increased the risk of many of factors (including homelessness) that then were associated with a greater risk for adult victimization. At a minimum, these results suggest that that more attention should be paid to the treatment of child victimization and a greater effort should be made to prevent child maltreatment. The women in our qualitative study spoke of childhoods filled with violence that led many to leave their childhood homes and many others ill prepared to develop healthy relationships. Homeless shelters are focused on the most pressing and immediate needs, like a place to sleep for the night. Rarely are they equipped to handle the myriad of problems with which these women and men struggle. They may not be prepared to delve deep into the childhood experiences of the women that arrive at their facilities. Consequently these men and women are in danger of repeating a cycle of homelessness and victimization.

CONCLUSIONS

The Florida Four-City Survey marks the first large sample study evaluating homeless women's experience with violence, including domestic violence. In addition, our

Table 11.3
"Would You Say Your Adult Partner . . ."

	No Childhood Violence	Experienced Childhood Violence
Has a hard time seeing things from your viewpoint?	2.32[a]	2.63
Is jealous or possessive?	2.16	2.68
Tries to provoke arguments?	1.86	2.29
Tries to limit your contact with family or friends?	1.75	2.00
Insists on knowing who you are with at all times?	2.05	2.54
Calls you names or puts you down in front of others?	1.59	2.01
Makes you feel inadequate?	1.73	2.16
Is frightened of you?	3.69	3.61[b]
Shouts or swears at you?	1.71	2.21
Frightens you?	1.61	2.02
Prevents you from knowing about or having access to money even when you ask?	1.54	1.85
Prevents you from working?	1.30	1.60
Insists on changing where you are living even when you don't need or want to?	1.28	1.73
Threatens you with the safety of your children?	1.17	1.35
Threatens you with the safety of your animals?	1.08	1.16
Threatens you with the safety of your friends?	1.14	1.40
Insists on you having sex without a condom?	1.55	2.07
Prevents you from seeking medical attention?	1.19	1.38
Disappears for a day or days at a time?	1.41	1.71
Leaves you alone without food, money, or supplies?	1.22	1.55
Steals from you?	1.25	1.50
"Borrows" your credit card or money and does not pay you back?	1.22	1.52

[a] Numbers are mean scores. Responses for all questions ranged from 4 (Almost always) to 1 (Never). A higher score indicates the behavior occurred more often.
[b] All analyses with the exception of this are statistically significant.

use of standardized measurements allows us to make comparisons with other research using samples of housed women. Much of what we found mirrors research using housed populations and differs only to the extent that these women experienced greater levels of victimization. Although the women we surveyed were staying in a homeless shelter, Wright and Devine[11] argue that "street homeless and sheltered homeless are not distinct populations; nearly all the homeless people in this sample spend at least an occasional night in an emergency shelter and nearly all of them also occasionally sleep out of doors. Which homeless people are considered "sheltered homeless" depends a great deal on who makes it to the shelter line first. Limitations aside, we now know a great deal more about the experience of violence in the lives of homeless women than was known before our study was conducted.

Table 11.4
Logistic Regression Analysis Predicting Adult Victimization (Physical or Sexual Assault or Stalking) ($N = 632$)

Variable	B	S.E.	Odds Ratio	*P* Value
Experienced childhood violence	1.43	.23	4.19	.000
Current alcohol use	.76	.26	2.15	.003
Current drug use	0.7	.31	1.07	.827
Marital status				
Cohabitating	.25	.78	1.29	.748
Divorced	1.02	.42	2.77	.016
Separated	1.34	.58	3.81	.020
Widowed	.82	.74	2.26	.268
Single	.02	.39	1.02	.964
Race				
African American	−.28	.27	.76	.302
Hispanic	−.52	.36	.59	.147
Other racial group	−.01	.67	.99	.987
City of interview				
Miami	−.68	.31	.51	.030
Jacksonville	−.26	.33	.77	.419
Tampa	−.08	.33	.92	.801
Who homeless with				
Homeless with adult	.04	.42	1.04	.925
Homeless with kids	.02	.31	1.02	.955
Homeless with kids & adults	−.21	.45	.81	.641
Age first homeless	−.01	.01	.99	.294
# of times homeless	.28	.11	1.32	.012
Total amount of time homeless	.06	.08	1.06	.499
# of children	.18	.07	1.19	.010
Depressed	.40	.17	1.50	.018
Constant	−.99	.75	.37	.183

Note: The reference groups for dummy variables are as follows: for marital status, married; for race, White; for city, Orlando; and for who are you homeless with, by themselves. Model Chi-square 200.406, *P* .001; Nagelkerke *R* square = .401.

A common theme in the victimization literature is the relationship between childhood victimization experiences and later adult victimization, perpetration, and other negative outcomes. These relationships also exist among the homeless women in the Florida Four City Study. As we have seen, abuse of all sorts was common in the young lives of these women. This was poignantly illustrated by the qualitative interviews, in which sixteen of the 20 participants recalled physical or sexual abuse, and all were neglected or emotionally abused in some way. The effects of this abuse were far-reaching, setting the women up for social, emotional, and behavioral deficits that bled into later life decisions and choices.

One significant consequence of being abused as a child is that it led some of the women to "early independence" or a premature departure from the childhood home at a younger-than-average age. This is consistent with research that finds that among homeless and runaway youth, a substantial proportion experienced child abuse.[15–18] In 8 of the 20 cases, the women left home in their teens by way of marriage or pregnancy, and 6 of the women were kicked out or ran away. Others thought they were starting over by leaving the childhood home for some other living situation, only to find their new situation as abusive and unsatisfactory as the old. Consider Cammie, who left home and got married at 18 and tried to "use" her first marriage to start a new family blueprint: "Because I was very much in love with the guy that I was marrying and I had it in my head that I was going to be able to show my parents that you could have a marriage and make it work and you know, children, and not have alcohol and drugs in the middle of it and do things right. And I mean, I looked at it in a very positive light . . . My thought was, I'm going to show everybody in my family, especially my parents that you can have a family and you can do it right."

Cammie then endured years of mental and physical abuse from her husband. In contrast, Eliza, at 13, did not pursue a relationship with an older man, but drifted into it while wandering the streets hungry, looking to stay away from her parents' abuse. "He said, 'What's your name?' He was real nice; he had a pocket full of money, wallet full of money. It was a summer night and I got in his car and I felt safe. And we rode over to where we ate. And he actually fed me and I was actually full . . . He would feed me. I would be hungry. And I would still go home and act like this kid I was. But I'd get hungry. And sometimes there wasn't a pot of beans or some bread in the oven and I'd go find it. And he'd say, 'You eat?' And I'd say, 'no' And he'd say, 'Let's go get something to eat.' He fed me . . . But again, it was a nightmare. It was a daydream, waking up from a nightmare, because I thought he was just so nice, and then after I gave up my virginity and the babies started coming, he wasn't so nice anymore . . . I couldn't go tell my mother because I always see her get beat up, her head split open, or her throwing a frying pan and splitting my father's head, so it was kind of [one] abuse upon another."

Women who grew up in household where adults were yelling or hitting each other were not as happy as women who grew up in households where these events did not happen. For some of these women, these negative childhood experiences led them to leave home early, setting the stage for later victimization. In addition, women who experienced childhood violence were more likely to report unhappy childhoods compared to women who were not victimized as children. Childhood violence also appears to be related to homelessness as these women were first homeless at a younger age, were homeless more frequently and for longer periods of time. Finally, childhood experiences of violence appear to be associated with adult negative outcomes as well.

As these women have described, the path to homelessness is fraught with peril and frequently begins early in life. Childhood violence often provides an unstable foundation upon which to build a life and sets the stage for later unhealthy

relationships and behaviors. By the time homeless women arrive at a shelter, their cumulative negative experiences have shaped their view of the world and the chances of obtaining a "normal" life may be beyond reach. Shelters and shelter workers are prepared to deal with the external issues of being homeless such as food, clothing, and shelter, but it is likely they are ill prepared for the complex internal issues resulting from years of violent terror and betrayal. The barriers to self-sufficiency for these women, who have endured years of psychological, physical, and sexual abuse, are massive. They cannot be overcome by simply being provided with a place to sleep.

In recent years, homelessness has faded from prominence as a national political issue. There seems to be a widespread sense among both policy makers and the public that the programs of assistance enacted in the 1980s, while perhaps imperfect, have done as much as can or should be done to address this problem and that homeless people, like poor people in general, need to work themselves out of their condition. As we have seen, however, many of the processes that work to put homeless people out on the streets can be traced to events, experiences, victimizations, and misfortunes that began in early childhood. And certainly, the experience of violence would be high on this list of misfortunes. That many homeless women are homeless because of violence, and many more victims of more violence in a year than many people can expect to experience in their entire lifetimes, does not make homelessness any easier to resolve, but it does, we think, make the resolution all that more urgent.

NOTES

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Edited by Barbara A. Arrighi and David J. Maume

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To our children
Eiler, Elena, and Megan
and
Meghan and Allison
Our concern for their welfare piqued our interest in the welfare of all children

Contents

Acknowledgments

First, we wish to thank all of the contributors to the four volumes for the exceptional caliber of their research. Their dedication and commitment to understanding the causes of child and family poverty is remarkable. It has been a pleasure to work with such a fine group of scholars. It is noteworthy, too, that more than a few of the contributors endured family emergencies and/or experienced personal crises during the research and writing phase, yet remained committed to the project. For that, we are grateful.

We are honored that Diana Pearce is the author of the Introduction for Volume 1: Families and Children. Professor Pearce has written a thoughtful essay weaving common threads among diverse chapters. She is a tireless researcher who has been a pioneer in examining the causes and effects of poverty in the lives of women and children. Not only has Professor Pearce illuminated the way for other researchers in explaining the complex factors influencing women's poverty, she has been an ardent advocate for ending the feminization of poverty.

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Introduction

Barbara A. Arrighi

> "Access to quality care is necessary, but not sufficient to eliminate children's health disparities. We cannot narrow the gap in health without addressing disparities in educational opportunity, employment, economic security, and housing."
>
> Marian Wright Edelman, President and Founder of the Children's Defense Fund

A recent report from the Children's Defense Fund offers a disturbing estimate: "For the first time in the nation's history, the projected life expectancy for children may be *less* than that of their parents."[1] However, not all children have an equal chance of dying younger. Children who live in poverty are at greater risk.

The health disparities among different segments of the population begin to show up within the first year of life. For example, the infant mortality rate for blacks is more than twice that of whites (13.9 for blacks and 5.8 for whites, respectively) and maternal mortality rate for mothers who are black is four times that of whites (24.9 and 6 respectively).[2] In fact, the United States—the wealthiest nation in the world with the most advanced medical technology—is ranked 25th in infant mortality,[3] in part, because not all citizens have equal access to health care from the time of conception.

Healthy infants begin with healthy parents, especially healthy mothers. However, young girl children living in poverty are at risk for growing up to be women living in poverty. Prenatal care would be best thought of as care that occurs years before the nine months of pregnancy. When a life begins in the womb of a woman who has experienced a matrix of long-term unhealthy physical and emotional conditions prior to pregnancy—food insecurity, spotty or nonexistent health and dental care, neighborhood violence, dilapidated living spaces, exposure to lead poisoning, perhaps homelessness, asthma—can it be said that the life developing within her has an equal

start in life? Can the cumulative physical and psychological stressors that children in poverty experience well into adulthood be neutralized by prenatal care in the first trimester? That the majority of women now seek medical care within the first trimester of pregnancy[4] is laudable, but is it enough? That the wealthiest nation, with the most advanced medical technology, can do better for its youngest and most vulnerable citizens is indisputable? Does it have the will to do so is the question. Other nations that have less do more.

Food insecurity is one of the many issues that children living in poverty face and is addressed in Alaimo's Chapter. About 14 million households suffered food insecurity during 2004,[5] meaning people didn't know if they would be able to provide enough food for all members of their families. If children do not have consistent and sufficient caloric intake, their physical and mental development can be irreversibly compromised. Will the young child who consistently suffers food insecurity during her formative years mature into a healthy young woman whose body is capable of providing the nourishing environment vital for a developing embryo?

The harmful effects of poverty extend beyond infancy. Lead poisoning is a silent threat to children that can and does cause irreversible brain damage. There is mounting evidence that children with lead poisoning have lower IQs, more behavior problems, difficulty learning, and are more likely to engage in criminal behavior.[6] National statistics suggest children receiving Medicaid and children in poverty seem to be disproportionately affected—Medicaid represents 60 percent of children with elevated lead levels in their blood.[7] One reason poor kids are more likely to be affected is because they are more likely to live in older, dilapidated housing with peeling paint that contains lead. In fact, they are more than five times likely to have higher levels of lead in their blood than are children from higher-income families.[8]

There is an expectation that public health organizations will be dogged in tracking harmful conditions. Recently, the Cincinnati Department of Health was ordered by the Ohio Supreme Court to open its records concerning lead paint in rental properties. Five hundred seventy kids suffered lead poisoning in Cincinnati since 2002—250; kids age 6 and younger suffered dangerously high levels of lead in their blood in 2004.[9] The records revealed that although about 300 homes and apartments in Cincinnati were cited for lead paint, the City did nothing to enforce corrective measures. Although jail time was added for offenders in 1994, Cincinnati took less than 1 percent of the cases to court. In fact, of the 300 open cases, 250 exceeded the statute of limitations and require re-filing. The Cincinnati Enquirer (noted for its conservative leanings) reported that a property owner living in Cincinnati is thousands of times more likely to be cited for litter (17,000 property owners were cited) than for renting property with lead paint (only five taken to court). Cincinnati failed to follow through on remedies, even when given federal dollars to do so. For instance, in 1994 Cincinnati received $6 million dollars in Federal funding for lead abatement but not even half of the properties were abated.

Dental care is yet another health issue that separates the rich and the poor. Poor oral health care disproportionately affects children in low-income families. They are more than two times as likely as kids in higher-income families to have untreated cavities

and almost a quarter have not been to a dentist within the last year.[10] Not only can poor dental hygiene lead to gum disease, poor eating, and digestive issues, but there is some evidence that, if untreated, poor dental hygiene can lead to heart disease. The thinking is that the bacteria that collects around the gums gets into the bloodstream increasing the risk of blood clots and damaging heart tissue[11] Despite the fact that a connection exists between dental health and overall health, dental health is woefully lacking for children living in poverty. Only about 10 percent of dentists are willing to treat Medicaid patients and only about 20 percent of children covered by Medicaid were seen by a dentist.[12] The dental care statistics indicate that the lack of oral health care for poor children is just one more factor that puts them at increased risk for not being healthy adults.

The universal health care provided by other industrialized countries for their children through age 12 (or older) demonstrates a commitment to proactive preventive care that fosters healthier children and thus, healthier adult citizens. In the United States, federal/state health care for children is means tested, meaning it is available only to low-income children and families. Even at that, despite public health insurance programs like Medicaid and the State Children's Health Insurance Program (SCHIP), over 9 million children in the United States do not have health insurance. Rather than exhausting resources to expand coverage to all children, the federal government, in the last few years, has been shifting fiscal responsibility (but dwindling dollars) from the federal budget to state budgets.[13] Strapped under the increased burden and facing their own fiscal crises, states, in some instances, have shifted Medicaid dollars to other programs. In 1996, Medicaid state spending was 3 percent of state budgets. In 2003, it was approximately 12.7 percent, but in 2006 it declined to 5.5 percent. States are being forced to do more with less.[14]

Unfortunately, things are about to get worse for both state budgets and families living in poverty. The current administration recently proposed to ". . . reduce Medicaid payments to . . . public hospitals . . . by reducing allowable costs.[15] The administration claims "stricter limits" were necessary because federal payments were more than state costs. However, the fear for some is it will simply mean access to health care for the poor will be even more limited. In some areas, such as Los Angeles County, about a third of residents are uninsured and most likely use public hospitals for health care. Reductions in payments could spell disaster for public health in that County. The cuts don't stop at hospitals. The administration plans to tighten Medicaid for school-based health services, expecting to save more than $12.2 billion in the next five years.[16]

The proposed cuts are striking because public health initiatives play a crucial role in reducing health risks for the general population as well as costs. For example, the Centers for Disease Control estimate that a dollar spent on preventive immunization saves $16 in medical treatment for the diseases.[17] And public health immunization programs like Vaccines for Children (VFC) have been instrumental in children starting school with the required immunizations. Immunization programs check the spread of disease and decreases school and work absenteeism. Even at that children of color living in poverty lag behind in their immunizations. As Medicaid increasingly

limits coverage for families, what entities have the capacity to carry the fiscal burden and produce the health care results for millions of people?

Federal safety nets are dismantled and states face increasing fiscal challenges, families and children in poverty, underserved by government, are cast off to the private sector. For example, as food stamps become scarce for families and the issue of food insecurity increases for school-age children, backpack clubs have emerged around the country.[18] To ensure school children do not go without a meal over the weekend, kids are given a backpack filled with food items that don't require can openers or cooking. The children return the bag for a refill the next week. The question is what is the nutritional value of the food items in the bag? Do the foods contain higher levels of sodium as most processed foods do? Although the intent of backpack club is positive, there are two issues: (1) School usurps family as the source of nourishment; (2) Family voice is weakened in what the child consumes. A better solution would be for parents to have decent paying jobs so their families do not suffer food insecurity?

One entrepreneur, Gary Davis, used lobbyists and former Senators Dole and McGovern to chase federal dollars (two billion dollars) for his "grab-and-go" Breakfast Breaks for eligible children in poverty. In courting schools to accept his program "He aligned with nonprofits Share our Strength and the Alliance to End Hunger and donates a portion of his sales to those and other groups; for 2006, he expects donations to total about $1 million."[19] Not to be outdone, Kellogg Cereal giant created Morning Jump Starts a box that contains Froot Loops, Pop-Tarts or Graham crackers, and fruit juice.[20] In response to concerns about the healthiness of Froot Loops and Pop Tarts for breakfast, Ruth Jonen, past president of the School Nutrition Association said: "If it improves participation in the breakfast program, we'll take it and hopefully improve on it over time."[21] Do not poor children deserve the highest standard of breakfast now? Should poor children have to wait for *possible* improvements to a bureaucratic program *over time*? Time is not on their side. Should poor children have to settle for complacency from those who ought to be their most potent advocates?

Other nongovernmental aid is coming from nonprofits and corporate partnerships in an attempt to improve the odds for moms and their newborns. For example, Proctor and Gamble partnered with a nonprofit group to form Every Child Succeeds, a program that targets at-risk, low-income pregnant woman and new mothers, usually single.[22] The program is designed to improve both the health of the mothers prenatally and the infants postnatally, thereby decreasing the infant mortality rate. A relatively small and narrowly focused program in existence since 1999, it has served almost 2,000 women and infants. Can it be expanded to hundreds of thousands? Evidence indicates a number of positive outcomes: A majority of mothers quit smoking, more women chose to breastfeed their infants, many women reported eating healthfully, and women were returning to school or obtaining a job."[23]

The chapters in this text examine the struggles that families and children living in poverty endure from the moment of birth. Oberg and Rinaldi's analysis of infant mortality rates illustrates the intersection of poverty and race, ethnicity, and the infant mortality rate. It is a tribute to the health care in the United States that the infant

mortality rate (IMR) dropped from 21.8 in 1968 to 7.2 in 1998 as the authors report and that by 2010, the expectation is that it will be at 4.5. However, the authors note that an IMR of 4.5 has been achieved by non-Hispanic whites in some states. Yet the rate for black infants was 13.3 in 2001. Then, too, it is higher for infants born into poverty. Oberg and Rinaldi examine the campaigns to decrease sudden infant death (SIDs) by advancing the Back-to-Sleep (BTS) campaign (having infants sleep on their backs to reduce the risk of SIDs) and the campaign to reduce neural tube defects (NTD) by using a folic acid supplement. Oberg and Rinaldi consider the Diffusion of Innovation (DOI) theory as a guide to advance public health initiatives like Back-to-Sleep and folic acid intake to combat Neural Tube Defects.

Alaimo's chapter is especially timely because it exemplifies life in paradoxical America. While the United States has the highest rate of obesity in the world, it also has one of the highest rates of food insecurity among industrialized nations. The author presents a comprehensive analysis of food insecurity, linking it to multiple variables, including poor health, delayed motor skill, cognitive deficits, decreased school performance, increased rates of infection, as well as depression.

Alaimo notes that the United States has not ratified and signed the Convention on the Rights of the Child, a document signed by all other industrial countries and adopted by the UN in 1990. The document simply states, in part, the "right of the child to the enjoyment of the highest attainable standard of health." The wealthiest nation in the world can ensure a decent standard for its young citizens who represent the nation's future? Can the wealthiest nation—that cares for its children—be satisfied that 13 million children within its borders are impoverished? Alaimo reminds readers that rights must be "socially negotiated and necessitate enforcement by societal institutions."

In a concise yet comprehensive examination of the interaction of race, poverty, and illness, Clark analyzes asthma, a chronic and potentially fatal condition for children. Asthma triggers can be found in the physical and psychological environments in which children of impoverished families live. Potential dangers exist, too often, in the lack of effective communication not only because of social class differences but because of perceived sociocultural differences. Although anxiety can trigger asthma, anxiety can be a consequence of asthma—asthma can increase a child's feeling of vulnerability, especially when it interrupts children's daily lives.

Using ethnographic research Skinner, Lachicotte, and Burton, interviewed 42 families who live in poverty and have at least one child with a disability (seizures, Down's syndrome, autism, pervasive development disorder, asthma). Using interviews over a matter of several years the researchers determine if changes occurred in the families' status—economically, health, as well as in terms of support networks. The authors provide a detailed analysis of the enormous task of a family's daily physical care routine, advocacy, coordination of medical and therapeutic (physical and psychological) services, transportation, and constant mounds of bureaucratic paperwork—the task of a caregiver who is too often not in good health. The research provides an understanding of why families with children who have a disabling condition are almost twice as likely as others to be in poverty.

Similar to Skinner, Lachicotte, and Burton's study, Fletcher and Winter's qualitative research presents a descriptive analysis of 35 families living in poverty who have at least one child who suffers from chronic health conditions (autism, developmental delays, seizure, ADHD, mental retardation). What complicates each family's daily situation is the fact that they live in a rural area, with limited medical resources readily accessible. Treatment for the children, then, in addition to the coordination that Skinner's research delineates, requires an inordinate amount of travel time. For example, one child suffers from a seizure disorder and requires frequent airlifts or 8-hour ambulance rides for treatment. The research illustrates how family life revolves around one child's needs. It is a full-time job that prevents caregivers from taking a job. A constant concern of caregivers is loss of health insurance for their children and, of course, lack of adequate financial resources. Therein is the catch-22. If caregivers take a job, they risk losing insurance for their child's condition. On the other hand, not having a job means lower income and precludes obtaining additional needed therapies. Living in a rural area exacerbates the family's constraints: fewer job opportunities and disallows access to health care. Overall, Fletcher and Winter's study provides an important examination of the difficulty of maneuvering the health care system with limited resources over long distances.

Eiraldi and Mazzuca's research examines a segment of the population that continues to be understudied despite the fact Latinos represent the largest minority group in the United States. Children of Latino backgrounds represent the fastest growing minority group. First, the researchers argue for the disaggregation of the Latino population into appropriate subgroups rather than analyzing all—because of a common language—with a broad monolithic brush. The researchers note, too, the intersection of ethnicity and poverty. In their study of children with ADHD, Eiraldi and Mazzuca are interested in why Latino children are less likely to receive mental health services. Building on prior help-seeking models, they construct a model using multiple variables that influence the process Latino parents tend to follow in seeking health care assistance for their children.

In a study somewhat similar to Eiraldi and Mazzuca, Spencer et al examine the parental perceptions of preschool mental health services. The study focuses on low-income African Americans because although the use of mental health services has doubled in the last two decades, that has not been the case for minorities. Although prior research has targeted adult services, the present study is interested in children's services. The authors discuss the themes that emerge as well as the constraints perceived by parents that impede access to services.

Two studies examine immigrant families and health services. First, using data from the *National Health Interview Survey*, Szaflarski and Ying examine the intersection of child immigrant status, poverty, indicators of child's health, and access to health care (such as health insurance). The researchers found that immigrant children were less likely to have access to health care and they were less likely to have health problems. The study found that the effects of poverty varied by immigrant status, race, and ethnicity.

In an exploratory study Segal, Segal, and Diwakaran compare perceptions of low-income immigrant families with perceptions of low-income native born families on a variety of economic, social, physical, psychological, and health variables. The researchers used a Likert-type questionnaire administered to families as they waited in the examination room at a hospital. Two hundred thirty-five responded (170 native born, 17 second generation, 30 immigrants). Using factor analysis four underlying perceptual dimensions were identified: antisocial behavior; helplessness; low levels of belonging; poor financial resources.

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CHAPTER 1

UNDERSTANDING POVERTY, RACE, AND INFANT MORTALITY*

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The national health objective for 2010 targets an infant mortality rate (IMR) of 4.5 infant deaths per 1,000 live births. In addition, an overarching goal calls for eliminating disparities by income, race, and/or ethnicity. The IMR is defined as the number of infants per 1,000 live births who die prior to the age of 1. Infant deaths are categorized as either neonatal deaths (those which occur from birth through 28 days of life) or postneonatal deaths (those occurring from 29 days to age 1). Over the course of the twentieth century, the United States has made remarkable strides in reducing the infant mortality rate. In the 30 years between 1968 and 1998, the IMR dropped from 21.8 to 7.2 deaths per 1,000 live births.

A report from the Centers for Disease Control and Prevention (CDC) shows that the 2001 infant mortality rate in the United States reached a record low of 6.8 per 1,000 live births.[1] However, data that linked birth/infant death data sets for 1995–2002, which was analyzed from the National Vital Statistics System and maintained by CDC's National Center for Health, indicates that the overall IMR in the United States declined from 7.6 infant deaths per 1,000 live births in 1995 to 6.8 in 2001, and then increased to 7.0 in 2002.[2]

These data further indicate that the national target of 4.5 infant deaths per 1,000 live births was achieved for a select few racial/ethnic populations and in few states. The IMR data for the years of 1995–2002 indicates that the 2010 target of 4.5 infant deaths per 1,000 live births was achieved among infants of non-Hispanic white mothers in Washington DC, Massachusetts, New Hampshire, and New Jersey. Additionally, this target was reached for infants of Asian/Pacific Islander mothers in eight states (Connecticut, Massachusetts, Missouri, New Jersey, New York, Oregon, Pennsylvania, and Texas). However, the target was not achieved in any state for

infants of non-Hispanic black, Hispanic, or American Indian/Alaska Native mothers. A further decline of 36 percent overall is needed to reach the target IMR of 4.5 infant deaths per 1,000 live births in 2010, and even greater declines are required for certain racial/ethnic populations to reach the target.

The next section of this chapter will provide an overview of child health disparities and the complex interface between poverty, race, and ethnicity. The paper will then go on to explore infant mortality with an examination of two recent public health interventions to improve birth outcomes; the "Back to Sleep" campaign to address Sudden Infant Death Syndrome (SIDS) and the supplementation of folic acid to reduce neural tube defects. Finally, the Diffusion of Innovation (DOI) theory will be applied to examine the effectiveness of these interventions across poverty, race, and ethnicity.

UNRAVELING HEALTH DISPARITIES—THE INTERFACE OF POVERTY AND RACE/ETHNICITY

The interface of poverty, race, and ethnicity in unraveling and understanding persistent health disparities for children is a "complex" issue and cannot be treated as a one-dimensional phenomenon.[3] It is influenced by the ability of families with children to meet basic needs and secure a basic level of shelter, nutrition, and health care. It is also influenced by the increased risk of detrimental influences faced by families living in poverty such as marital conflict, psychological distress, depression, and loss of self-esteem. Brofenbrenner's ecological approach mandates a contextual view that incorporates the attributes of the child in a home environment duly placed in a community striving to meet unmet needs and the need to obtain long-term resources.[4] Therefore, the impact of childhood poverty needs to be examined epidemiologically from the perspective of adverse health outcomes and the disproportionate burden it places on minority families.

A seminal study from the early 1970s demonstrated the effect of both family characteristics and income on infant and child well-being. The National Collaborative Perinatal Project (NCPP) was conducted as an in-depth follow-up of 26,700 infants. The two factors most predictive of intellectual performance at 4 years of age were family income, represented by socioeconomic status (SES), and maternal education.[5] In addition, Duncan and his colleagues at the University of Michigan two decades later found that children born at low birthweight, or less than 2500 grams, who lived in poverty for their first 5 years of life had IQs that were 9.1 points lower than low birthweight infants never subjected to poverty.[6]

Werner and her colleagues conducted one of the longest longitudinal works comparing perinatal and environmental factors in the developmental outcomes of children. The study was initiated in 1955 and followed 6,987 children born on the island of Kauai, Hawaii. These children, who were exposed to significant perinatal stress, experienced an increased incident of neonatal health problems, learning disabilities, mental retardation, and increased rates of delinquency and teen pregnancy. However, the effects of the family environment and the long-term impact of the care were

actually more powerful than the residual effect of perinatal compilations with the risks blunted by an enriched environment in a family with high SES.[7]

It is also well documented that the escalation of childhood poverty witnessed over the past three decades and the burden it places on families has been disproportionately carried by children of color. Whereas the poverty rate in 2003 for white non-Hispanic children is at 10 percent, the rate for black children is 34 percent and 30 percent for Hispanic children. In addition, the number of black children living in extreme poverty, as defined as living in families with incomes less than 50 percent of the Federal Poverty Threshold, is at its highest level in 23 years and is more than four times the rate for white children.[8]

A study by Bazargan and colleagues in 2005 provided a physical and mental health profile of African American and Latino children aged 18 years and younger in public housing communities in Los Angeles County. Results of the study suggest that publicly housed minority children are a particularly vulnerable subgroup in underserved communities. Results indicate that children of poor families living in public housing suffer from chronic physical and mental conditions such as asthma, dental and vision problems, ADHD, and depression, at two to four times the rate of the children in the general population.[9]

Pediatric health disparities are defined as differences in health indicators that exist across subgroups of a population. Just as it has been demonstrated that children of color are disproportionately poor, it has also been demonstrated repeatedly that minority children face greater health disparities.[10] This interplay between income and race/ethnicity though well established has not been adequately explored on the contribution each makes to adverse health outcomes experienced by children of color. Whereas, the socioeconomic disparities in health indicators and utilizations have been well documented for adults, the interface is less clear for infants and children.[11]

Chen, Martin, and Mathews conducted a study to determine whether childhood health disparities are best understood as effects of race, socioeconomic status, or a synergistic effect of the two. The study utilized data provided by the National Health Interview Survey of children aged 0 through 18 years old. The researchers analyzed race by socioeconomic status, which was based on parental education, to predict health outcomes in a large, nationally representative sample of U.S. children.

Results of the analysis indicated that the effects of race and SES are best understood when analyzed together. The study revealed that SES had a significant effect on health outcomes as children from less educated families were more likely to be in fair/poor health. Significant effects of race on health outcomes were evident for black, Hispanic, and Asian children such that children from each minority group were more likely to be rated in fair/poor health than were white children. Lastly, the education by race interaction effect was not significant for black compared to white children, indicating that both white and black children had similar education gradients for fair/poor health. However, the interaction effect was significant for Hispanic compared to white children ($p < 0.001$) and for Asian compared to white children ($p = 0.08$) indicating that education gradients for Hispanics and Asians were less steep for fair/poor health than for white children.[12]

As the Institute of Medicine's report on *Unequal Treatment* states: "Attempts to control for SES differences are inconsistent, with some researchers employing patient income or education as sole indicators of SES, and others using proxy variables such as estimates of income on the basis of patients' zip code information."[13] We are left with this interface where it is evident that poverty contributes substantially to the heath disparities and yet when income and class are controlled for, disparities persist though less striking than when both poverty and race/ethnicity are evident. The next section will provide an overview of infant mortality and epidemiological trends by income, race, and ethnicity.

OVERVIEW OF INFANT MORTALITY TRENDS

While the IMR for most racial/ethnic populations declined over the past several years, major disparities in the rates by race and ethnicity exist. In 2001, rates ranged from 3.2 per 1,000 live births for Chinese mothers to 13.3 for black mothers. Between 1995 and 2001, the overall infant mortality rate declined by 10.5 percent, but rates were down 9 percent for black infants and 14 percent for infants of Hispanic mothers. Infant mortality rates were higher for infants whose mothers were poor, had no prenatal care, were teenagers, had less education, and were unmarried or smoked during pregnancy. Infant mortality rates are higher for infants of U.S.-born women compared to women born outside the United States. Infant mortality rates are higher for male infants, multiple births, and infants born preterm or at low birthweight. Infant mortality also varied greatly by state. Rates are generally higher for states in the South and lowest for states in the West and Northeast. Infant mortality rates among states ranged from 10.4 for Mississippi to 4.9 for Massachusetts.[1]

In addition to the disparities in IMR among most racial/ethnic groups, little improvement has been noted in the relative differences in IMRs among the different racial and ethnic populations. Blacks and American Indian/Alaska Natives continue to have higher rates than whites, Hispanics, and Asian/Pacific Islanders as well as rates above the national average.

Examination of the IMR stratified by race further emphasizes the impressive racial disparity. Analysis of these data, which are expressed as black/white IMR ratios, reveals a number of significant trends. First, the IMR decreased substantially for both whites and black infants over the last 50 years, which most likely reflects improvements in both the medical and public health systems. However, the rate of decline has been less significant for black infants. Figure 1.1, depicts this differential rate of deceleration and the disparities are even more striking when visualized graphically. As can be seen in the diagram, the IMR black/white ratio increased from 1.89 to 2.50 between 1970 and 2000 respectively. These results highlight the powerful influence of race on health disparities. These observations are by no means new, and the effect of both racial and financial income differences on health outcomes has been the focus of study.

A recent study by Shen and colleagues demonstrated that African American women had more pregnancy and childbirth complications, which contribute to this widening disparity in infant deaths. Compared to white women, African American women

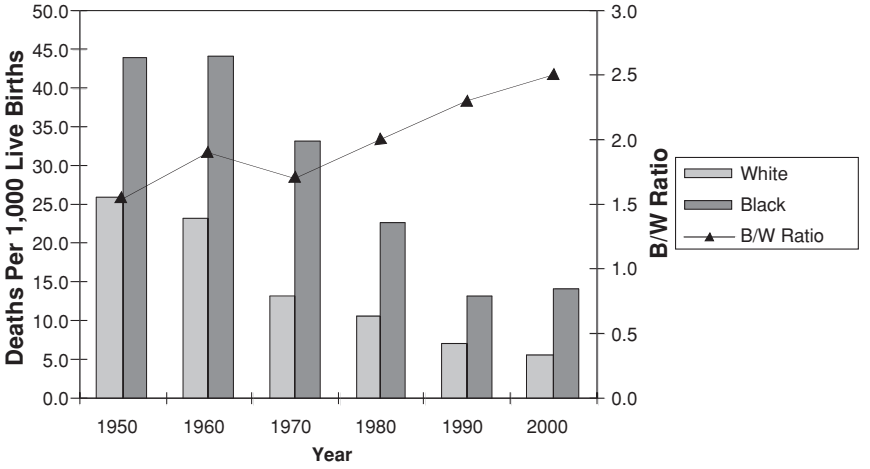

Figure 1.1
Comparison of Black/White Ratio of IMR, 1950–2000

had higher rates of preterm labor, preeclampsia, transient and pregnancy-inducted hypertension, diabetes, placenta previa, placental abruption, premature rupture of membrane (PROM), infection, and cesarean section, all of which can contribute to low birthweight and preterm infants who are a great risk for infant mortality.[14]

Examination of the distribution and frequency of causes of infant death provides insight into the source of the differential IMRs. A recent study linked birth and infant death records of over 23 million singletons belonging to six birth cohorts (1989–1991 and 1995–1997). The results highlight racial differences in the overall and cause-specific infant mortality rates across time in the United States. Infant deaths were predominately attributable to congenital anomalies, short gestation/low birthweight, sudden infant death syndrome, respiratory distress syndrome, and maternal complications. The comparative data between 1989–1991 and 1995–1997 reveal that the overall IMR declined 19.9 percent in the 1995–1997 cohorts compared to the 1989–1991 cohorts. In each birth cohort, non-Hispanic whites, Asian/Pacific Islanders, and Hispanics had lower IMRs than the non-Hispanic blacks and American Indians. In addition, the smallest gains over time were found in the non-Hispanic black population.[15]

Sudden Infant Death Syndrome

One of the major causes of infant death is Sudden Infant Death Syndrome (SIDS). SIDS is the leading diagnosis of infant death in babies who survive past the first month of life and accounts for nearly one third of postneonatal deaths. Despite recent changes in the epidemiology of sudden unexpected death in infancy, it remains one of the most significant causes of infant death in developed countries.

A systematic review of fifty-two studies, undertaken in 16 countries and including over 10,000 sudden unexpected infant deaths during the period 1956 to 1998 was conducted on the relationship between SIDS and socioeconomic status.[16] Socioeconomic status represents a constellation of factors reflecting social position and social circumstances including income, occupation, education, and ownership of resources such as housing. For the purposes of this study, marital status and maternal age, which are not strictly socioeconomic status variables, but have been consistently shown to be strongly associated with measures of social status especially in studies of pregnancy and infant outcome, were used as proxy for economic status.[16] The results of the review show an increased risk of sudden unexpected infant death associated with low socioeconomic status, measured by a range of indicators, which is consistent over time and between countries.

Another recent study from New Zealand also examined the relationship between economic deprivation and one's geographic area of residence and SIDS. The results again confirmed that the risk of SIDS increases significantly as one's residential area of residence becomes more deprived. Specifically, the infants living in the most economically disadvantaged locations were 5.9 times more likely to die of SIDS as compared with infants living in the most affluent areas.[17] The findings of this study suggest that socioeconomic factors have an important role in the pathways leading to SIDS.

Congenital Anomalies: Neural Tube Defects

Congenital anomalies are responsible for a significant proportion of infant deaths during the first year of life. Opportunities to reduce infant mortality and/or morbidity associated with congenital anomalies exist from preconception through the postneonatal period. Interventions may be directed to both the prevention of congenital anomalies and prevention of death from these birth defects. Neural tube defects (NTDs), a term which encompasses a spectrum of disorders from Spina Bifida Occulta to Anencephaly, represent a major preventable source for infant mortality and morbidity.

Table 1.1 reveals that the aggregated NTD-specific IMR for the years 1996–1998 varied by race and ethnicity. While black infants with a NTD were 27 percent less likely than white infants with NTD to die in the first year of life, there was a marked disparity in the high NTD-specific IMR among Hispanics. Hispanic infants had a 50 percent higher NTD-specific IMR when compared to non-Hispanic white infants and this risk was even higher for infants of Mexican descent. Genetics, cultural differences, dietary preferences, and attitudes toward multivitamin use all likely contribute to the disparities. Importantly, the figures underscore the need to focus prevention programs on the Hispanic population.[18]

THE THEORY OF DIFFUSION OF INNOVATION (DOI)

The Diffusion of Innovation theory initially emerged in the early twentieth century from the fields of sociology and communication theory. Everett Rogers formalized the

Table 1.1
NTD-Specific IMR by Maternal Race and Ethnicity, United States, 1996–1998

	Total U.S. Live births	NTD Deaths	NTD IMR[a]	Relative risk (95% CI)
Maternal race				
White	9,284,424	1,081	11.6	–
Black	1,804,596	154	8.6	0.73 (0.62–0.87)
Native American	116,724	13	11.5	0.96 (0.55–1.65)
Asian/Pacific Islander	508,197	50	9.8	0.85 (0.64–1.12)
Ethnicity				
Non-Hispanic white	7,053,814	729	10.3	–
Non-Hispanic black	1,752,657	151	8.6	0.83 (0.70–0.99)
Total Hispanic	2,145,767	330	15.4	1.49 (1.31–1.69)
Mexican	1,504,701	255	17.0	1.64 (1.42–1.89)
Puerto Rican	167,662	17	10.4	0.98 (0.61–1.59)
Central/South American	293,519	35	11.9	1.15 (0.82–1.62)
Total	11,713,941[b]	1.299[b]	11.1	

[a] Per 1000,000 live births.
[b] Sum of categories may not equal total due to missing values.

constructs and broadened its applicability to public health.[19] Diffusion is defined as the process through which an innovation perceived as new, spreads via certain communication channels over time among members of a particular social system. Thus, the theory has four main elements; the innovation, communication channels, time, and a social system. Application of DOI theory into practice has the potential to expand the number of people reached by successful interventions thereby strengthening the public health impact.

In regard to the topic of examining the issue of infant deaths, the first element is innovation and would consist of the new strategies to reduce the IMR for selected populations. The second element is the channels of communication. The innovation transitions through the channels of knowledge, persuasion, decision, implementation, and confirmation. Awareness of these channels of communication create the opportunity for public health professionals to target intervention activities toward influential stages of communication, such as the knowledge and persuasion stages, to create behavior change more effectively.[20] For instance, in the knowledge stage, the target population is learning about the intervention. During this stage, the professional focuses on spreading information by means of mass media to introduce the innovation to the community. During persuasion, when people form an opinion of the program, the public health professional must focus on interpersonal channels of communication and leverage influential capacities of change agents, influential people in the community. The final two elements of DOI are the variables of time and social systems which indicate that adoption varies over time for selected populations that contribute to economic and racial disparities.

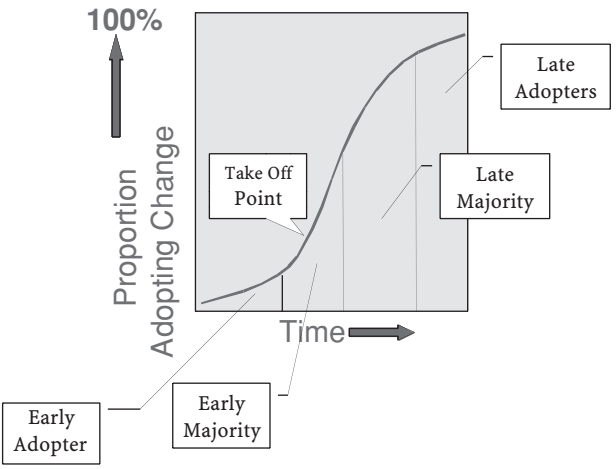

Figure 1.2
The "Classic" Diffusion Cure

The Diffusion of Innovation (DOI) theory also allows us to quantitate and measure change. The theory states that behavior change is contextual thus consistent with Brofenbrenner's work mentioned earlier. Human behavior is formed in the context of multiple factors (e.g., social, political, economic, and individual). Secondly, we presume that the factors that influence our behavior are modifiable and amenable to intervention. This axiom makes the diffusion perspective a more complex theory. Third, change can be measured, not only at the individual level, but also at the organizational, community, and societal level. Fourth, change is continuous. Finally, the rate of change can be influenced.

Diffusion theory states that the percentage of the population that adopts a new behavior follows a predictable pattern over time. Researchers have found that the adoption process is most often described by a curve that resembles an "S-shaped" curve. Figure 1.2, provides a schematic of the classic diffusion curve. On the "Y" axis is the percent of the population adopting a certain intervention with the goal of 100 percent adoption for any particular intervention. The "X" axis is time. All interventions have a very similar pattern for the diffusion curve in the beginning. Research indicates that a program must reach approximately 25 percent, the takeoff point, to ensure a successful intervention in a significant percentage of the population. If an intervention is able to reach this take-off point it has a chance of broad acceptance and the incorporation of the desired behavioral change.

The exact shape of the diffusion curve varies from innovation to innovation. The innovation adoption curve or diffusion curve is a model that classifies adopters of innovations into various categories based on the idea that certain individuals are inevitably more open to adaptation than others. The process begins with the Early Adopters (frequently, innovators and opinion leaders) who will take the lead and

incorporate a change into their behavior. The Early Adopters are the first 16 percent to adopt the behavior change. The next class of adopters is the early majority, who comprise the next 34 percent. Behavior change by the early adopters achieves the 50 percent point of adoption of an intervention by a community. At the 50 percent point, the slope of the curve changes and creates a mirror image, with the next 34 percent representing the Late Majority and the last 16 percent representing the Late Adopters.[21] The total of 100 percent does not mean that 100 percent of the population adopts the change but rather the total of 100 percent of those who choose to change. The number represents a cumulative percentage. When an innovation is introduced the majority of the population has intervention adoption rates that fall in between the Early Adopters and the Late Adopters. By identifying the characteristics of people in each adopter category, professionals are able to more effectively plan and implement strategies customized to their needs.

APPLICATION OF DOI TO TWO SELECTED PUBLIC HEALTH INTERVENTION STRATEGIES

The Diffusion of Innovation (DOI) theory has been used successfully for forty years in health, education, and the social sciences. Examples include the expansion of nutrition interventions, tobacco control, and the initiation of family planning and prevention of HIV/AIDS.[22,23] The generalizability of the diffusion model allows the theoretical framework to be applied to a variety of problems.

In a review of the literature on DOI, a discussion was not found on how diffusion theory relates to the two interventions mentioned in the previous section, the "Back-to-Sleep" campaign and folic acid supplementation. While both campaigns achieved some success, an understanding of the Diffusion of Innovation theory clarifies why the interventions were not as successful in certain segments of our population. If applied successfully, the Diffusion of Innovation theory has the potential to help reduce racial/ethnic disparities in IMRs. The campaigns were not as effective initially in the first two channels of DOI, increasing knowledge and persuading communities of color to adopt the changes or in addressing the characteristics of an innovation.

The Back-to-Sleep Campaign and SIDS

The National Institute of Child Health and Human Development (NICHD) and the Maternal and Child Health Bureau (MCHB) developed a national health education campaign in 1994 to encourage parents to put their infants "Back to Sleep." The campaign was based on research showing that a supine sleeping position (infants sleeping on their backs rather than abdomens) greatly decreases the risk of SIDS among full-term, healthy infants.[24,25] The campaign was launched through primary health providers and was embraced by the American Academy of Pediatrics (AAP). As indicated in Figure 1.3, a significant reduction in prone sleeping following the initiation of the "Back to Sleep" campaign was associated with a concomitant decrease in the incidence of SIDS.[26]

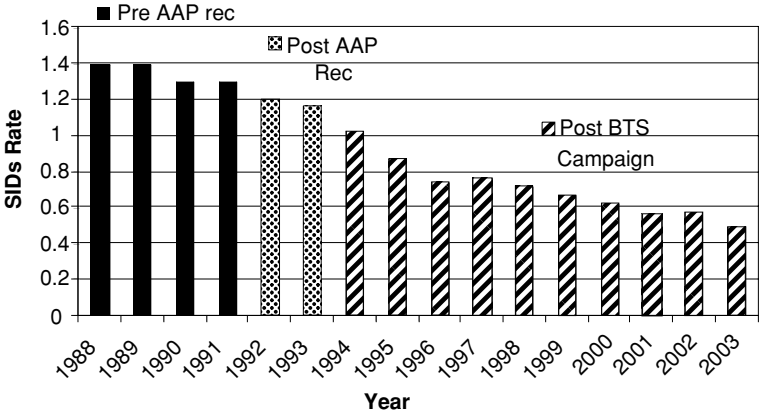

Figure 1.3
SIDs Rate, 1998–2003 (Deaths per 1,000 Live Births)

Figure 1.4 reveals that the substantial drop in sudden infant death syndrome (SIDS) was not shared by all racial and ethnic groups. The figure reflects the "S" shape of the classic diffusion curve with the highest rate of adoption by non-Hispanic whites and Asian families. It is evident that the Back-to-Sleep intervention was less effective in the African American community, in which the SIDS rate remained significantly higher among African American as compared to whites. In 2001 the SIDS rate for infants of black and American Indian mothers was more than double that of non-Hispanic white mothers.

A study conducted by Pickett, Lou, and Lauderdale examined social inequalities in risk of SIDS before and after the introduction of the Back-to-Sleep campaign. The study utilized a cohort of data from the U.S. National Center for Health Statistics

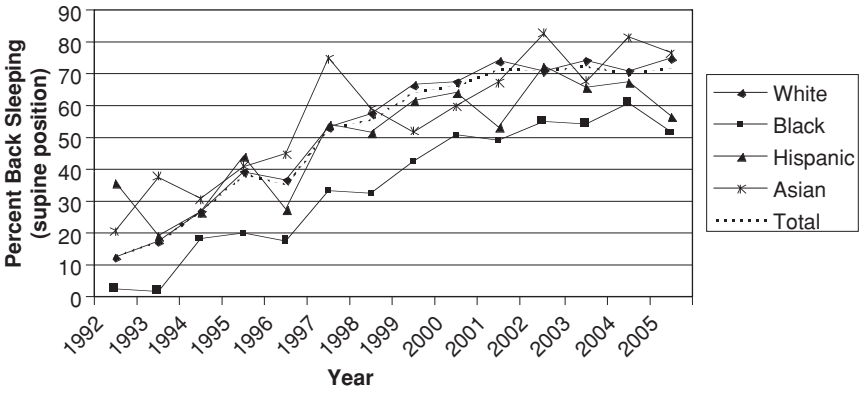

Figure 1.4
Percent of Children Sleeping on Their Back by Year and Race

linked birth and death certificate data on all infants born in the United States and those who die in the first year of life. Data analysis compared birth outcomes in pre-campaign years (1989–1990) and post-campaign years (1996–1998).

The results indicate that infants born in the post-campaign cohort were significantly less likely to die from SIDS ($p. < 0.001$) than infants born in the pre-campaign cohort. The decline was more pronounced for infants born to Hispanic women ($OR = 0.51$) and less pronounced for infants born to black women ($OR = 0.63$) as compared to white women ($OR = 0.58$).[27] In addition, rates declined within each education and race/ethnicity category. In all education groups and in both birth cohorts, infants born to black mothers were at higher risk of death than those born to white mothers, and infants born to Hispanic mothers were at lower risk of death than those born to white mothers.[27]

In sum, the study found that social class inequities in SIDS, as measured by maternal education, did not narrow after the Back-to-Sleep campaign compared with the pre-campaign era. Although the absolute risk of SIDS was reduced for all social class groups, a widening social class inequality was evident as mothers with more education experienced a greater decline than women with less education.

Pickett and colleagues examined the effectiveness of the Back-to-Sleep campaign as a function of social class. Social class was measured by maternal educational achievement. The researchers used data sets of all infant deaths caused by SIDS for the years 1989–1991 and 1996–1998 from the U.S. National Center for Health Statistics linked birth and death certificate data on all infants born in the United States and those who died in the first year. In sum, the study found that social class inequities in SIDS, measured by maternal education, did not narrow after the Back-to-Sleep campaign compared with the pre-campaign era. Absolute risk of SIDS was reduced for all social class groups, though a widening social class inequity was evident as women with more education experienced a greater decline than women with less education.[27]

Following the initial success of the "Back-to-Sleep" campaign and because of the persistent disparity in its adoption, the educational efforts were expanded to include additional community organizations so as to achieve greater penetration into the black community. For example, the U.S. Department of Health and Human Services' Office of Minority Health launched a new public education campaign in 2005 to reduce infant mortality in African American communities entitled "Know What to Do for Life". The campaign uses health prevention messages aimed at fathers, caretakers, and expectant mothers to encourage early prenatal care, abstinence from alcohol and tobacco, proper nutrition, and adoption of a prone sleeping position for infants.[28] This effort will increase knowledge; an important facet of a successful intervention.

It is always important to remember that health professionals, researchers, and public health educators need to continue to assess the environment and identity changes in populations that may be at risk. A recent study in the United Kingdom analyzed five years of case control data to highlight the changing etiology of SIDS. The results indicated that the Back-to-Sleep campaign had been successful in the United Kingdom in reducing the rate of SIDS. However the epidemiology of SIDS has

shifted to with SIDS occurring increasingly from low SES families that also included an increase in single parents, younger mothers, and low birthweight infants.[29]

However, as mentioned, it is evident that in addition to increasing knowledge, the second channel, persuasion, and the characteristics of an innovation, relative advantage, compatibility, complexity, trialability, and observability need to be addressed in order to achieve successful adoption in the African American community. Incorporating elements of the Diffusion of Innovation theory into the "Know What to Do for Life" campaign may enhance adoption of behaviors in this segment of the population that will reduce IMR.

Folic Acid Supplementation and Neural Tube Defects

It is well recognized that inadequate intake of folic acid prior to conception and during early pregnancy contributes to the development of NTDs. Nutritional supplementation with the recommended 400 micrograms of folic acid per day not only is associated with a significant reduction in NTDs but also seems to confer a protective effect against low birthweight deliveries.[30–32] Unfortunately, results from the 1991 to 1994 National Health and Nutrition Examination Survey (NHANES) revealed that only 21 percent of non-pregnant women aged 15 to 44 years consumed the recommended daily 400 micrograms of folic acid from any source, including diet, fortified foods, or dietary supplements. As closure of the embryonic neural tube occurs in the first 4–8 weeks of fetal development, pre-pregnancy nutrition is critical as women often are unaware of the conception by this early stage. With improper closure of the neural tube, a spectrum of disorders from Spina Bifida Occulta to Anencephaly may arise. It has been estimated that approximately 50 percent of NTDs may have been prevented with adequate consumption of folic acid from 1 month prior to conception through the end of the first trimester of pregnancy.[33,34]

Naturally occurring dietary sources of folic acid, a synthetic form of the B-vitamin folate, are limited and occur primarily in foods such as beans, legumes, spinach, orange juice, and various meats. As a result, in 1998, the Food and Drug Administration (FDA) mandated that 100 micrograms of folic acid be added to a variety of grain products including breads, rice, and cereals.[35] Despite this dietary fortification, a 2003 March of Dimes/Gallup poll demonstrated that two-thirds of American women of childbearing age still were not receiving the daily-recommended 400 micrograms of folic acid.[36] Successful strategies to further reduce the 2,000 children born each year in the United States with NTDs might include an increase in the folic acid supplementation from the current 100 up to 200 micrograms.[37]

A recent study looked at the initiation of folic acid supplementation based on income and/or SES. Relton and colleagues assessed the use of folic acid supplementations in a small sample of pregnant women suing a social derivation measurement in the United Kingdom. The measure used was the Townsend deprivation index, which is a geographic based measure of social deprivation and poverty. A striking finding was that as the level of deprivation increased there was a concomitant reduction in the correct use of folic acid supplementation. Younger women and/or women who

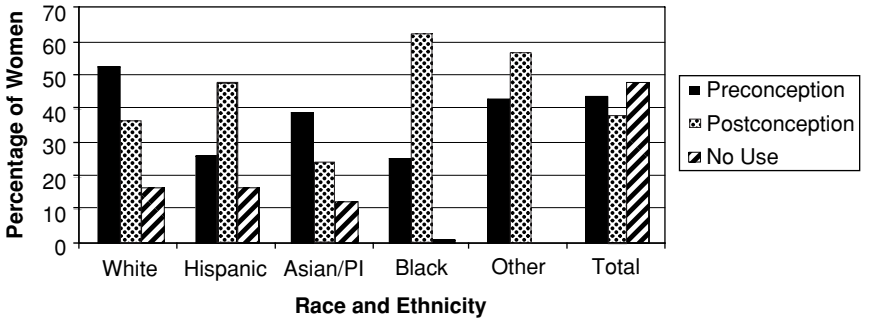

Figure 1.5
Use of Folic Acid Containing Supplements in the Current Pregnancy by Race and Ethnicity (2003–2004)

were more SES disadvantaged were less likely to use folic acid during the critical preconception period.[38]

Further evidence of disparities in consumption were revealed in a 2002 retrospective study using period linked infant birth/death data from the National Center for Health Statistics (NCHS). Figure 1.5 demonstrates the use of consumption of folic acid by race and initiation of supplementation. As can be seen whites and blacks have the highest consumption in the pre-pregnancy and prenatal periods with the lowest in the Hispanic and Asian communities.

The fortification of food with folic acid campaign may also benefit from application of the Diffusion of Innovation theory. To be effective, the increase in folic acid consumption has to occur in the pre-pregnancy period due to the fact that the neural tube closes in the first eight weeks of gestation (during the germinal and embryonic periods) prior to when many women are aware of the pregnancy. For instance, based on DOI theory, an intervention should focus on knowledge of this fact followed by a persuasion campaign to increase the intake of folic acid either through a diet more rich in folic acid or through greater consumption of folic acid fortified grains for all women of childbearing age. To that extent, if the public health intervention is focused toward a shifting of prenatal supplementation for the Hispanic and non-Hispanic black to the pre-pregnancy period, a concomitant reduction in neural tube defects would be realized.

A recent national folic acid campaign was launched in the Netherlands to boost the early and appropriate consumption of folic acid prior to pregnancy. The goal was to reach women from low SES due to the documentation that women from low SES situations had a greater risk of NTDs than higher SES women. The intervention was the use of a mass media campaign to educate women on the importance of folic acid. The results were mixed, showing that once information reached women, it was equally well understood by all groups irrespective of SES and educational backgrounds. However, they did document that the media campaign was not as effective as reaching the women of lower SES status. The conclusion was that to

enhance the effectiveness of a media campaign strategies must utilize new effective channels of communications that not only include a focus on income but also address the normative expectations of the woman as well as her partner, friends, and extended family would be to explore in the future.[39]

CONCLUSION

As we continue to work toward reaching the 2010 goals for infant mortality with the elimination of disparities across income, race, and ethnicity, it will be necessary to transform our interventions from a one size fits all to interventions that address unique characteristics of all segments of the population. Once this is achieved, the United States will then realize equity in that all children will be able to live and reach their full potential. It is becoming increasingly important to address both poverty and social class and how it contributes to the health disparities experience by children of color. As Chen and colleagues have recently demonstrated, to better understand and address childhood health disparities we must examine the synergy between both race and socioeconomic status and how each contributes to unmet health-care needs.[12]

The diffusion model provides valuable insights into why some interventions are effective in changing behavior and others are not as successful. The theory's components may serve as a guide for those who work to promote adoption of best evidence practice. Application of the diffusion of innovation theory concepts to public health interventions has the potential to expand the number of people exposed to the program and strengthen the public health impact.

However, developing effective programs is not enough. There are numerous examples of interventions that research has shown to be efficacious but which have failed to translate the research into public health adoption and action. The efficacy of public health interventions is determined in part by the extent to which it is implemented and adopted by individuals, groups of individuals, larger segments of a community and, ultimately, the population at large. Diffusion theory offers a plausible explanation as to why some behaviors are adopted rapidly and others not, despite strong evidence of their potential benefits. Some clinical behaviors may be adopted relatively easily because of the nature of the behavior itself, while others may involve a complex interplay between social systems, communication style, and the decision-making process. Intervention is the process of taking research and translating and disseminating it into communities to effect change. We must disseminate and diffuse the programs effectively in order to reach their full potential for improving population health among all racial and ethnic populations.

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CHAPTER 2

CHILD HUNGER IN THE UNITED STATES: AN OVERVIEW

Katherine Alaimo

> I cried only once. I was in a soup kitchen one night, trying but failing to appear inconspicuous, when a young mother rushed in with three children—an infant and twin boys. She was running from something, but no one seemed to care. Her boys were about 4, dressed in rags and bone thin, and they attacked a tray of peanut butter sandwiches as if they hadn't seen food in a month. A volunteer fixed them a place with cookies, an apple, a cup of vegetable soup and more sandwiches. They ate furiously, their eyes darting in all directions as if someone might stop them. They stuffed themselves, because they knew the uncertainties of tomorrow. Little street soldiers, preparing for the coming battles. Is this the Third World, I asked myself? Or is this America?
>
> —John Grisham, on his experiences researching his novel, *The Street Lawyer*[1]

Although the United States is one of the wealthiest nations in the world, a significant segment of U.S. population do not reap the benefits, including children. According to a recent UNICEF report, the United States has the second highest relative child poverty rate (percentage of children below 50% of the median household income) of 24 other rich countries.[2] Absolute poverty levels are also comparatively high; almost 20 percent of U.S. children are poor, when using the U.S. poverty line as a measurement standard, in contrast to less than 10 percent in 11 other countries, including Canada, France, and Germany.[3] This translates into over 13 million children currently growing up in poverty the United States.[4]

For many, the issue of poverty in America is intertwined with images of hunger. As the opening quote illustrates, the immediacy of a hungry child has a strong psychological impact, and the extraordinary network of feeding programs available—food banks and soup kitchens, government food assistance, such as the Food Stamp Program and School Lunch Program, food drives and donations by corporations and

religious and service institutions, and the community food security movement are a testament to our collective discomfort with a child going without food.

But clearly, these supports are not adequate. This chapter addresses the subject of food deprivation in the United States and it's effects on children. Specifically, this chapter summarizes the latest research on the consequences of food deprivation on children's health, growth, and academic achievement, explores the multiple layers of effects that food deprivation can have on children within the context of their families, and describes recent research on Federal food security programs and child outcomes.

FOOD INSECURITY AND HUNGER

Today, Federal policymakers, antihunger advocates, and researchers use the terms "food insecurity" and "hunger" to describe the phenomenon of food deprivation in the United States.[5] Food insecurity is defined as "the limited or uncertain availability of nutritionally adequate and safe foods, or limited, or uncertain ability to acquire acceptable foods in socially acceptable ways," while hunger is more narrowly used to mean the "uneasy or painful sensation caused by a lack of food" or "the recurrent and involuntary lack of access to food."[6] The definition of food insecurity is based upon a consensus that hunger, or food restriction that elicits the sensation of hunger, is not the only socially meaningful characteristic of food deprivation that matters to society; the definition also encompasses the concepts of access, availability, and safety of food in addition to the social meaning of food acquisition methods.

Our current understanding of the phenomena of food insecurity and hunger draw from a rich research base of ethnographic research conducted with low-income North American women and families since the 1980s.[7] There are four flexible, though most commonly staged, components described by people experiencing household-based food insecurity. First, there is a sense of worry about the food situation as food resources diminish, a core characteristic of food insecurity that Radimer et al.[8] called "food anxiety" and Hamelin, et al.[9] labeled "preoccupation with access to enough food." This uncertainty often is about the immediate situation, but could also include longer-term worry about the future. Second, diminished resources result in constraints to purchase or acquire food that is not considered acceptable quality or types. This refers to meals that are monotonous and reflect a lack of intrameal and intermeal variety; and also to the safety freshness, and nutritional value of the food supply.[10] Eventually, food supplies could become small enough to result in a shortage of food in the household, the third component of food insecurity. Several studies have shown that food supplies are lower among food insecure households.[11] In addition, intake among some low-income families, and food stamp program recipients in particular, declines throughout the month as food resources become further unavailable.[12]

Finally, qualitative research has found a strong sense among food-insecure families of shame over a lack of control over their situation, as many resort to acquiring food in socially unacceptable ways, such as at shelters or by purchasing out-dated food.[13] Hamelin et al. labeled this core characteristic of food insecurity as "alienation: lack of control over the food situation," and "the need to hide it."[14] Acquiring food

from food banks, soup kitchens, friends, or neighbors are strategies undertaken by households who no longer have other choices; further, there is a lack of choice in food type, quality, and quantity inherent in accepting food from most charitable sources. According to one study, this is "a state of frustration due to being deprived of access to food and subjected to unmodifiable conditions. Because the adults could not feed their household properly and did not anticipate any improvement in the near future, they felt they did not have a fit place in society."[15]

MAGNITUDE OF FOOD INSECURITY AND HUNGER IN THE UNITED STATES

Utilizing the conceptualizations of household food insecurity and hunger, a U.S. Household Food Security Survey Module (HFSSM) was developed in the early 1990's and has now been administered as part of the U.S. Census Bureau's Current Population Survey (CPS) annually since 1995.[16] The measure was developed with wide consensus among antihunger advocates, researchers, academics, and government officials and is broadly accepted, used, and disseminated by each of these sectors, including the Federal government. It includes 18 questions, asked of a household respondent—10 items about household food insecurity and adult hunger, and 8 items about child food insecurity and hunger. Households with children are asked all 18 items, while households without children are asked only the 10 items about household food insecurity and adult hunger. Households are thought to be "food insecure without hunger" if members are habitually concerned about their food situation or if the adult(s) in the household occasionally go without food (for example, skip meals).[17] A household will be categorized as "food insecure with hunger" if the adult(s) in the household go(es) without food or a child is cutting the size of their meals or "not eating enough."

In 2004, the prevalence of food insecurity in the United States was 11.9 percent of all households, and 3.9 percent of households experienced hunger at some point throughout the year.[18] Households with children are particularly at risk, and those with single parents even more so. Almost 17 percent of households with children experience food insecurity at some point throughout the year, and more than a third of female-headed households with children experience food insecurity.[19]

In 2001, Nord and Bickel published an in-depth analysis of children's food insecurity and hunger status using the CPS data from 1995 to 1999 and concluded that the prevalence of childhood hunger from 1998 to 1999 was 0.7 percent.[20] However, a reanalysis of the 1995 CPS data for a National Academy of Sciences report showed that, in 1995, 3.1 percent of households with children in that year responded positively to at least one of the items referring to child hunger, including: "cutting the size of children's meals," "children were not eating enough," "a child skipped a meal," or "a child did not eat for whole day."[21] In any case, the official figures are likely an underestimate; several vulnerable populations are not captured by the survey including the homeless or those households who do not have telephone service.

Food is just one of many material necessities that may be lacking in a poor family's life, and the trends in food insecurity closely track those of poverty in the United States. In this country, poverty is defined by a threshold income level defined by three times the USDA Thrifty Food Plan.[22] It is intended to be set at a level at which a family's income is inadequate to meet its basic material needs, such as housing, food, health care, child care, and clothing, although it is not tied to budgets that allow for those needs, except for food. While the percentages of Americans who are food insecure and poor are in close alignment, food-insecure households are not necessarily the same households that fall below the poverty line. Only 35.1 percent of households with incomes below the poverty line experienced food insecurity in 2003, and only approximately 50 percent of families affected by hunger have incomes below the poverty line.[23]

CONSEQUENCES OF FOOD INSECURITY AND HUNGER FOR CHILDREN IN UNITED STATES

Studies of poverty in the United States have also shown important consequences of children growing up without sufficient income resources. In a comprehensive review of the literature up until 1995, Crooks[24] concluded that poor children were more likely to have low birthweight, chronic illness, and lead poisoning, higher rates of stunting, and deficits in cognitive and academic functioning. In their summary of several longitudinal studies in *Consequences of Growing Up Poor*, Duncan and Brooks-Gunn[25] also conclude that poverty has a strong effect on children's cognition and academic achievement and later earning ability.

Fewer studies have been conducted in the United States to understand the consequences specifically associated with food deprivation. The distinction is important because, as stated previously, not all poor children are hungry or food insecure; and not all food insecure children have family incomes below the poverty line. Until recent developments in measuring food insecurity, hunger, and food insufficiency (defined as "an inadequate amount of food intake due to lack of resources" and used by some government surveys before the development of the HFSSM), indicators of malnutrition in poor children, such as anthropometric measures, were used as a proxy for food deprivation. These studies often found positive relationships between height or weight, and either cognition, achievement, or both.[26]

The main problem with these studies is that anthropometric indicators of nutrition status (such as height and weight) are not specific, nor sensitive enough for policy purposes. Food and income assistance programs are designed to aid families and children who do not have access to enough food due to resource limitations. Height, or stunting, for example, is affected by genetic factors as well as malnutrition and associations with poor outcomes do not necessarily mean that hungry children do worse, or that shorter children do worse. In addition, labeling only shorter children as "hungry" will miss many children who did not get enough food to eat, but whose height was not affected.

In more recent years, researchers have documented effects of hunger for U.S. children using questionnaire-based methods. Various indicators of hunger, food insecurity or food insufficiency have been associated with child physical and psychological health outcomes in both community and national surveys, controlling for confounding factors such as family income, parent's education, and health insurance status. Child physical health outcomes associated with food insecurity, hunger, or food insufficiency include higher prevalence of fair/poor health status, increased stomach aches and headaches, increased hospitalizations, and increased colds (among preschool children).[27] Psychological and social outcomes that have been found to be associated with a measure of food deprivation include increased internalizing and externalizing behaviors, increased anxiety, increased aggression and difficulty getting along with other children, hyperactivity, impaired psychosocial functioning and social skills.[28] In one study, researchers found food insufficiency was associated with depression and suicidal symptoms among teenagers.[29] This finding was significant because poorer children were *less* likely to be depressed, except if they were food insufficient.

Food insecurity, hunger, and food insufficiency have also been shown to be associated with a range of academic outcomes among school-aged children, including lower math scores, repeating a grade, tardiness, and absenteeism.[30] However, reading scores are not lower among food insecure or hungry children, and importantly, food insufficiency and hunger has not been associated in the United States with cognitive measures, such as portions of the IQ test.[31]

In 1994, Dietz published a case study describing a child who was both hungry and overweight, and hypothesized that food insecurity could cause weight gain.[32] The theory is that individuals who are food deprived may tend to overeat when food does become available, and/or that individuals who are food insecure are more likely to eat cheaper foods, which tend to be energy-dense and nutrient poor.[33] This association has been tested in both adults and children data. While studies of weight among food insecure women has shown a significant association, there is little evidence of an association among children; if anything, food insecure and particularly hungry children are more likely to be underweight.[34]

HOW FOOD DEPRIVATION AFFECTS CHILDREN

Food shortage at the household level can affect children biologically, by causing a reduction of food intake among children within that household and/or the diminished nutritional quality of children's diets, such as nutrient deficiencies like iron or vitamin A. These concepts are traditionally what we have meant by the terms "hunger," the sensation that occurs when one is unable to eat, or does not eat to satiety, and "malnutrition." Poverty, malnutrition, and harsh environmental conditions are often much more severe and life-threatening in developing countries than they are in developed countries such as the United States and studies of malnutrition and hunger in poorer countries have clearly documented devastating consequences of food deprivation

for children—including poor health status, delays in motor skills, cognitive deficits, decreases in school performance, greater rates of infection and death.[35] Current theory postulates that malnutrition's effect on children occurs through motivational and emotional behaviors.[36] Severely malnourished children have been shown to be apathetic, withdrawn, and passive and have decreased motivation and heightened anxiety.[37]

It is important to understand, however, that household food insecurity can also affect children even if they are eating "enough" to assuage hunger and nutrient deficiencies. In addition to actual deprivation, as stated above, food insecurity also causes a strong *sense* of deprivation.[38] This feeling associated with food insecurity may be of equal importance to the actual sensation of hunger and/or nutritional quality in terms of consequences of food insecurity, particularly with regard to outcomes such as depression.

A exceptionally illuminating paper describes in-depth qualitative interviews with Mississippi children 11–16 years of age about food insecurity and hunger among people they know.[39] In addition to food behaviors associated with food insecurity (eating less, eating "cheap" foods, eating less desirable foods, or eating larger amounts/faster), content analysis revealed that the children clearly recognized the social and psychological dimensions of family food insecurity. These included worry/anxiety/sadness about the family food supply ("They make those sad faces"; "They will look crazy and try to borrow food"); shame/fear of being labeled as "poor" (". . . well, where we stay, they will [tease them]. . . push them in the head and talk about them. They will bring up something like that that they had to come to their house and eat their food"); and limited participation in social activities (due to lack of money).[40]

It is also likely that family food insufficiency affects children's outcomes through food deprivation of their *parent(s)*. Food insecurity is a "managed process" affecting whole families, not just children.[41] There is strong evidence that food allocation in food-insecure and hungry families in the United States is such that parents (most commonly mothers) deprive themselves of food before they allow their children to go hungry.[42] Both qualitative and quantitative research has described the prioritization of children's food intake over their parents within households in North America.[43] Further, food insecure parents can also feel powerless in relation to their food situation. Words used by food insecure respondents to describe their feelings include: loss of dignity, shame, embarrassment, guilt, powerlessness, fear, and frustration. As one respondent stated: "Hunger is more than physical pain, it hurts inside."[44]

Among women and mothers, food insecurity has been shown to be associated with poorer health status, overweight, and importantly, depression.[45] A lack of food and/or the constant anxiety associated with not having enough food may cause parental distress or irritability which, in turn, can affect children through parenting behaviors.[46] Thus, it is possible that parental food deprivation can have developmental consequences for children, again, even if the children are eating "enough." Several of the respondents in Hamelin et al.'s study reported disturbed parent–child dynamics associated with lack of food.[47] For example, one respondent

stated: "When I don't eat, I become aggressive (or rude or angered) with my children."[48] Parents' stress and psychological impairment are among the strongest predictors of child developmental and psychological problems.[49]

POLICIES THAT WORK

Education reformers recognize that the cure for distressed school districts (such as those in inner cities) necessitates addressing the poverty in which children in those school districts live. As Anyon states, "Attempting to fix inner city schools without fixing the city in which they are embedded is like trying to clean the air on one side of a screen door."[50] Children are whole individuals and cannot be compartmentalized into education, housing, food, and other single issues. Solving one of these without addressing the others does not create whole, healthy, successful students.

The same could be said for childhood hunger—ensuring that all children are fed without fixing the family economic insecurity underlying the problem will allow us to come closer to our goal of having healthy children, but will not succeed completely. Providing food to children while parents go without will not necessarily improve child outcomes, nor will ensuring that families have food, but not other necessities. *Food security*, in contrast to *food sufficiency* (an inadequate amount of food), requires ready availability of food as well as "the assured ability to acquire acceptable foods in socially acceptable ways (e.g., without resorting to emergency food supplies, scavenging, stealing, and other coping strategies)." This latter condition, "assured ability," is only possible for families who have sufficient resources, that is, who are economically secure. Economic security, as used here, incorporates not only the ideas of a family having income above the poverty line, but also a family's ability to endure sudden economic changes such as loss of employment or food stamps, or large expenses for health care, housing, or child care.

A main distinction is whether society supports low-income families by providing charitable food assistance, or by providing an economic structure whereby families are able to make ends meet for themselves through their own labor. This means employment locally available that pays enough; and if the pay is not enough (a common occurrence with the erosion of the minimum wage rate), then government supports are available to make up the difference. In addition to food (including cooking facilities), successful families require enough resources for safe housing, health insurance, clothing, child care, transportation, adequate training/education, and time off to care for illness. Increasingly, however, working families, with incomes below or sometimes up to twice the poverty line, are unable to meet these necessities with only the income and benefits provided by their employer.[51]

Many people think of antihunger programs as those program that provide food, but any program that increases families' resources acts as a buffer to hunger and food insecurity. Likewise, government food programs serve as both economic and food security needs. Recently, nutrition, medical, and policy researchers have turned their attention to the outcomes associated with Federal policies aimed at reducing poverty and the material hardships associated with poverty such as food insecurity, hunger,

and homelessness. Although there are limitations in study designs due to selection bias (families who are worse off self-select to participate in programs), many studies that control for selection bias find that the federal programs we have in place *work* in terms of reducing food insecurity and improving outcomes for children, but the programs are inadequately funded and offered to cover enough children and their families to provide an adequate nutritional and economic safety net.[52]

For example, the Food Stamp Program has been shown to reduce the depth of poverty, increase family food purchases (among single-parent families), and improve food security status.[53] However, changes in the program administration that accompanied the 1996 Welfare Reforms significantly reduced food stamp coverage for many low-income families, including making it harder for families to receive benefits and reducing the benefit levels. Recent studies from the Children's Sentinel Nutrition Assessment Program have found that these losses are associated with increased food insecurity, and that participation in the Food Stamp Program reduces the negative effect of food insecurity on children's general health status.[54]

Similarly, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), which currently provides benefits to almost half of all infants in the United States and about a quarter of the children ages 1–4,[55] has shown to be effective in increasing mean birthweight, reducing the incidence of low birthweight, decreasing birth-related Medicaid costs, increasing nutrient intake among infants and young children, and improving children's health status.[56] It is not clear, however, if WIC affects a family's food insecurity status. Two studies addressing improvements in food security status in families accessing WIC found conflicting results.[57]

There have been other studies that underscore the importance of whole family economic policies, not just those that address food issues. Two studies have examined the trade-off that low-income families face in winter months when faced with heating bills. One found that during winter months, poor families reduce food expenditures by roughly the same amount as the increase in fuel expenditures, while rich families increase their food expenditures. This translated into a reduction in about 200 kilocalories among poor adults and children during winter months.[58] Another study found that children who visit emergency rooms were twice as likely to be hungry or at risk of hunger if their families were without heat or were threatened with a utility turn-off during the previous winter. Further, children presenting during the winter months were more likely to have weight-for-age scores below the fifth percentile.[59] A recent study to determine variations in hunger rates among states found that "to reduce hunger rates, policymakers should consider ways to mitigate income shocks associated with high mobility (i.e., frequent housing moves) and unemployment and reduce the share of income spent on rent by low-income families."[60] Indeed, one study of housing subsidies among food insecure families showed a significant improvement in weight-for-age among those receiving the subsidy.[61]

The United States is the only industrial nation that has not yet ratified and signed the Convention on the Rights of the Child, which was adopted in 1989 and entered into force by the General Assembly of the United Nations in 1990.[62] This document

establishes "the right of the child to the enjoyment of the highest attainable standard of health" and "the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development."[63] Rights are not natural in the sense that humans have inherent rights as individuals, but they are instead socially negotiated and necessitate enforcement by societal institutions. Basic rights specify the basic minimum we believe no one should fall below. It can be argued that economic security or subsistence rights are no less basic or genuine than the civil and political rights the U.S. Constitution currently recognizes.[64] This review of child food insecurity and hunger in the United States demonstrates that the closer we come to achieving those rights, the more we will benefit our children, who are our nation's future.

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CHAPTER 3

Breathing Poorly: Childhood Asthma and Poverty

Cindy Dell Clark

Although one in five American children are poor, poverty has not been childproofed. Being poor reeks havoc on children's health in a variety of ways, starting with higher rates of infant mortality, lower birthweight, and followed by a myriad of problems sustained throughout childhood including missed school days and days spent in bed.[1] Asthma, the most common chronic illness among American children, disproportionately burdens poor children in America. In total 6.2 million children under 18 had asthma in 2003, of which 4 million experienced an asthma attack that year. Pediatric deaths from asthma nearly tripled in the United States from 1979 to 1996, reflecting a worsening of the illness in the United States as well as elsewhere.[2] Yet the total of 6.2 million children with asthma obscures marked differences above and below poverty levels.[3] Among welfare or TANF-receiving families in 2003, 11 percent of children had asthma, versus a 5 percent level among children in families not receiving aid.[4]

Asthma is more prevalent and especially more severe among urban, African American poor children than among poor children of other ethnicities. African American children are more likely to die of asthma than white or Latino children, and are more likely to have intensely severe cases of asthma.[5] (Among Latino children, Puerto Ricans have the highest prevalence of asthma, but not to the degree of African American youngsters.)[6] To date, no scientific or scholarly consensus exists on a model of why asthma severity is so problematic for African American children, whose rates of hospitalization and death from asthma are unduly high. Do high levels of poverty explain inner-city asthma? Is it related to culturally distinctive practices? Is it traceable to biological sources, such as genetics? What is clear is that inner-city living patterns (housing, external environment, interactions with medical care, and other factors)

place poor, African American inner-city children at a pronounced risk for asthma, and especially severe asthma, relative to other groups.

This article will consider the factors that seem orchestrated to create this risk, as well as the consequences for children in life experience and personal well-being.

ASTHMA AND ITS TREATMENT

Asthma occurs when the airways are obstructed by inflammation, occurring in response to stimuli. The breathing passages in effect become narrowed, as the muscles around the airways tighten and mucus is secreted to further impede the flow of air. Breathing, a process normally taken for granted by most people most of the time (unless exposed to extreme irritants such as smoke from a fire), is challenged in asthma by tightened and inflamed airways. Wheezing is a common outer sign that the air required to oxygenate the blood is not passing freely. From the child's perspective, the breathlessness often carries anxious implications, for children (and no doubt adults) associate breathing with maintaining life.[7]

The stimuli that give rise to this response, known in medical parlance as "triggers," vary from child to child. Triggers are wide-ranging, including some entities highly pervasive in children's lives: colds and infections, exercise, mold, pollen from trees, grass and other plants, particular foods and additives, animals (dogs, cats, horses, birds, cockroaches, dust mites, mice, rats), smoke, air pollution, wind, rain, cold air, aspirin, beta-blockers, aerosol sprays, odors, dust, paint fumes, perfume, extended stress, laughing, crying, hyperventilation, and perhaps ironically, holding one's breath.[8] A child under medical treatment for asthma is assessed (with parental input) for which particular triggers are known to be problematic. Then parents are instructed to eliminate or minimize key triggers from the child's life: to keep the child indoors on days of extreme cold or high air pollution, to get rid of pets, to remove draperies and carpeting that could increase dust levels, to obtain a humidifier which will reduce air-borne triggers, to prevent the child from sleeping with transitional objects that may be dust-carrying (security blankets or teddy bears), to have parents quit smoking, and so on.

Treating severe asthma typically involves a complex regimen of prescribed medications and monitoring. One category of medicines, bronchodilators, acts to open the airways to make breathing easier, reversing airway obstruction. Another category of medicines (corticosteroids) prevents inflammation and must be taken preventively. A third group of medicines, such as chromolyn, interferes with the allergic process, and so are taken as prevention. Bronchodilators can be used during an attack to bring relief immediately, and are known as "rescue" or "quick relief" medicines. Corticosteroids and chromolyn work in a long-term fashion, precluding an attack, but only if taken regularly as prescribed for prevention.

Drugs are likely to be prescribed in combination for severe asthma, sometimes involving a fairly intricate timetable for giving children the varied prescribed medicines. Medicines for childhood asthma necessitate owning or using devices more complicated than the usual spoon or glass of water used to take ordinary pediatric medicines. That is, prescribed substances may be taken in liquid form (or pill form for older

children), but may also be taken through an inhaler for which there is a particular, proper inhalation technique. For inhaled medications to be optimally delivered to children's lungs, a "spacer," a kind of extension tube that improves drug delivery, may be provided to attach to a child's inhaler. Prescribed drugs may also be taken through a nebulizer, a machine using tubing and a facemask to deliver medication, inhaled over a prolonged period as the child is tethered (by tubing) to the nebulizer.

Much as a thermometer is used to monitor a child's temperature, it is recommended that asthma be monitored using a peak flow meter, a device gauging the child's maximum breath as a means to catch early signs of deterioration. Research shows, however, that a peak flow meter is not actively possessed or used by many children, despite the recommendations of clinicians, just one example of the problematic level of adherence to asthma treatment prevailing across social groups.[9] Medication taking and medical appointments are also subject to nonadherence by young asthmatic patients. Adherence is an especially pronounced problem among inner-city children.

Asthma is known to recur within families, and research into the genetic transmission of asthma has been underway for several years.[10] Still, available evidence finds that the higher the degree of poverty within an ethnic group such as African Americans, the more concentrated are the differences in asthma severity, suggesting that social and environmental exposures may accompany or in some ways overshadow genetic factors in inner-city asthma.[11] Indeed, a complex array of conditions imposed on inner-city children can be linked to asthma incidence and severity, based on mounting evidence from a large and growing body of research.

FACTORS IMPLICATED IN INNER-CITY ASTHMA

The levels and severity of inner-city asthma have led to what amounts to a physical injustice: African American inner-city children suffer twice the incidence of asthma, are hospitalized and visit emergency rooms more, and are six times as likely to die from asthma as white children.[12] Moreover, the price tag to American society for treating poor children's asthma in emergency rooms and hospitals is high, with more money going to "crisis therapy" following an asthma attack than to prevention.[13] These disturbing facts, with obvious implications about children's suffering, have motivated considerable investigation of the factors entailed in urban asthma.

The trail of investigation has led to a multifactorial explanation for the problem of inner-city asthma in children, including: (1) asthma resultant from the physical environment outside the home, such as pollution; (2) asthma resultant from indoor environmental factors; (3) asthma related to indoor, sedentary lifestyles; (4) asthma traceable to a lack of proper medical care; (5) asthma traceable to a lack of family adherence to care provisions; (6) unbridged sociocultural differences between medical care providers, on one hand, and caretakers and patients, on the other hand; and (7) issues of mental health, including caregiver depression and psychological response to community violence. There is no single quick fix to the problem of inner-city asthma, but a need to understand and address a full gamut of interacting and entwisted factors.

Physical Environment Outside the Home

Respiratory problems (including childhood asthma) have become indicative markers of poor air quality. Children, research has shown, are more physically susceptible than adults to the impact of environmental pollution.[14] Even prenatally, exposure to airborne particles from diesel exhaust and other combustion sources (polycyclic aromatic hydrocarbons) is associated after birth with childhood respiratory impairment.[15] In cities the world over, outdoor air pollution correlates with emergency room visits for asthma, in line with increased symptoms and decreased lung function.[16] Ozone, nitrogen oxide, sulfur dioxide, and particulates in the air all lead to increased respiratory risk for children.[17]

When traffic is reduced in an urban area, this translates to less pollution and improved asthma. For instance, during the Olympic games, weekday traffic volumes in Atlanta fell 22 percent, resulting in a 28 percent drop in peak daily ozone levels and a large reduction in visits to treat acute asthma. Plant closures (such as during a strike at a Utah steel mill) have also been shown to decrease hospital admissions for asthma. Economically disadvantaged children more often live and go to school close to automotive traffic, which is known to increase asthma severity.[18] Outdoor exercise for children living in polluted inner-city places can, due to pollution, promote respiratory illness instead of the intended health.

In short, poor inner-city children are disadvantaged in the very air they breathe, a factor predisposing them to asthmatic symptoms. This problem of pollution as a factor in poor inner-city neighborhoods increases asthma risk in low-income African American children.

Indoor Environmental Factors

Inner-city children living in high-crime, densely populated settings spend ample time indoors, breathing indoor air. Poor African American children are prone to live in public and substandard housing in urban areas, settings in which indoor air quality is not ideal. A study of the residences of school-age youth living in Baltimore, for example, found that children's homes were deteriorating, with a quarter of the homes having leaking roofs. Plaster was broken, paint was peeling, and/or there were cracks in the walls or doors in the majority of dwellings. Cockroach and rodent infestation was common.[19] When samples were taken of particulate matter in children's sleeping rooms, mouse was an allergen found in large quantity and in more concentrated amounts than cat or dog allergens. Altogether, the elevated levels of indoor pollution and allergens (often found together with pollutants from tobacco smoke) are all significant risk factors for asthma exacerbation.

Nor were these concentrations of indoor air pollution restricted to Baltimore's low-income residences. Another study done in impoverished Boston neighborhoods surveyed residents and found that housing conditions were characterized by moisture and mold growth (a common allergen), by infestation by allergen-causing pests such as mice, cockroaches, and dust mites, by inadequate ventilation, and by other indoor hazards.[20]

Even school locations can be hazardous environments for children's health, as documented by a study conducted within the Los Angeles Unified School District. This study examined the relationship between educational outcomes and respiratory risks due to factors of school environment. Substantial differences were found in schools with the highest estimated respiratory hazard, whose students performed 20 percent lower in academic performance relative to students in other schools.[21]

One factor of children's indoor environments that correlates with low income and poverty is cigarette smoking, a known respiratory hazard for children inhaling secondary smoke. Tobacco marketers have saturated inner-city African American communities with cigarette billboards; to take the example of Baltimore, the intensity of cigarette billboards has been 3.8 times greater in African American neighborhoods than in white neighborhoods—and billboards have occupied positions next to homes, schools, churches, parks, playgrounds, health centers, and stadiums. Among national magazines, the most intense concentration of tobacco advertisements can be found in African American publications.[22] In line with such racially skewed promotion of cigarette use, smoking is common in the homes of poor African American children, including children with asthma. Exposure to smoking in turn leads to infantile and childhood wheezing, increased hospitalizations for lower respiratory tract infections, elevated sensitization to allergens, and hyperresponsive airways.[23] The combined exposure to outdoor pollutants and indoor tobacco smoke increases respiratory symptoms and asthma risk as early as 12–24 months of age.[24] In a major investigation of inner-city African American children with asthma, the proportion of children living with at least one smoker was 59 percent, with 48 percent of children having urine tests showing significant tobacco smoke exposure.[25] Cigarette smoke is an irritant to already inflamed lungs, contributing to children's asthma.

Sedentary Lifestyles

Increased attention and research has been devoted to the study of childhood obesity, which like asthma, is a pronounced problem for African American inner-city poor children. Low-income children, regardless of their respiratory health, have elevated chances of developing obesity.[26] A body of evidence now suggests that obesity and asthma occur in correlation, although it is unclear what the causative connection might be. Many experts have assumed that poor breathing, in asthma, makes it difficult to exercise, leading to obesity.[27] Yet obesity may at the same time leave children vulnerable to asthma; obese children wheeze more, have more unscheduled emergency room visits, and receive more medications for asthma.[28]

Children with asthma face a number of restrictions, but limitations on physical activity resulting from disabling asthma are particularly influential on children's lives. Children with uncontrolled asthma are limited in their sports performance, which becomes stigmatizing and marginalizing, especially for boys. It can seem as if, one boy in an interview study put it, one can "never catch up" with the others. Boys and girls alike face physical restrictions during recreation and school activities, stemming from asthma.[29]

Children living in high crime, poor neighborhoods are vulnerable to living a life restricted in its outdoor activities, made worse when poorly controlled asthma necessitates further reductions in activity. Reciprocal problems of inactivity, obesity, and asthma morbidity seem to conspire to promote childhood asthma in the inner city.

Lack of Proper Medical Care

The optimal and most economic way to care for childhood asthma places emphasis on prevention. Good preventive treatment would normally involve a long-term relationship with the same health-care provider, an advantage often missing from the treatment of poor, African American children.[30] Ironically, urban impoverished children with asthma access more expensive forms of care than do children with greater means. Low-income minority children are more apt to use emergency departments rather than primary care providers as sources of asthma care, thereby reducing their access to sustained continuous care by the same provider.[31] In one investigation, 75 percent of urban parents of asthmatic children identified the emergency department as their usual source of care.[32]

Overall, the asthma of inner-city children is often undertreated and not addressed preventively, despite frequent asthma symptoms. Even though 92 percent of inner-city children surveyed in a major study had health insurance (73% Medicaid, 11% health maintenance organizations, 9% private insurance), the majority had difficulty obtaining follow-up care.[33] Poor continuity of care with a particular provider is associated with less use of preventive anti-inflammatory asthma medications, and with a lack of a prescribed parental action plan to be followed during asthma exacerbations.

Studies indicate that poor African American asthmatic children make fewer visits to physicians than others. Yet they experience more hospitalizations.[34] While impoverished children may have some source of care, then, barriers and deficiencies in care are evident.

Families of these children may have difficulty obtaining the supplies needed to manage children's asthma; a study of 100 pharmacies in the Bronx, New York, found spacers for metered dose inhalers to be in stock in only 68 percent of pharmacies, with even lower availability for nebulizers (33%) and peak flow meters (17%).[35]

Guidelines established by National Heart, Lung and Blood Institute (NHLBI) for home management of asthma episodes are not followed or even known in many families of poor inner-city children. Only half the families of children hospitalized for asthma at one urban medical center had a written asthma action plan, only 30 percent had peak flow meters, and only 39 percent were providing children with anti-inflammatory agents as recommended by the NHLBI guidelines. These same families generally did not know the recommended steps to follow during an acute asthma exacerbation.[36]

Responsibility for proper treatment of a child with asthma lies with the clinician and the child's family caretaker, who ideally work together to keep symptoms at bay

and to keep the child as well as possible. When there is no continuous relationship between caretaker and clinician, this is not likely to happen.[37]

As for the child's family caretaker, effective prevention calls for keeping medical appointments, having emergency plans, dispensing medications, and optimizing the home environment (e.g., eliminating tobacco smoke and allergens). In a report, a physician's assistant detailed how families at an inner-city clinic lacked preparedness to prevent further emergency department visits or hospitalizations for their child.[38]

> At the clinic . . . we see a population of parents who invariably come in after an ED visit or a hospitalization. Parents do not know exactly when to use one inhaler instead of another for their children, and rarely are patients maintained on inhaled corticosteroids [anti-inflammatories]. The new leukotriene inhibitor . . . Singulair, is not in the formulary; often peak flow meters, spacers, and nebulizers are unavailable. We have the luxury of a part-time nurse health educator, but seeing her the day of an acute visit is usually not feasible and patients rarely return for follow-up education.

Poverty brings with it deficits and crises of many sorts, and the management of children's asthma care is no exception. Preventive care requires particular resources of technical knowledge, services and supplies, all relatively lacking for caretakers of poor asthmatic children. Unprevented asthma in poor, urban children of color is more likely to reach the point of severe, dangerous crisis.

Adherence to Care Provisions

Following a regimen of asthma treatment is no easy task, even for economically advantaged families. The activities of treatment involve time and effort: making follow-up visits or calls to a physician, having the inventory of proper medicines and supplies on hand, competently giving a child his or her medicine according to the proper schedule, and enforcing the prescribed activity when the treatment is disliked or boring to the child (such as nebulizer treatment).[39] Adherence to treatment for asthmatic children within the total population (let alone among stressed, inner-city families) is typically reported as less than 50 percent.[40] Despite the availability of effective treatments, children do not always get the medical benefit of the optimal approaches: medicines left untaken cannot stave off asthma emergencies. As mentioned earlier, adherence is especially a problem for preventive, anti-inflammatory medicines that professional guidelines consider to be a standard part of the treatment regimen for children with severe asthma.

Among poor, urban children of color, the majority of children with moderate or severe asthma do not receive anti-inflammatory, preventive medicines.[41] This lack of preventive treatment is at least partly due to physicians' not prescribing anti-inflammatory medicines or making an inaccurate assessment of asthma severity.[42] The result of underuse of preventive treatment, unfortunately, is an increased risk of avoidable hospitalization for asthma.[43]

Even when preventive, anti-inflammatory drugs are prescribed appropriately, parental or caretaker follow-through in administering preventive treatment is apt to be incomplete. It is as if parents treat asthma as an acute disorder, using corrective medicines for the attack but avoiding preventive treatments, while physicians see asthma as a chronic disorder, in which preventive medicines should be taken to eliminate or minimize attacks. Many urban parents do not follow the asthma management plan prescribed by their health-care provider, but instead modify the plan based on their personal health beliefs. For example, parents might put aside the preventive medication and instead try nonmedical alternatives such as calming breathing or diet manipulations. Resistance to "pushing drugs" for children who are not, at the moment, having an obvious crisis is an attitude that impedes acceptance of preventive medicines.[44] Waiting to see if the early signs of asthma clear up on their own, rather than treating emergent asthma symptoms with anti-inflammatory medicine, is a predilection seen both inside and outside the inner city.[45] In one study of impoverished children with asthma, 29 percent of family caretakers whose child received a prescription for inhaled anti-inflammatory medicine were not convinced that the medicine would help their child. In the same study, 35 percent of family caretakers expressed fear about possible addiction to the medicine, and 42 percent admitted fear of side effects.[46] Much nonadherence is intentional rather than due to economic constraints, suggesting that issues of meaning and values (how treatments and illness are perceived and culturally represented) are significantly at stake in low adherence.[47]

Children play a role in adherence as well, since they are active participants and hold some responsibility in treatment,[48] such as when awaking with nocturnal asthma exacerbations and treating themselves[49] or when recognizing and seeking care for symptoms at school.[50] Coping with asthma is a shared matter between the child and the parent,[51] with children rating themselves to have more responsibility for self-care than parents estimate.[52] Accomplishing the needed technique for using inhalers, spacers, and nebulizers involves challenges to young users. Inhalers can be awkward for children (and some parents) to use properly. Keeping inhalers and nebulizers clean can be a problem, too. Since children may need parental help with these tasks, the time-consuming treatments may be skipped at times. Among younger children, nebulizer treatments may be confining and/or frightening due to the required facemask, resulting in adherence to nebulizer use that is as low as 33 percent in some studies.[53] A national research project conducted for the American Lung Association showed that many parents in the overall population underrate their child's symptoms, relative to the child's own assessment of breathing problems, coughing, wheezing, and shortness of breath. Children in this study reported more symptoms and more impeded activities due to symptoms than their parents did.[54] It is possible that parents, underestimating their child's breathing distress, may modify the treatment plan toward a more passive approach, perhaps at the very times when their child is experiencing difficulty. At the very least, studies show that parents believe that children are more actively adherent than they really are. Developing methods to help parents to exercise closer supervision and monitoring could be helpful.[55]

In the final analysis, successful treatment of childhood asthma is a three-pronged interactive effort between the parent, the child, and the medical practitioner.[56] Adherence depends to a large degree on the effective communication and interaction between these parties, a process made particularly difficult when there are social class and/or ethnic differences between the medical provider and the child's family caretaker (a topic to be discussed in the next section). Neither parents nor physicians are consistently good at communicating with children and understanding experiences with illness from the youngster's perspective. In a national survey across all social groups, 77 percent of parent–child pairs answered differently when asked how often asthma led children to cancel, postpone, interrupt, or stop an activity. The survey, reporting an array of factors for which parental and child reports did not match, concluded that the disparity between child and adult perceptions could be problematic: "Parents cannot always be with their child to observe symptoms—and children do not want to worry others about their symptoms."[57] Other studies have also shown that a lack of parental supervision can lead to poorer adherence than parents seem aware.[58]

Physician–child communication also raises concerns. Many physicians more readily communicate with parents than with children, due to parents' roles as primary agents of care.[59] Overall, more research on inner-city children's own roles in treatment would be worthwhile. Such child-centered research might lead to approaches that enhance adherence and well-being, in the face of numerous stresses and burdens for impoverished family caretakers.

Unbridged Sociocultural Differences

Investigations of adherence to asthma treatment often cite the doctor–patient relationship as a crucial way to advance, or on the other hand to scuttle, adherence. As one study concluded, "Continuity of care enhances the provider's ongoing knowledge about the child, family, and parental capabilities in problem solving and management of asthma and provides the family with security that the provider truly knows and respects them."[60] An ongoing relationship with a medical care provider creates the circumstances and mutual give and take needed for adherence. Conflict between a family and a physician is associated with poor adherence, even a child's increased risk of death from asthma.[61] As already explained, low-income inner-city children often depend for treatment on emergency rooms and hospital stays, which are not very suited for establishing continuous, familiar relationships of trust.

Another barrier to adherence-enhancing health-care relationships has to do with the elusive gaps between the cultural world of the inner-city family versus the cultural world of medical care providers. This is, in part, a matter of language: to avoid misunderstanding, health-care providers need to communicate in the language of the patient rather than in jargon that is meaningless to the patient.[62] It may be that poor African American families differ even from middle-class African American families in their manner of communication with their physician. Annette Lareau, in her book on family class distinctions, described a physician's visit by a middle-class African

American child that involved comfortable conversational exchange with the doctor by both the child and parent. Neither was intimidated or afraid to raise issues to be discussed with the physician. But an African American family living in a housing project, also studied by Lareau, conducted the visit and behaved very differently; the verbal rejoinders were more strained and indicated a lower level of trust extended by the mother. The mother in the latter family was quiet or even inaudible during the doctor's visit, and had a difficult time answering the doctor's questions. She did not know some of the terms used by the physician, and answered vaguely and timidly, as did her son. According to Lareau, these distinctions reflect sociocultural behavior patterns practiced at home and elsewhere, by which conversational exchange and verbal discourse is less emphasized in working-class and poor families than in middle-class families.[63] The fact that clinical conversation may be intimidating to some families raises an important challenge, since to form a treatment-building alliance works best when the patient and mother feel able to react openly about specific recommendations, in an atmosphere of mutual exchange.

It is essential, studies suggest, that medical personnel treating inner-city children seek to understand the culture and everyday dilemmas of low-income families with asthmatic children. Clinicians should adjust the interaction in the medical encounter to bring about a mutual, level playing field. Demonstrations and hands on approaches might go further than strictly verbal explanation, especially for children. In the end, the medical encounter at its best is a mutual interaction that organizes and interprets the child's asthma in a manner that participants find credible and sensible, with the result that the agreed upon course of handling the illness is *mutually* acceptable.[64]

Issues of Mental Health, Depression, and Violence

To say that life in the inner city is stressful for families is an understatement. With extensive hardships, and fewer means of coping with hardship, poor children are prone to find themselves in families marked by depression or other mental health challenges, all the while living amidst violent, high crime surroundings. A child's asthma is more likely to be fostered in such a family ecology. Stress, research has established, is a risk factor for asthma morbidity.[65]

In one study focusing on exposure to violence, caretakers of inner-city asthmatic children reported on the violent events in their neighborhoods during 6 months. Such events were strikingly evident. Fights including weapons occurred in 28 percent of locations, violent arguments between neighbors took place in 33 percent of places, gang-related violence in 15 percent of locations, and robberies or muggings in 38 percent of locales.[66] Fully 38 percent of those queried expressed fear that their child could be hurt by the reported violence nearby, with 34 percent of caretakers keeping their child indoors as a safeguard from violence. Smoking by caretakers and skipping of medications both occurred more often with such violent exposure, thereby connecting urban violence to increased health risk and increased nonadherence.

Conflict among a child's relations has also been shown in studies to indicate increased risk for asthma morbidity, including increased risk of mortality from asthma.

Notably, when a parental caretaker is in conflict with the child, or the child lacks secure attachment to the parent, this serves to differentiate urban children likely to have asthma from those who are healthy. Asthma morbidity and hospitalizations have been shown to worsen in line with life stress or compromised mental health of the caretaker.[67]

The hopelessness and lessened sense of control of impoverished lives takes a toll on the mental health of parents, as does dealing with anxious concerns, including asthma. One review showed that 44.5 percent of welfare recipients caring for asthmatic children reported depressive symptoms, a factor correlating with severity of their children's asthma.[69] Mothers with depressive symptoms are apt to have reduced adherence to medication regimens, such as difficulties with children's proper use of inhalers.[70] Issues of stress, anxiety, depression, and violence conspire to degrade the health of children with asthma in the inner city.

THE EXPERIENCE OF ASTHMA

Asthma is by no means an illness for which a single-minded, reductionist rendering of cause and effect is a workable model. A quick fix, simple solution is not likely to be effective against asthma in poor African American children, especially if it does not account for the multifaceted human factors involved. Even biomedical treatment innovations cannot necessarily improve the condition of inner-city childhood asthma, for noncooperation or nonadherence with biomedical treatment is an issue that can short-circuit biomedical drug delivery, even in families with insurance. The way in which biomedical care takes into account the mindset and everyday life context of young sufferers is crucial to achieving good outcomes.

The horrible factors contributing to inner-city asthma are in effect orchestrated to make children vulnerable to the respiratory ravages of asthma: the environment inside and outside their homes and schools, the family stresses accompanying poverty and violence, the cultural discomfort with health-care institutions and clinicians all contribute.

Above and beyond all these contributing factors, it is worthwhile to consider how asthma affects the child's sense of self and personal experience. Asthma is more than a diagnosis, more than a sick role fulfilled by the child, but a felt experience of the young patient—an aspect of the illness experience not always captured in analyses of asthma as a biological disease entity.

Illness is known to be grounded in the selfhood and daily worlds of sufferers, and asthma is a case in point. Studies exploring subjective experiences of asthma among inner-city children have found, often through child-engaging qualitative methods, that particular recurring themes characterize children's own experiences of asthma. For example, asthma is an illness experienced with unsettling anxiety and feelings of vulnerability. Breathlessness is associated by children, including urban children, as being a dire threat to existence.[71] Feelings of panic and fear commonly accompany the onset of a severe attack, feelings that do not always dissipate with repeated experience of attacks.[72] The sense of helplessness that accompanies worsening respiratory distress

was videotaped in a study by Michael Rich and Richard Chalfen, who found that the videotape informed even the most experienced clinicians about the powerless and fearfulness of an urban child's asthma attack as she traveled to the hospital, driven by her mother.

> For four long minutes, one watches as JW's respiratory distress increases. She coughs, followed by high-pitched wheezing exhalations. Initially, as her breathing worsens, she remains calm, closing her eyes to focus on the problem. As JW tires, her eyes widen with fear. It becomes increasingly hard to breathe. There are deep audible wheezes throughout her breathing cycle. As they pull into the parking lot, JW purses her lips, blowing hard to maintain air pressure in her lungs. Finally, in the well-lit emergency room, we hear the reassuring hiss of JW's medication nebulizer. JW relaxes, inhaling the relieving medicine, wiping her brow.[73]

When this video was shown to clinicians, even the most experienced found the segment difficult to watch; the video captures, and then replicates in those who view it, the "helplessness, fear and uncertainty with which many young people with asthma live their *lives.*"[74] Interview studies with children have similarly concluded that asthma conveys a sense of powerlessness and anxiety, along with a reliance on reactive responses ("I lay down," "drink water" or "go to the hospital") and identification of danger signs as asthma worsens ("ears will turn blue").[75] Children's experiences of asthma, in an urban environment, are punctuated by breathless crises and trips to the emergency room or hospital for treatment (but not necessarily marked by proactive prevention). This experience is emotionally laced with intermittent trauma and powerlessness.

Another trend of thought among youthful asthma sufferers is the way in which the risk of asthma is felt to pervade children's sense of place and experience. A study in which children were shown photographs of places found that children with asthma described unfamiliar places (such as a forest and a mountainside lake) as scary and isolating, a finding consistent with other research.[76] Children often mentioned asthma as a reason to be concerned about safety, which contrasted with healthy children, who felt that violence threatened safety. In other words, to asthmatic children the lack of safety associated with asthma was a more salient concern than violence. Summing up, the authors stated, "children with asthma find threats in environments that other people would describe as harmless."[77] Moreover, inner-city children with asthma have limitations on activity, which in many ways hems in their life experience: They are limited in how well they breathe, and this places restrictions on how they live. Asthma is a powerful interruption of daily life—in how much time a child can spend outside, in how much time a child can be fully active, and (stemming from the prior two problems) in how much time they can be with friends.[78] Overall, while the restricted breathing of an asthma attack may be short-lived once treated at the emergency room, the way in which asthma restricts an urban child's daily life is pervasive, and contributes to a sense of being unsafe and hindered.

A final dimension uncovered in research on children's felt experiences of asthma has to do with the pronounced gap between the biomedical messages conveyed by

professional clinicians and the reality of day-to-day family living. Based on videos of children's own environments presented by children themselves, the number of asthma triggers to which children are exposed far exceed what is disclosed when a physician takes a medical history. Exposures to dust, mold, tobacco smoke, pets, and other indoor hazards are more common, in videotape, than in reports to medical professionals. One participant, for example, lived in the same residence as several cats belonging to her mother, but asserted that the cats were not allowed in her room. Nevertheless, the child's video revealed a kitten sleeping in her bed.[79]

Moreover, videotaped observations focusing on children's own lives also confirm that medicines are not necessarily taken using the proper technique, even in circumstances where explicit instruction was part of comprehensive clinic education.[80] Patients' own notions of illness, attitudes, and actions govern the outcomes of treatment. Adherence to asthma treatment is so partial that inner-city parents may be said to have an inclination to treat asthma as an acute crisis, rather than a chronic condition necessitating ongoing, preventive measures. This possibility would explain the reliance on emergency treatment and hospitals rather than being dedicated to preventive management in conjunction with a trusted care provider.

Whether or not patients live the life their doctors would prescribe to prevent childhood asthma, it is clear that no biomedical intervention can fully dictate or mold the family's role in treatment. Neither children nor parents can be regarded as the means to an end, that is, the means to the delivery of biomedical treatment.[81] On the contrary, each child and family ought to be regarded as the goal of treatment, not the means. The intrinsic value of children and families should be the central, humane thrust to any program of treatment, for ultimately, only a humane and holistic effort will be able to empower and improve the environments and lives of poor asthmatic children.

Implied in a humane and holistic approach is the need for society to work toward a clean, nontoxic urban environment rather than marginalizing the poor to places of greatest risk. Asthma has become the touchstone of vulnerable children living in marginalizing urban poverty, pollution, mental health problems, violence, vermin, and lack of medical literacy. Unless asthma is tackled broadly, there is a danger that unaddressed factors will ultimately outweigh half done interventions. Unless asthma is countered humanely, issues of meaning may be overlooked, to the detriment of adherence and family cohesion and coping. (Family rituals, for example, help children to cope with the stressors of asthma, and such vehicles of resilience need to be fostered.[81]) Eliminating asthma, closely tied to stubborn challenges of poverty, will require a committed and integrated approach, if poor African American children are to be released from asthma's disabling grip.

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CHAPTER 4

Childhood Disability and Poverty: How Families Navigate Health Care and Coverage

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Poverty, disability, and poor health are conjoined for a substantial number of families in the United States. Environmental and social conditions associated with poverty can cause or exacerbate disabilities and chronic health problems,[1] and medical costs associated with health problems or loss of employment due to illness or disability can plunge a family into poverty.[2] Prevalence studies bear out this association. Census 2000 data indicate that families with members with a disability are more likely to be in poverty (12.8%) compared to families who do not experience disability (7.7%).[3] Conversely, studies indicate that both child and adult rates of disability are higher among poor families. In 1996, the rate of disability for children aged 3–21 at or below the poverty line (11%) was nearly twice that of children above the poverty line (6%).[4] Studies of adult welfare recipients show high rates of mental health impairments and physical disabilities.[5] A nationwide 1999 Survey of Income and Program Participation (SIPP) found that 44 percent of welfare beneficiaries reported physical or mental impairments at three times the rate of the nonwelfare population.[6] Major depression, a significant barrier to work, may alone affect approximately 25 percent or more adult women welfare recipients.[7] Health-care access and coverage are of vital importance to all families, but especially to those who have members with chronic illness or physical or mental disabilities. For low-income families, Medicaid is the primary means of health-care coverage. Since its inception under Title XIX of the Social Security Act of 1965, the Medicaid program has grown with the expansion of the health-care sector of the economy. In 2002, Medicaid accounted for 17 percent of all health-care expenditures in the United States—1,236 billion dollars. Twenty-five million children (more than 1 in 4), and 26 million adults were covered under the program.[8] Medicaid, along with charity care, is the foundation of what has been

called the "medical safety net" for low-income Americans. Yet Medicaid remains a net with large holes, especially for adults. Among low-income individuals in the United States, it is estimated that 21 percent of children, 36 percent of adults with dependent children, and fully 42 percent of adults without dependents remain uninsured.[9]

Other means-tested programs for low-income families, such as Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF), food stamps, and housing assistance also provide crucial resources to families who care for individuals with disabilities. Families often "bundle" these resources to meet the needs of their members, but these programs are increasingly difficult to access, and come with stringent eligibility requirements.[10] Finding out about these services, providing all the requisite materials to access them and multitudinous records to maintain them, going through eligibility redeterminations, and correcting mistakes made by agencies take an enormous amount of caregivers' time and resourcefulness.

While research on families in poverty and on families of children with disabilities has been extensive, relatively few studies have examined the unique set of challenges brought about by the intersection of poverty and disability. We know little about how low-income families access necessary medical and therapeutic services, make ends meet, and negotiate the governmental programs that support, or sometimes hinder them, in these efforts. The ethnographic account presented here of 42 low-income families of young children with moderate to severe disabilities portrays caregivers' intense efforts to care for their children while navigating the complex worlds of disability and poverty programs, and suggests ways in which programs could be reformed to improve delivery of services.

THE STUDY

This study is based on 3 years of ethnographic research with 42 families (12 African American, 14 non-Hispanic white, and 16 Hispanic/Latino) who had at least one child 8 years of age or younger, with moderate to severe disabilities (e.g., moderate to severe delays in cognitive, communicative, behavioral, motor, and/or adaptive skills). It is a component of a larger, multimethod study of family life conducted in Boston, Chicago, and San Antonio during 1999–2003, a period in which the early effects of welfare reform were becoming manifest (a detailed description of the Welfare, Children and Families: A Three-City Study and a series of reports are available at www.jhu.edu/~welfare).

All 42 families had household incomes that were below 200 percent of the federal poverty line (in 2001, the federal poverty level for a family of three was $14,630 per year, or $1,219 per month). At the time of recruitment, 22 households received TANF, and five were former beneficiaries. The vast majority of primary caregivers were the child's biological mother (81%). About one-fourth of the caregivers were married and the remainder were never married, divorced, separated, or widowed. Only 10 primary caregivers were working at the time of recruitment, mostly at part-time and low-paying jobs with no benefits.

Fieldworkers interviewed the primary caregiver of each family approximately once a month for 12–18 months and then conducted follow-up interviews every 6 months until the end of the study to ascertain changes in families' lives. Interviews addressed a wide range of topics, including health and health access; families' experiences with TANF, SSI, Medicaid, and other public assistance programs; work experiences; family economics and support networks; and child care. Ethnographers also engaged in participant observation, following caregivers and children to welfare offices, health centers, grocery stores, and workplaces, and taking note of the interactions and contexts of those places. The resulting datasets of interview transcripts and fieldnotes were coded in QSR6, a computer software program that aids in qualitative data analysis. We also used matrices to record specific information related to health care and coverage for each family and compiled "family profiles," or case summaries of families' perspectives on and experiences with health care and social welfare programs.

FINDINGS

Health Status of Children, Caregivers, and Other Household Members

Because this was a study of the impact of childhood disability on low-income families, we purposely recruited families who had at least one child with a disability significant enough to affect daily functioning and family routines. Diagnoses of the focal children in the 42 families included cerebral palsy, Down syndrome, seizure disorder, severe ADHD, significant developmental delays, visual and hearing impairments, spina bifida, Pervasive Developmental Disorder, autism, chondrodysplasia punctata, various syndromes (e.g., Kartagener syndrome, Angelman syndrome, and Cri-du-chat syndrome), severe asthma, and other involved medical conditions (e.g., heart congenital heart problems; brain damage, lung disease) that resulted in developmental delay and disability. Over half the children had multiple disabilities. Because of their conditions, the children had extensive health-care needs. Most were receiving medical and therapeutic treatments. Some required periodic hospitalizations and operations, as well as specialized equipment for feeding, mobility, or communication. Others had significant mental health disorders that called for behavioral interventions and medications.

In addition to childhood disability, we found general poor health among caregivers. Only a few mothers stated that they thought their health was good.[11] Over the course of the project, a majority of the caregivers reported mental health problems (e.g., depression, anxiety), chronic physical health problems (e.g., arthritis, diabetes), and learning disabilities (e.g., dyslexia) that, while not disabling, caused them some difficulty in carrying out daily activities. In addition, 29 percent of the caretakers reported having a disability (e.g., sickle cell anemia, bipolar disorder, epilepsy, cerebral palsy) that limited their ability to perform major life activities, including work and child care. Ten of the households had additional children or adults with a disability. In all, 83 percent of the households had two or more members with conditions or disabilities that resulted in some functional limitations.

Caregivers' Activities

Mothers' activities revolved around caregiving; accessing medical, educational, and therapeutic services, and managing the bureaucracy of social service programs needed for financial assistance. Many mothers worked long hours to attend to their children's health-care needs and accessing a range of services. None of the mothers of children with disabilities under the age of 3 was employed outside the home. Center-based child care was not an option for most of these families since slots available for young children with moderate or severe disabilities are rare.[12] Even if caregivers could have found child care, they did not trust that others would provide the specialized care their children with disabilities required, and feared that they might be harmed. At the end of the ethnographic study in 2003, few caregivers had been able to get or keep full-time jobs. Even if the child with a disability was in child care or a school setting, caregivers still felt they were "on call" for medical and behavioral emergencies. Several mothers lost their jobs over the course of the study because of having to miss work to handle their children's needs.[13]

Mothers were not only the primary caregivers of their children with disabilities, but also acted as their therapists, service coordinators, and advocates. In addition to taking care of other children and adults in the household, mothers' daily and weekly schedules often involved multiple doctors' appointments; meeting with early interventionists; administering recommended therapies; preparing and feeding of special diets, procuring specialized equipment, seeking out needed services, and arranging transportation. They were also crisis managers when their children's conditions required emergency care or hospitalizations. Their responsibilities lessened only slightly when their children were old enough to attend center or school-based programs. Mothers were frequently called to school to deal with their children's medical or behavioral problems. Most mothers who attempted to work outside the home found they had to miss numerous days taking care of their children's special needs, with some losing their jobs because of this. Janice's case in this regard is not unusual. Janice lived in Chicago with her four children, including Elisa, a 4-year-old daughter with multiple severe disabilities. Janice's husband left her 2 months after Elisa was born and did not provide any financial support. Elisa required specialized care around the clock. Although Janice had some in-home nursing care for her daughter, nurses frequently called in sick and she had to take over their shifts. Janice said that even if she could find a child-care center that would accept her daughter, she did not trust that they could care for her properly. In spite of these issues, Janice's welfare caseworker could not understand why she was unable to find and keep a job.

Most caregivers also had to search out social services and public assistance programs to provide necessities for the child and family (e.g., SSI, TANF, food stamps, Medicaid, transportation, specialized equipment); and other family supports (e.g., counseling, parent education, advocacy and legal efforts). Locating and managing health and social services was time-consuming and required stamina, persistence, and skills. With the exception of early intervention services, most disability and poverty programs were not easily accessed, and often necessitated ponderous paperwork and numerous

applications and appeals. The caregiver's ability to locate services, correctly do the paperwork involved, get around bureaucratic quagmires, and advocate for their child's services and rights made a difference in the health care their children received and the overall quality of life of the household.

Health Coverage and Access Issues

For caregivers of children with disabilities and chronic health problems, health-care coverage and access were paramount. By most caregivers' assessments, children with disabilities were receiving adequate or even high quality care, and they did not ordinarily lack insurance coverage. All but five of the children with disabilities were covered by Medicaid, four had Medicaid and private insurance; and one child was covered entirely by private insurance. Coverage for caregivers was not as uniform. Twenty-four of the 42 primary caregivers were covered solely by Medicaid, one had Medicaid and private insurance, six were covered solely by private insurance, and 11 were uninsured. Nearly half of the uninsured caregivers lived in San Antonio, where Medicaid coverage was relatively restrictive.[14]

For the most part, Medicaid was working well for the child with disabilities, providing a comprehensive benefit package and access to medical specialists for these children with special health-care needs. It also covered most of the children's medications, therapies, and equipment.[15] For Emily, these benefits provided crucial services for her daughter, Suzy, who had severe visual impairment and developmental delays. Medicaid covered Suzy's visits to numerous medical specialists. She also received diapers, along with the shampoos and lotions she needed for her sensitive skin. Emily's only problem with Medicaid was getting Suzy a special wheelchair and a helmet to protect her head. Caregivers noted that many of these services were not covered by private plans and they appreciated that Medicaid did not impose premiums or co-pays that would be hard for them to meet given their limited budgets. They also were grateful that Medicaid covered many medications and procedures that private plans (in this age of "managed care") do not.

Overall, caregivers positively evaluated Medicaid's coverage for their children with disabilities, but there were some problems. Health insurance—whether private or Medicaid, HMO or fee-for-service—was confusing. The first problem is one familiar to most Americans these days: how to choose a plan among the options available to you? Medicaid is now provided with a number of optional, "HMO-like" managed care plans. These options are intended to provide different kinds of services depending on the needs of families. However, as one particularly savvy mom remarked, it is hard to figure out the advantages and disadvantages of the plans, indeed, hard to determine what is covered and what is not even for those who are highly literate or experienced in strategic planning. Caregivers shared the popular distrust of HMOs and other managed care programs. Many, especially in Chicago, expressed a preference for "straight" Medicaid, the classic, fee-for-service option. The basis of this preference was not just its familiarity, but the consumers' belief that the "straight plan" preserved a broader choice of providers.

Another problem with Medicaid included problematic gaps in coverage. Many beneficiaries avoided treatment for services that were not covered. Preventive or restorative dental care for adults was rarely covered, or covered only under certain options. For example, many of the Chicago parents had bad teeth because, while children's cleanings were covered, Medicaid only covered extraction for adults. One mother reported that she had not had her teeth cleaned since she was a little girl because Medicaid did not cover this service. However, since Medicaid covered extractions, she had an abscessed tooth removed. Caregivers also noted that is difficult to find the specialized dental care that is required for children with disabilities.

Other challenges to health care included the slowness of allowance or denial of reimbursement. The latter posed particular problems for those who qualified for alternative coverage of certain services (such as durable medical equipment) only after Medicaid denied coverage. Another problem, more common in Chicago, concerned what appeared to be the monthly delivery of the card that certified Medicaid eligibility. Some of the caregivers spoke of having to delay medical treatment because their cards went awry, either in the mail or in issuance. These problems were mainly nuisances, but they sometimes delayed care in situations where time was critical. In other cases, the regulations of Medicaid and other programs combined to create highly problematic situations for some families. One such case involved Alicia, who lost Medicaid benefits for her son when she moved from one Boston neighborhood to another. She had changed her address with MassHealth, but her card had not arrived. Without the card, she had no proof of insurance, and so had to stop taking Jonathan, her son with behavioral disorders, to therapy sessions. As a consequence, the Department of Social Services charged Alicia with neglect. Alicia was outraged because she had to wait for the insurance to be restored to pay for the therapy. Though the neglect charge was eventually resolved, it took time and created additional stress.

Some families had a difficult time finding physicians who would accept Medicaid. In Chicago, especially, parents complained about limited appointment times for families on public assistance that meant long waits for appointments or having to take their children out of school because they could only be seen in the mornings. For example, Connie, whose 8-year-old son had cerebral palsy, did not like the fact that there were only limited appointment times for "public aid patients" at her health-care center in Chicago. She could only get appointments in the morning, as the more convenient evening hours were reserved for private pay patients. Dan had up to ten appointments in a month, so Connie could not keep mornings free for work.

Whether insured by Medicaid or private companies, coverage and access did not come easy. Caregivers had to devote a great deal of time and energy to locating appropriate health services and negotiating gaps or lapses in coverage. Families often did not receive adequate information about what services were available to them or how they should access and choose among services. Also, a lack of information in Spanish created difficulties for Latino families who were not proficient in English. There were also numerous challenges in obtaining equipment and medication that were ruled not to be medically necessary. For example, one mother encountered a

problem getting Medicaid to cover a car seat that cost $500 for her son with multiple disabilities because he did not weigh the requisite 46 pounds. Another mother could not get approval for both a wheelchair and stroller, although her daughter needed both. Helena, mother of David, an eight-year-old with Down syndrome, a hearing impairment, and other health problems, detailed the efforts needed to obtain a portable nebulizer. Helena first called her Blue Cross HMO and was told that she could rent one but that it would take 2 months and she would first need her doctor to write a referral. Even with the referral, the HMO denied the request because they had replaced David's regular electric nebulizer when it had broken. Helena called every day and eventually the HMO approved it. Said Helena "This is what you do, you spend hours on the phone with people." These stories of making numerous phone calls, following up daily, and fighting for services were common.

Another major health-care challenge was finding appropriate care and coverage for mental health diagnostics and treatment for children with psychiatric disorders.[16] Parents reported feeling that doctors did not understand the nature or depth of their children's behavioral and mental conditions. For example, Tonya, the mother of Andy, her 3-year-old adopted son diagnosed with severe ADHD and a sensory perceptual disorder, suspected that Andy may have been misdiagnosed. She thought he really suffered from bipolar disorder, a condition exacerbated by the antidepressants prescribed for him. Another family in Texas could not get appropriate services for their son, Jerry, diagnosed with severe ADHD, oppositional-defiant disorder, and bipolar I disorder with psychotic features. Jerry was sometimes violent and had injured family members. His family located a psychiatrist, who prescribed medication, but his mother thought the treatment was only superficial, and that Jerry needed to be in a group home to get the help he needed. They were told that Medicaid would only cover the cost of residential care if they made Jerry a ward of the state, but once he became a ward of the state, they could not take him back.

Families with private insurance were not necessarily better off than those receiving Medicaid. They often got hit with steep copayments, especially on prescriptions, and these out-of-pocket costs created financial hardships. For the few families who had private insurance coverage through work, there was one rule: don't change jobs; don't change plans. Helena, introduced above, who herself suffered from a disabling rheumatic disorder, made clear the reasons for the rule. She and her child were covered under her husband's insurance, provided by his employer in Chicago. Her husband wanted to change to a better job, but the family's health needs were a part of calculating the benefits of any such move. Helena explained that her and her son's disabilities—the "preexisting conditions" that no insurer would want to underwrite—constituted one large roadblock. Only employers with a sufficiently large group policy could "write off" (defray in an actuarial sense) the problem cases, and, even so, the vendors or administrators of the plan might deny them. Since these kinds of employers are rare, job mobility was, in effect, not much of an option for families with members with disabilities. Helena had the sense of being trapped by this lack of "portability." These concerns of portability and insurability also affected families with more income and fewer needs than Helena's.

Navigating Health Care in Contexts of Poverty and Social Programs

Many factors coalescenced to affect families' abilities to obtain the health care and other services their children required. One was the health of the caregiver. Caregivers had to amass time and energy to locate and access health care and social services. This was a challenge for all caregivers, but especially for those with poor physical and mental health. Sometimes the effort and frustration involved in caring for their children, getting services, and making ends meet took their toll. Caregivers talked about being constantly worried, feeling overwhelmed and stressed, and being depressed. Their own health suffered, and was often exacerbated by forfeiting or postponing health care for themselves. Some mothers would not take prescription drugs, either because they could not afford them or because the side effects made them too sleepy to care for their children. Others refused operations or other medical treatments because they felt they could not take time away from their child care duties. One such case involved Marjorie, a mother living in Boston, who neglected seeking treatment not only for her enduring psychiatric disorder, but also for cervical cancer. She said that treatments left her too exhausted to watch her four children, three of whom had special needs. At one point, her doctor wanted to hospitalize her for pneumonia, but she had no one to care for her four children and could not obtain emergency child-care funds, so she recovered at home. In spite of multiple health problems, Marjorie spent a great deal of effort managing her children's services and took justifiable pride in her parenting, but some days she just did not have the energy to deal with everyday routines. Postponing health care proved to be a counter-productive strategy when the caregiver's health deteriorated to a point where it affected everyday activities, including child-care and accessing services.[17]

Another factor determining health-care access was the nexus of social and disability programs that caregivers found themselves in, and the myriad policies that regulated eligibility for Medicaid and monetary benefits such as TANF and SSI. Welfare reforms of 1996 uncoupled or "delinked" eligibility for TANF and Medicaid. Families who were not eligible for enrollment in TANF, or who left TANF, were not always aware that they could still qualify for Medicaid. Indeed, studies have shown a decline in families receiving Medicaid once off TANF rolls, although it is not clear the extent to which this is due to families no longer being eligible or to their not being aware of continuing eligibility.[18]

Caregivers in the study feared losing Medicaid for the child with disabilities if they returned to work. The type of jobs most of them could obtain were those that offered few, if any, benefits. If health insurance was offered, they could not afford the premiums. Choosing between work with no or limited benefits and keeping Medicaid was a major decision for some families. Yet for those welfare recipients who were not exempt from work participation requirements or time limits, staying on welfare was not an option. At the time of the study, Massachusetts's TANF program allowed exemptions from both time limits and work requirements if the caregiver had disabilities or was caring for a disabled household member. Texas exempted these individuals from work, but not from the 60-month lifetime limit for TANF.

In Illinois, persons with disabilities or their caregivers were not considered exempt from the 5-year TANF time limit, but they could be temporarily exempted from work participation because of medical or other barriers. In the majority of states (28), caregivers of a child or adult with a disability were not exempt from the time limit and, presumably, needed to enter the workforce once their TANF benefits ended.[19] This situation created real dilemmas for a number of families who shared the fear of losing Medicaid and not being able to obtain other health insurance for their children.

This was the case for Emily, a mother of a child with disabilities, who lived in Illinois and was therefore subject to TANF time limits. Emily experienced intense stress from the dilemmas she faced in trying to make ends meet and care for Suzy, her daughter who had multiple disabilities. Emily wanted to work, but did not want to stop her daughter's therapies during the day, nor were child-care slots available for children like Suzy. Emily was enrolled in a cooking school and planned to work as a chef when Suzy became old enough to go to a school-based child-care program, but she worried about being able to keep a job because of Suzy's extensive health-care needs. She also worried about losing Medicaid for Suzy once she got a job, and not being able to obtain private insurance because of Suzy's preexisting medical conditions. The threat of losing TANF and Medicaid and not being able to work due to her daughter's condition increased her stress, and she often felt overwhelmed and hopeless. Her physical and mental health deteriorated over the course of the study.

SUPPORTING FAMILIES OF CHILDREN WITH DISABILITIES

There are many supports that would assist low-income families of children with disabilities in their move to work and economic security. To work outside the home, they need child-care providers who can provide the specialized care their children require.[20] They need a flexible workplace, flexible work hours, and an employer that understands when time has to be taken away from work to manage the child's medical, educational, and therapeutic needs. Families also need affordable health-care coverage for their children and for themselves, and to be assured that coverage of their children with disabilities will not be put in jeopardy by their working.

This 3-year ethnographic examination of low-income families with children with disabilities highlights several important points that should be considered in any further reforms in TANF, SSI, and Medicaid. During the time of the study, we found that Medicaid worked for children with disabilities. For the most part, these children had access to a wide range of specialists who were dedicated to their health care and development. Although some families experienced scheduling difficulties and long waits, overall, most parents positively evaluated the services their children received through Medicaid programs.

However, Medicaid could be improved. Caregivers spoke of a need to have clearer explanations (and to have explanations in Spanish) of benefits and options. They preferred plans that could be tailored for their individual situations, like MassHealth.

They told of problems that stemmed from lack of coverage of dental care for adults, inadequate mental health services, and lack of coordinated care between mental health and substance abuse services. They discussed the need for better assessments of what specialized equipment is required for individuals with disabilities and the need for service providers to offer more flexible appointment times.

We also found uneven insurance coverage within families. Whereas a disability, especially one that meets the criteria for SSI benefits, virtually guarantees access to Medicaid for the individual with the disability, other members of the family, especially adults, may not be covered. They may not have access to other insurance plans through the workplace, or can afford them if they do.[21] In this study, all of the caregivers wanted to work and had plans for work when they could locate appropriate child care. Yet, they feared that they would lose Medicaid once their income increased and not be able to obtain insurance through the workplace, especially for the child with disabilities. For these families, transitional Medicaid that could be extended even longer than the current 1-year limit would be a major incentive and support to work. But what working poor and nonworking families need most is a universal health-care program that covers all family members, not just those with "eligible" disabilities. Health coverage is a crucial support to families in their quest to care for their children and attain economic security.[22]

Since universal health care may not occur in our lifetime, what can help families now is more collaboration between disability agencies and poverty programs. For the most part, professionals who work with individuals with disabilities are not familiar with poverty programs or the needs of poor families. Conversely, TANF caseworkers are largely unaware of the difference disability makes in families' abilities to meet program requirements or of disability programs that could assist these families.[23] What would help low-income families who have children with disabilities is for disability professionals to refer families to appropriate programs and services for those in poverty, and vice versa. For example, TANF caseworkers could receive training on childhood disability and its impact on caregivers' ability to work. They could maintain a list of agencies to which they could refer clients for additional resources and supports. Conversely, disability professionals such as early intervention caseworkers could receive training on how to assist families in applying for and appealing applications to TANF, Medicaid, SSI, and other means-tested programs. Such information and supports would better aid families in being able to access and provide health care for all their members.

NOTES

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CHAPTER 5

CHILDREN, RURAL POVERTY, AND DISABILITY: CASE STUDIES FROM THE HEARTLAND

Cynthia Needles Fletcher and Mary Winter

THE RURAL CONTEXT

About 1 in 5 Americans (17%) live in rural areas. A careful study of rural areas reveals a great deal of demographic and economic diversity. The proportion of the total population and the absolute numbers of children that are rural continue to shrink, although urban expansion, high immigration and birth rates, and the migration of retirees all have boosted the population in some rural areas. In addition to changes in population size, rural areas also are becoming more diverse racially, ethnically, and economically. In general, lower levels of human capital, higher underemployment rates, and lower wages distinguish rural economies compared to urban centers.[1] Poverty is more prevalent and more persistent in rural America. Nearly 14 percent of rural Americans live below the poverty line and 95 percent of persistent-poverty counties, designated so if 20 percent or more of their populations were living in poverty over the last 30 years, are rural.[2]

Consistent with national trends, Iowa's economic base and much of its population are moving from strictly rural areas to urban areas in the state. The rural population in Iowa continues to shrink, although a few communities have experienced an influx of immigrants attracted by jobs in food processing plants. Iowa ranks near the bottom among all states in terms of population growth and near the top, second only to North Dakota, in the proportion of its population age 85 and older. Nearly half of Iowa's counties, primarily rural, experienced population loss during the 1990s. The state lags the nation in per capita and median household income levels. Iowa has a lower incidence of rural poverty (9.2 %) and, in contrast to national averages, there is no rural-urban difference in the poverty rate. No Iowa counties are counted among

the persistently poor.[3] These structural shifts create challenges in how best to serve Iowa's most vulnerable rural citizens: poor children and poor elderly.

Rural areas, as a whole, are more disadvantaged than urban ones across numerous health indicators. Access to health-care facilities is more limited; rates of health insurance coverage are similar in rural and urban areas, but private insurance is less common in rural areas; and spells without insurance coverage are longer. Many studies illustrate that the structure, access to, and use of social supports and institutions differ between rural and urban communities. Many rural areas have seen health-care facilities shuttered. Lack of transportation is a key barrier to accessing services in rural communities. These findings, culled from national data sets mask local differences, however.[4] For example, state-specific data reveal that rural-urban differences in access and utilization are not present to the same degree in all states.[5] Observations from community case studies in the seven Iowa communities that were the sites for this study provide county-specific data that are consistent with the state-specific findings. In each county, the health-care system met the most basic needs of low-income families to varying degrees. No community seemed to address all the difficulties inherent in trying to meet the needs of a geographically dispersed, low-income population, however. In particular, rural residents routinely traveled to metropolitan areas to obtain highly specialized health-care treatment.[6] A growing body of literature demonstrates that long-term economic trends, coupled with low population densities and limited community resources, affect health-care service delivery and, in turn, the well-being of rural children and their families. Few studies, however, have used a qualitative approach to understand what it means to be poor, to cope with a child's health problems, and to navigate a rural health-care system.

DATA AND METHODS

Data for this study are from a series of in-depth interviews with 35 families (five families in each of seven Iowa communities) who were receiving payments under Iowa's cash assistance program, called the Family Investment Program or FIP, in mid-1997. The focus on recipient families was one phase of a comprehensive study of welfare reform in Iowa.[7] The seven communities represented a continuum ranging from an extremely rural community with a population of 1,800 to a metropolitan community of 109,000. Families were selected randomly from the list of welfare recipients in each of the seven counties in which the targeted communities were located. Two Iowa State University Extension staff members who served the community conducted each interview, taking detailed notes and tape recording the interview.

The interview protocols were a combination of structured and semistructured questions. Six in-depth interviews were conducted approximately every 6 months between late 1997 and early 2001. Parents—primarily mothers—discussed many dimensions of family life, including the health status of each family member. The respondent was the same through all interviews; however, other people (usually her partner) often were present during the interviews. Tapes were transcribed and coded following standard qualitative research protocols. Baseline demographic and program participation

characteristics were entered into a database for quantitative analysis. Qualitative data analysis was completed the old-fashioned way: by reading and rereading the transcripts, searching for common themes throughout the interviews. The three families featured in this chapter all live in rural communities. The names, places, and some of the circumstances that might identify a particular family have been changed, but the stories told present a detailed picture of the tremendous challenges faced by rural poor families with children who have significant physical and behavioral health problems.

CHILDREN'S HEALTH IN RURAL AREAS

Our examination of the data identifies several themes. First, a striking number of the families have a child with significant chronic health problems. We draw upon the data to develop thick descriptions of the health conditions of the children. Second, we describe the challenges of accessing health care and support services for disabled children in rural areas and the roles that mothers play as advocates for their children in obtaining services. Third, we describe some of the effects that having a child with health problems have on the family.

The Children in the Study

At the time of the first interviews, 74 children lived in the 35 households. They ranged in age from $3^1/_2$ weeks to 17 years. Thirteen of the children, *more than one-sixth of the kids*, were disabled or had other serious health problems, according to a report from a parent. The health problems of the children included autism, developmental delays, seizures, skeletal problems that led to several surgeries, mental retardation, and Attention Deficit Hyperactivity Disorder (ADHD). In three of the 35 families, children either had been removed from the home or were removed over the course of the interviews, and placed in foster care. Two older boys in one family were in trouble with the law for vandalism. The situations of three children and their families illustrate the themes that have emerged from the data.

Bailey's Health

Bailey, the 8-month old daughter of Mary and Tom, lives in a very small community in northern Iowa with her parents and her half-sister, Sally; during the course of the interviews, a baby brother is born. Bailey suffers from seizures and is on heavy medication. She requires special liquid formula at $20 per can because of concerns about food allergies. At the first interview, Mary reported that Bailey recently was ill and lost about 2 pounds—dropping from 19 to 17 pounds. The family travels to Des Moines, the nearest metro area—135 miles one way—for appointments with a specialist every 2 or 3 months. At the second interview, Mary describes Bailey's very serious health problems: ". . . . she's been in the hospital every 2 weeks [in the past 6 months]. She has uncontrollable epileptic seizure disorder. She has febrile seizures and epileptic seizures. The hospital stay we just got done with is a little different. They

finally got the seizures under control, then we transferred to [specialized university hospitals in] Iowa City. Her temperature at [the children's hospital in Des Moines] got to 107.2 degrees. We sat up in Iowa City—they're good doctors—they ran every test they could to find out what's going on with her. . . . All her tests came back negative. They did find an infection in her bowels that was causing it [high temperatures] really bad."

At the third interview, Mary reflects on the challenges of raising Bailey: ". . . her longest seizure has been 3½ hours and that's the one that put her on life support. It's like a constant battle. Actually we're doing really good right now. She's been sick this week and had seizures. In the last 6 months it was every 2 weeks on the dot, we were in the Des Moines hospital. We were Life Flighted [or] rushed by ambulance. Sometimes we'd actually already be in Des Moines because we had just been to the doctor that day. When she gets sick she gets sick fast . . . that's another reason why we don't leave the house very often. She's very prone to any illnesses or viral infections that go around. She catches them."

At the fifth interview, Bailey—almost 3—is still facing many health problems. Her mother reports: "We've been up in Des Moines and Iowa City every week for the last . . . I don't know how many weeks. We've been to every specialist there is. . . . She has always been on the 95th percentile for her height and weight—always. Right now she is 55 percent for her height and she is 27 percent for her weight. She is losing weight . . . big time. They don't seem to be concerned about it but, I'm sorry, the kid's wrists are the size of a newborn's. She aches like she has arthritis. January 3 we go to Iowa City to see a bone specialist. We've seen an allergist. We've seen a behavior specialist. We've seen a dietitian. They said we're doing every thing we should be doing—giving her the extra butter, extra peanut butter, extra fat. . . . She eats all the time, and she's still losing weight."

Devon's Autism

At the first interview, Devon, age 6, lives with his parents, Cindy and Bob, and 4-year-old brother, David, in a small town in west central Iowa. At the age of 3, Devon was diagnosed as autistic by specialists in Minneapolis. The diagnosis was the beginning of a long and often frustrating journey for Devon's parents. "They [the doctors in Minneapolis] were talking way over our heads. We didn't understand a thing. We had no clue what they were talking about." The interviews provide a glimpse of both the physical and behavioral health problems of this young boy.

A chronic digestive problem has resulted in a swollen esophagus that the local doctor was unable to treat. In the second interview, Cindy describes the problem and treatment: ". . . . vomiting but he [Devon] won't vomit, he swallows it back. . . . We doctored with Dr. Swanson and he said 'I can't do no more'. The only scope in Iowa is Iowa City. . . . Every three months we have to go back [to Iowa City]." At this same interview, Cindy notes behavioral changes in Devon: "The attitude he's had through the sickness is not good. . . . It's not violent, but he's back into the biting stage. His autism is more demanding."

At the last interview, Devon—now age 9—has made great progress in school. Cindy observes, "Devon's physical [condition] is tremendously better. . . . Mrs. Beem [his teacher] says he's come a long way with friends and being social." However, in the same interview Cindy describes a recurrence of Devon's digestive problems and ponders the cause: ". . . you don't know what it is—if it's physical, mental or. . . . So we're going down to see the upper GI doctor on the same date with an ear specialist, plus his autism doctor."

Jake's Learning Disability

Jake, age 17, lives with his father, Bill, his step-mother, Patsy, and 13-year-old sister, Brandy, in a small town in western Iowa. At the first interview, his stepmother says Jake is retarded. He would like to be a policeman or fireman, but the family is aware that he will not be able to meet those goals. In addition to being labeled as learning disabled, Jake has a history of depression and violence. During the course of the interviews, he is taking Prozac. When he has forgotten to take his medicine, he has dark moods, and has hit his mother and his sister. Patsy tells the interviewer "It's up and down. If he forgets to take his Prozac it gets bad." And Jake replies, "Sometimes I take it late; sometimes I forget."

Jake's physical health is also at issue. He is obese and has high cholesterol. Patsy reports that Jake "weighs 300 pounds. That's a little too overweight. . . . We had him to the doctor. . . . They said to watch his cholesterol because it was high at the time, but he won't listen. We went to church one Sunday and came back and he had cooked himself three pounds of hamburger and didn't leave none for anybody else. He's a meat eater—constantly into meat every half hour. He just eats constantly. He don't know when to quit."

Jake is listed as being in "eighth grade special education" during the first two interviews, and in "ninth grade special education" at interview three. At interview four, he is 18 and has graduated from high school. While still in high school, Jake begins to participate in the local work activity center. When asked how he received that opportunity, Patsy replies, "His teacher at school does that for the kids—for all of the kids that have slow learning disabilities. She puts all her class in there that needs it." He continues to work through this program after he leaves school, going to several different communities each week. When asked what he does, Patsy responds, "At [business] he puts boxes together. At [another business] he's a custodian. At [a third business] he packs boxes of cheese . . . and he loves it." At the last interview, he is 20, living at home and looking for work.

Access to Health Care and the Advocacy Role of Mothers

Families in rural areas must travel long distances to access specialized medical care for their children. Although Bailey might be better served elsewhere, her mother describes a decision to stick with services in Des Moines rather than continuing treatment at the University Hospitals in Iowa City, more than 200 miles from her

home: "Des Moines has to be the break off point because it's half way between for her medical emergency. It's [Iowa City] too far for Life Flight to come. Otherwise it's an 8-hour trip for an ambulance to come down and get us and take us back—it's too far. We're still going to deal with our doctors in Des Moines."

Devon's mother also has had to make difficult choices about dealing with her son's autism, particularly in the quest for an "autism doctor." Cindy describes one series of interactions with the various systems: "I called . . . [Devon's] autistic doctor in Iowa City. He's no longer in practice. So now I have to sign on with a doctor in Des Moines. This afternoon I have to go through paperwork to resubmit him with a doctor. DHS [the Iowa Department of Human Services] says to me, 'we might not be able to pay for this because [Devon] was signed on with a doctor and that doctor hasn't told us he was out of practice.' So we might have to pay for another doctor's evaluation. . . . The reevaluation runs anywhere from $2000 to $4000. . . . This is our third diagnosis because we've been to Minneapolis because they [presumably DHS] wanted to try out this new doctor in Minneapolis. She's wonderful. But her Minnesota title won't fit Iowa. So then two years later we go to Iowa City. I loved [the physician in Iowa City], he helped me in a lot of different ways, but he didn't tell us he was quitting. *So here we go*. This is all happening this month."

Devon's disability has thrown his mother into the labyrinth of support systems for children with conditions like autism: the school system, the Area Education Agency (AEA), the Department of Human Services (DHS), and the medical system, none of which are located in their community. The DHS office is located in the county seat, 10 miles away, and the respite care facilities are in a neighboring county 40 miles to the northwest, the opposite direction from Des Moines and Iowa City. On the day of one of the interviews, Cindy describes her attempt to find an orthodontist who will take an autistic patient with Title XIX (Medicaid): "I've called nine today and no one will take him." She finally finds one, about 50 miles away.

Poor rural families are very reliant on private transportation to meet regular health-care appointments. Personal vehicles owned by poor families are often not reliable. Mary describes her transportation problems: "It's [her van] really reliable—except when the alternator belt falls off. We got stuck that one Saturday night . . . the coldest wind chill factor of the year. . . . We were stranded. . . . We got cold. It took them an hour to get us." Long distances complicate the ability of rural families to maintain relationships with their doctors. Cindy reflects that she "couldn't really keep much contact with Minneapolis doctors because they're so far away. We called for help and it took them three or four days . . . to get the message." In addition to trips for medical care, Cindy comments on the travel costs of attending educational workshops: "Just to learn about autism . . . those big meetings I go to in Des Moines—just to go there it's $50. That's a lot of money."

A recurring theme throughout the interviews is the critical role that poor mothers can play in diagnosing and monitoring their child's health and then advocating for services within the health-care system. Mary describes her frustrations and her proactive role: "They keep saying, 'well, we can't find anything wrong.' We know there is something wrong, and I'm going to make them find it. I don't mean to sound

harsh, but if something happens to her, I will sue. I'm not going to lose my kid over their mistake or me sitting back. She [Bailey] kept having these little seizures. I kept telling them, 'something is wrong—something is wrong.'. . . . She has delayed development of the brain. Her brain is smaller than normal—which means there's extra fluid there to fill up the space. . . . After I got this absorbed, I called up there [to the neurologist] and said 'what's the name of this'? They said, 'it doesn't have a name.' Microcephalic is smaller than normal brain. Hydrocephalic is extra water on the brain. . . . I asked [specialists at] Iowa City and they said *I was right.*"

Devon's mother has a high school education, but has self-diagnosed learning disabilities. She admits that sometimes the paperwork involved in getting assistance is overwhelming, but that "You have to stay on top of it. There's no way I could have a full-time job. I don't know how parents do it [employment] full time and deal with it . . . with Devon's age I need all this extra assistance. So I have to stay on it full time." Although Cindy feels that her own learning disability sometimes makes it difficult for her to be a successful advocate for her son, she has found an ally in an educational program aide. "If I have any problems, I call Janice. I can deal with it. I've been dealing with it pretty good I think. I can do a certain amount, but then when it gets too hairy, or I get too frustrated, then that's when I call Janice."

Two instances, both reported to DHS, illustrate Cindy's experiences dealing with an autistic child and "the system." When Devon went to kindergarten, Cindy packed his lunch with foods he liked after he refused to eat school lunches. School officials viewed Cindy's lunches as "junk food." They "called DHS" and required her to work with a dietitian. In another instance, Cindy dealt with Devon's habit of biting his little brother by biting him herself: "I bit him. Now he knows what it feels like. . . . He doesn't know his own strength. He could bite an actual chunk out of David and not know it. . . . They'll [DHS] probably get me for abuse on that. . . . You're damned if you do and damned if you don't." One senses that Cindy's intentions are good, but her lack of knowledge and skills in parenting an autistic child have resulted in these run-ins with the system.

In the second interview, Devon is completing first grade. It is clear that his mother views his progress from a different perspective than the school: "Did you know that he missed 33 days [of school] this year? They [school officials] didn't think that was very good. *But look at what the child has been through.*" Cindy comments on the local school system: "I keep telling the teachers, 'hang in there, he's done good.' They've never dealt with autism. They're learning—we're all learning together." In a later interview, she complains that Devon's aide ". . . has no training. The therapist in Des Moines . . . sent letters to the school that they wanted to go through some sort of autism training. The school hasn't followed through." At one point Devon's aide asks if his family will finance her (the aide) for training. Cindy sighs, "I didn't blow up at her. . . ."

Although not the only reason, frustration with the school system is, in part, responsible for the family's move from their small older home they owned outright in a very small (less than 1,000 residents) community to 31 acres near a larger community. The family is pleased with their move. The school system is more

responsive to Devon's needs, and being able to have animals at home has been a big help to him.

In contrast to the activism of Mary and Cindy by their own admission, Patsy and Bill are fairly passive in terms of finding support for Jake. They are content to let the school system take the lead, in part, perhaps, because school systems, even those in small communities, have more experience with children who are mentally delayed than with those with other disabilities. His stepmother says that Jake has always been labeled as retarded or learning disabled. When asked what the family has done to help with that condition, she replies, "We haven't done a whole lot. It's mainly the people that worked with us—the school system, etc." The interviewer follows up: "What does the school do for you?" Patsy: "Meetings." Interviewer: "Are they group–parent meetings?" Patsy: "Yes." Interviewer: "What do they tell you at these meetings?" Patsy: "They have a few good things to say about him, then there are things that they don't—that needs a little more work done with him. They do their part and we just sit in on the meetings and listen and learn what needs to be done."

Family Impact

The challenges and stresses that a chronically ill child places on any family are acute, but the lack of resources within poor families, coupled with the lack of services in rural communities exacerbate problems for the rural poor. Mary, who has not been employed since Bailey was born, describes the economic strain that Bailey's health-care needs have placed on the family. She aptly describes the dilemma of getting ahead and the need for medical care: "I imagine I could go to work and work 40 hours, lose touch with my kids and my family, but in the long run I can't afford to lose her [Bailey's] medical. That's the only reason I'm not working. I'm going nuts sometimes at home, but it's the only time I'm not working—but we'll lose her medical. We can't afford a $5,000 Life Flight bill. We're so much in debt right now it's not even funny anyway."

Financial stresses compound problems in Devon's family as well. During the course of the six interviews, his father holds several different jobs. He is unemployed at the last interview, and receiving Supplemental Security Income (SSI) disability payments. Like Mary, Cindy has not been employed outside the home since Devon's birth. She describes how Devon's needs limit her ability to seek employment: "Everybody calls at the last minute to make appointments. I have to jump. I'm not complaining, but in a way—financially—we could use some extra income. We deal with it."

Interviewers asked families to reflect back on family life at the beginning of the study and compare condition 3 years later. Mary replies: "Probably a 9 (on a 10-point scale). Life was pretty smooth. I think that was when Bailey was just born. Life was smooth—easy going. We both worked." And asked to evaluate life now: "Life in general kind of sucks. Put all the stress and change and everything together—probably a 2 or 3. Bailey's seizures, this disorder—it's put a lot of stress and strain on everything. It's had us totally where we had to rearrange our lives around this. . . . We always end up in Des Moines at the hospital—Life Flighted, ambulance and all that.

We lived with suitcases packed; we had no choice. . . . Last year it's gotten easier . . . but it's still the stress of all the appointments, juggling Sally being in school, two kids at home, keeping the house clean, doing the doctor's appointments—especially when most doctor appointments are in Des Moines or Iowa City. It's just kind of nuts sometimes."

In contrast, Cindy says that their lives are getting better, in part because of their move to an acreage and in part because of her spouse's eligibility for SSI disability. Having horses and pigs and chickens on an "Old MacDonald Farm" has been a good thing for the boys, especially Devon. "It takes Devon 2½ hours to come in from the bus. He talks to every animal. He loves his horses. He just loves his horses." Although they still must travel long distances for special medical services, those provided by the school system and the Area Education Agency are superior to the ones they left. And, at 9, Devon is easier to handle than he was at age 6. Throughout the interviews, Bob had moved between part-time employment without benefits and being jobless. His eligibility for SSI has stabilized the family's income and has given him access to Medicaid coverage. This change has also removed an uncertainty about loss of Medicaid eligibility for the children; however, Cindy remains uninsured.

Patsy also reports that life is better at the last interview. The four of them have just moved to a different house in a smaller community, a house purchased with Bill's $14,000 lump sum disability settlement from Social Security as a down payment. The family has lived in the house for three weeks when interviewed, and are still basking in the large amount of space in the new dwelling and that they are now owners. In response to a question about why they like this house so much, Patsy replies, "It's ours. That's what I like most about it. It belongs to us. We don't have to worry about landlords. . . . In about five years we'll have it all paid off. It will be ours and we don't have to worry about nobody else. It's home. That's what I love about it." The house needs a lot of work, however, and the family has not begun to deal with the repairs needed. "I don't know what we're going to do. The porch leaks, we've had a few other leaks since we got here. One thing or another. . . . "

After working in the employment training program, Jake is now unemployed. He is looking for a job at a local store. His dad says, "He's got an application he's going to put in at the store . . . maybe in March when it's warm. . . . " When asked about challenges they are still facing, Patsy responds, "About the same old thing: their [Bill's and Jake's] tempers. . . . It's not as bad now that they are on the pills as it was before. It's not as often because this used to go on just about every day before Dr. Peterson put them on Prozac. Now it's more calm. It don't happen as often as before . . . [Jake] likes to tease when he isn't in one of his moods. . . . When he gets in one of his moods, he gets mean with me."

DISCUSSION

Case study findings illuminate the life experiences of poor rural families raising children with serious disabilities. Digging deep into a series of interviews with three families, patterns emerged; however our results cannot be generalized nor do they

provide the basis for broad policy recommendations. Our findings do raise questions for future research. First, thick descriptions obtained through open-ended interviews paint a vivid picture that the needs of children with serious physical and behavioral health problems can play havoc with daily routines—imposing stress, conflict, uncertainty, and financial strains on families that are struggling to keep afloat. Understanding the combined effects of disability and poverty during childhood and exploring spatial effects on children's long-term outcomes will require different longitudinal data than are currently available.

Second, it is not obvious that Bailey, Devon, or Jake would obtain better or different health care if they were insured through private rather than public health insurance systems. One obvious difference between poor and nonpoor families with ill children is the availability of financial resources. The extent to which money matters—for example, providing options of respite care, creating access to goods and services not covered by insurance, making reliable transportation available, and reducing the financial pressures that full-time caregiving by a parent may place on the family—is not well understood.

Finally, one of the most intriguing findings from our study points to the important role that mothers can play as advocates for their children within the various social systems that they and their children interact, including neighborhoods, schools, and the health-care network. It is clear that this is not an easy role. Without persistence, the systems and the professionals therein are prone to dismiss these mothers. Gaining a better understanding of how the human and social capital within a child's family influences not only access to treatment, but the quality of health-care needs further consideration.

These findings and conclusions support Katherine Newman's view that "the intrinsic value of qualitative research is in its capacity to dig deeper than any survey can go, to excavate the human terrain that lurks behind the numbers. Used properly, qualitative research can pry open that black box and tell us what lies inside."[8] New knowledge will begin to unfold when investigators imbed qualitative studies inside quantitative studies that are either cross-sectional or longitudinal panel designs. The fusion of the two approaches provides greater confidence in the representative nature of qualitative samples, and the capacity to move back and forth between statistical analyses and patterns in life histories renders either approach the richer for its partner.[9] It is likely that this dual approach to the study of rural children's health will yield the body of knowledge on which truly effective interventions and policies can be built.

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CHAPTER 6

Factors Affecting Utilization of Mental Health Services by Low-Income Latino Children: A Model of Parental Help-Seeking Behavior

Ricardo B. Eiraldi and Laurie B. Mazzuca

Despite a significant increase in the number of children who receive clinical services for mental health and academic problems, there is still a considerable level of unmet need among ethnic minority populations. Latino children continue to lag well behind their nonminority counterparts in the rate of diagnosis and treatment for behavioral, emotional, and academic disorders. A number of models have been proposed to assess the causes of service disparities. Several of the models focus on factors that affect parental help-seeking behavior. This chapter describes factors that are hypothesized to affect the help-seeking behavior of Latino parents who have children with behavioral, emotional, and/or academic disorders. Factors are integrated within the framework of a modified theoretical pathway model encompassing problem recognition, decision to seek help and service utilization. The authors hope that this model will spur research on the causes of service disparities among Latino children.

It is estimated that up to 20 percent of children in this country are in need of mental health services.[1,2] Research on the utilization of mental health services by children has yielded mixed results. Some reports indicate that service utilization has increased among children during the past 10 years, especially for pharmacological treatments.[3,4] However, in a recent analysis of three large population samples, only 2 percent to 3 percent of children ages 3–5 and 6 percent to 9 percent of children and adolescents ages 6–17 actually used mental health services during a 12-month period.[5] Nearly 80 percent of children and adolescents who were identified as needing mental health services in the 6- to 17-year-old age bracket, had not received care.[6] Studies also indicate that low-income and ethnic minority children continue to lag behind their middle-class, nonminority counterparts in the rate of service utilization.[7,8] There is clear evidence that unmet need for mental health services among Latino children is extraordinarily high, even as compared to African American children.[9,10]

Given that Latino children comprise the largest and fastest growing minority group in this country, the gap in service utilization for this population is a very significant public health problem. Unfortunately, to date there have been very few studies investigating factors contributing to service disparities among Latino children. For the most part, the research in this area lacks a strong theoretical foundation, and studies typically investigate only a few factors at a time. As William Vega and Steven Lopez point out, "fine grain research" is needed in order to elucidate the many potential factors that may be contributing to disparities in service utilization for mental disorders in various Latino communities.[11]

The low rate of service utilization among Latino children is probably the result of a myriad of systemic, individual and cultural factors, such as lack of health insurance, economic hardship, illegal residency status, lack of services, and lack of knowledge about the mental health system and about the warning signs of mental disorders. Also, it may be that low acculturation levels contribute to a lack of trust in doctors, and stigma and negative attitudes toward specific treatments such as treatment with medication.[12, 13] The purpose of this chapter is to present a theoretical model of help-seeking behavior that can be used to investigate factors that promote or hinder parental help-seeking behavior on behalf of Latino children with behavioral, emotional, or learning disorders.

LATINOS IN THE UNITED STATES

Latinos are individuals of "Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race" (Note 14 Office of Management and Budget, 1997). Although many Latinos share the same language, the same religion, and an emphasis on the importance of hard work and family, they have roots in countries with different histories and cultural influences. Latinos in the United States present vast differences in race, socioeconomic status (SES), education level, and legal residency status.[14] Intra-group differences among Latinos are so great, that questions have been raised as to the appropriateness of referring to all Latinos as if they are members of a homogeneous group. In fact, Martha Giménez suggests that Latinos should be identified by their subgroup (e.g., Puerto Rican, Mexican-American, etc.) to acknowledge the fact that they may share minority status in the United States , but can have different racial/ethnic backgrounds and nations of origin.[15] Latinos are the largest ethnic minority group in the United States with a population of more than 41 million. Without including the 3.9 million residents of Puerto Rico, Latinos in the United States now constitute 14 percent of the population.[16, 17] By the year 2030, it is estimated that Latinos will total over 73 million and constitute over 20 percent of the U.S. population.[18] The largest Latino subgroups in the United States are Mexican (67%), Central and South American (14%), Puerto Rican (9%), Cuban (4%), and Latinos of Other Hispanic (7%) origin.[19] Individuals of Mexican origin have the largest number of undocumented immigrants and the lowest level of health insurance coverage.[20] Those of Puerto Rican origin have the lowest income of

all Latino subgroups, but they have better access to health insurance due to their U.S. citizenship status.[21]

SERVICE DISPARITIES AMONG LATINO CHILDREN

Several recent population-based studies have reported that Latino children are significantly less likely to be diagnosed and treated for a psychiatric disorder than non-Latino children. Based on the combined sample of three large household surveys of over 48,000 children, Latino children were much less likely to receive services (4.7%) than their non-Latino white (7.23%) and African American (5.9%) counterparts.[22] Latino children with significant impairment were more than two and half times more likely to have unmet needs than non-Latino white children.[23] Kristen McCabe and colleagues reported that Latino youth were the group most consistently underrepresented in five public sectors of care in San Diego, CA.[24] In a study conducted by Philip Leaf and colleagues comparing service use by children in the United States with those in Puerto Rico, only 20 percent of children meeting criteria for a psychiatric diagnosis in Puerto Rico had received services during the previous 12 months compared to 38 percent in Atlanta, GA, 44 percent in New Haven, CT., and 41 percent in New York.[25]

Disparity in service use is also apparent in inpatient settings. In a study designed to determine the incidence of mental illness hospitalizations among elementary-school age children, Anand Chabra and colleagues found that non-Latino white and African American children were five times more likely than Latino children to be hospitalized for any mental health disorder.[26] Compared to non-Latino white children, Latino children were between eight and eleven times less likely to be hospitalized for anxiety disorders, impulse control disorders, and bipolar disorder.[27]

THE INFLUENCE OF ETHNICITY AND POVERTY ON SERVICE UTILIZATION

Poverty exerts its influence on service utilization among Latinos through its effect on access to health insurance, the ability to afford additional costs associated with services (e.g., deductibles, transportation), and on the health status of Latinos. U.S. Census data show that Latinos are more likely to be unemployed and earn less money for year-round, full-time work than non-Latino whites.[28] In 2002, the average per capita income of Latinos was $13,487, compared to $15,441 for African Americans, and $26,128 for non-Latino whites.[29]

Latino children are more likely to live in poverty than non-Latino white children, and only slightly less likely to be poor than African American children.[30] Flores, Bauchner, Feinstein, and Nguyen[31] found that Native American, Latino, and African American children are the least healthy children in the United States, are more likely to live below the poverty level, and have fewer doctor visits than non-Latino white children. In other words, poor Latino children may actually have an increased risk

for the development of health problems, yet, may be less likely to be able to afford healthcare services.

Research suggests that the Latino population in the United States is younger and less educated than is the non-Latino white population,[32,33] and therefore, many working Latinos occupy low-wage or part-time jobs (i.e., agriculture, forestry, housekeeping, construction, labor, etc.) that may not provide employer-based health insurance. In fact, a study of working Latinos in California found that even those Latinos who held full-time, full-year employment were significantly less likely to have employer-based health insurance than non-Latino whites and African Americans.[34] Moreover, research shows that working Latinos who are low-wage earners often cite inability to pay premiums, copays, and deductibles as the primary reason for lacking health insurance, even when offered by employers.[35] Poverty can impede access to health insurance and ultimately service utilization on many levels and this "trickle down effect" of poverty may be especially salient for undocumented, immigrant Latinos. Not only are they likely to occupy "underground" low-wage jobs that do not offer employer-based health insurance (or legal work visas), but they often cannot pay for private insurance; are typically not eligible for public or government-based insurance programs because they lack legal residency status; and often are afraid of interacting with health-care providers for fear of deportation.[36–39]

In summary, there is now strong evidence that Latino children living in the United States as well as those living in Puerto Rico are much less likely to receive mental health services than non-Latino white children or African American children. Latino children and families have a high risk of living in poverty, being in poor health, and experiencing both the financial and cultural barriers to care that are associated with poverty. Unfortunately, whereas significant progress has been made quantifying the extent of ethnic disparities in service use, no comparable progress has been made in investigating the causes of the disparities. A useful approach for identifying predictors of service utilization is to examine the help-seeking behavior of those who need services.[40] What follows is a brief discussion regarding the evolution of help-seeking behavior models. The section ends with a proposed pathway model to study help-seeking behavior among Latino parents.

HELP-SEEKING BEHAVIOR MODELS

An important assumption of early and subsequent models of service utilization was that when faced with a general health or mental health concern, individuals must first accept the idea that they have a problem. Subsequently, they have to weigh the pros and cons of different ways of dealing with the problem and decide whether they are willing to seek help. In the final stage, individuals select and then apply the type of service they think they need. Specifically, the help-seeking stages are *problem recognition*, *decision to seek help*, *service selection*, and *service utilization*.[41,42]

Ronald Andersen developed the most influential model for the study of access to medical care and help-seeking behavior, known as the Behavioral Model of Health Service Use.[43,44] Andersen observed that use of health services is a function of the

perceived need for services, predisposition to use services, factors that enable or impede their use, and need for care.[45,46] Andersen's model advanced the field by providing a better understanding of the help-seeking process (i.e., how people get services), and by identifying predictors of service use.

Harold Goldsmith et al. presented a reformulation and expansion of earlier models of help-seeking.[47] Goldsmith and colleagues emphasized the cognitive decision-making process of individuals considering services.[48] In their view, the process leading to the decision to seek services involves a cost-benefit analysis (i.e., whether the benefits of seeking help outweigh the costs). They presented a three-stage help-seeking pathway (i.e., problem recognition, decision to seek help, and decision to select specific services) and identified factors that may influence each stage.

Debra Srebnik and colleagues proposed a further expansion of the mental health help-seeking model by acknowledging the influence of social networks on the help-seeking process and by adapting the model for children and adolescents.[49] According to a social network theory, the interactions individuals have with members of their social network form the principal mechanism through which they recognize health problems, contact health facilities, and comply with medical advice.[50] In the Srebnik et al. model, the influence of social networks on help-seeking behavior can be seen as a barrier or a facilitator of service utilization.[51] Social networks are hypothesized to facilitate treatment when members of the network influence the parent to seek professional help, and constitute a barrier when they influence the parent not to seek services.

Ana Mari Cauce and colleagues proposed a further revision of the model to facilitate understanding of cultural and contextual factors affecting ethnic minority adolescents' pathways into services for mental health disorders.[52] Cauce and colleagues argued that culture and context impact help-seeking behavior through the influence of the community. Adolescents in need of mental health services are more or less likely to seek help depending on prevalent cultural and other contextual influences present in the community.[53] In their view, the effects of culture and context pervade the whole help-seeking process, and therefore, do not have specific foci in the pathway.[54] This model posits that minority and nonminority populations use different help-seeking pathways largely because of cultural and other contextual factors and, consequently, should be studied separately. Related to the effects of culture on service use, Hortensia Amaro and colleagues cited five sociocultural factors that are important to the understanding of both health status and health-care utilization among the Latino population.[55] Those factors are poverty, cultural beliefs, immigration and cultural adaptation, structural barriers to healthy development and health-care access, and the heterogeneity of the Latino population. These factors influence how, when, where, and if Latinos utilize health-care services.[56]

Finally, Eiraldi and colleagues recently proposed a further revision of the help-seeking behavior model in order to address the unique aspects of parental help-seeking behavior on behalf of children with ADHD.[57] This latest revision incorporated features of the help-seeking behavior models reviewed above. The stages in the

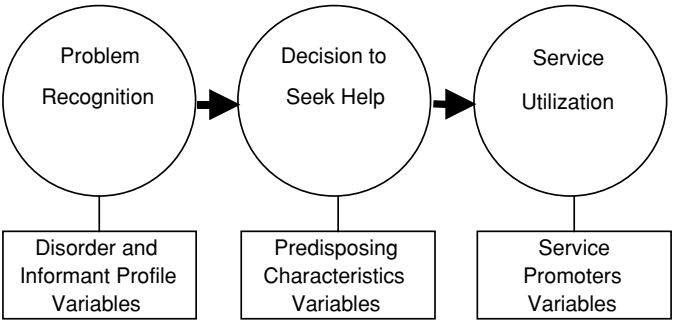

Figure 6.1
Stages of Help-Seeking Behavior. Adapted from Eiraldi et al., 2006; Goldsmith et al., 1988

help-seeking process (problem recognition; decision to seek help; service utilization patterns) are hypothesized to be influenced by characteristics of the disorder and the informant (e.g., parent), the predisposition to use services, factors that enable or impede the pursuit of services over time (see Figure 6.1).

It is hypothesized that most families who have children with emotional, behavioral, and/or learning disorders generally navigate the pathway in a voluntary and unidirectional fashion, first recognizing the problem, second deciding to seek help, and third, using services. However, as Pescosolido and colleagues have pointed out, sometimes individuals are made aware of the problem by others and at times they are forced or coerced into the mental health system.[58] For example, parents are sometimes made aware that their child has a problem by teachers or other professionals. Parents are sometimes influenced by school personnel into accepting services for their children (e.g., medication),[59] or in the case of children in the juvenile justice system, some may be pressured into continuing with treatment after the child is no longer in the system.[60]

The help-seeking process in most cases begins once the parent realizes or accepts the idea that the child might have a problem. *Disorder and Informant Profile* (see Figure 6.1) refers to a child's susceptibility to a given disorder or level of severity of symptoms and characteristics of adults involved in problem recognition. Some of the variables hypothesized to affect problem recognition are symptom severity, impairment level, parental psychopathology, parent–child relationship difficulties, and differential thresholds for distinguishing normal from abnormal behavior. Following problem recognition, parents need to decide whether to pursue further consultation or treatment. *Predisposing characteristics* are certain demographic characteristics such as age or gender, and relatively stable psychological and cultural factors that influence a person's readiness to seek help.[61] Psychological factors are aspects of an individual's personality that may increase or decrease readiness to seek help for a mental health condition. The term also pertains to beliefs about an individual's ability to perform

certain expected roles related to help seeking[62] and his or her knowledge of the mental health system. Some of the variables thought to affect the decision to seek help are child's age and gender, stigma, apprehension about legal status, acculturation level, beliefs and expectations about mental health services, and knowledge about mental health disorders and how and where to obtain services.

Due to space limitations, we limit the discussion of factors affecting the different help-seeking behavior stages to only those hypothesized to influence service utilization. Careful consideration has been given to choosing variables that pertain to behavioral, emotional, and/or learning disorders and, to a lesser extent, that are likely to differentiate Latino children from children of other ethnic groups. A detailed discussion of issues related to these variables is beyond the scope of this chapter.

SERVICE UTILIZATION

Once parents have made the decision to seek services, they need to investigate what services the child should receive and which ones are available to them. Parents are more likely to make an appointment and begin using services if they are affected by factors that facilitate use of services and if they do not face any significant barriers. According to Srebnik et al.,[63] any social, economic, or environmental pressures that can occur at the family, community, or at the larger society level can be barriers or facilitators for using services. At a theoretical level, factors influencing access to services could affect parents at three separate points: (a) making an appointment, (b) using services for the first time, and (c) using services over time. What follows is a discussion of factors that are hypothesized to affect initial contact with service providers, followed by factors affecting initial use and use of services over time (see Figure 6.2).

Initial Contact

Most Latinos place great importance on having a strong identification with and attachment to their nuclear and extended families. Latinos tend to be very loyal to and supportive of their families. This relationship is known as *familism* or *familismo*.[64] When Latino children and adolescents experience emotional and behavioral difficulties, parents are much more likely to talk to members of their social network first; this in most cases would be the parents' extended family. If Latino parents do not make a decision regarding what to do with their child after consulting with their extended family, they might talk to other members of their social network such as teachers, friends, or other individuals from the community. Social network members could influence parents to make initial contact with service providers (e.g., making an appointment; asking for information about services) depending on the type of opinions they express about mental health service, or, whether or not they themselves are willing to provide direct assistance to the parents. Providing direct assistance such as babysitting, emotional support, etc., might diminish need for professional services, at least in the short term.

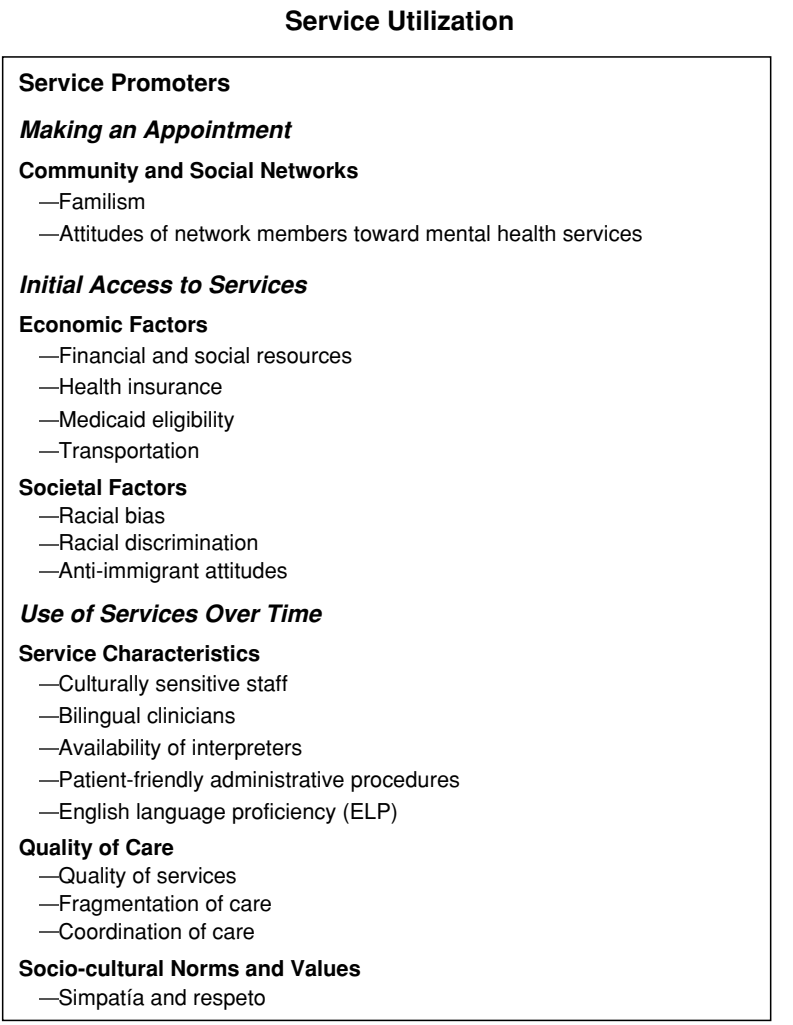

Figure 6.2
Service Utilization Factors for Latino Children with Behavioral, Emotional, or Learning Disorders. Adapted from Eiraldi et al., 2006; Goldsmith et al., 1988

Initial Access to Services

The low-income and low-insurability status of many Latinos represent a set of variables that potentially limit parents' ability to secure mental health services for their children. In the year 2004, 22.2 percent of Latinos lived in poverty compared to 8.4 percent of non-Latino white individuals.[65] As a group, Latinos have the lowest insurability rates of any ethnic group in this country. In the year 2000, 37 percent

of Latino children did not have health insurance for all or part of the year. This is compared to 20 percent for non-Latino white and 23 percent of African American children.[66] Rates of insurability are much lower among Latino immigrants. In the year 1997, 49 percent of foreign-born Latinos were uninsured compared to 24 percent of U.S.-born Latinos.[67] In a recent study it was noted that Medicaid eligibility has a profound impact on the racial disparity associated with psychopharmacological treatment for mental disorders among youths.[68] Not having or not being eligible for Medicaid is a very strong predictor of unmet need among children.[69] Other major factors that may inhibit access to services are distance from specialized treatment sites, the availability of affordable transportation, complicated intake processes, long waiting lists, and limited operating hours.[70]

There are several societal factors that negatively affect the quality of services available to ethnic minorities in this country, and by extension, parental help-seeking behavior, and rates of service utilization. Those factors include racial bias, discrimination, and anti-immigrant attitudes.[71–73] In a large population study assessing quality of health services nationwide, it was found that 19.4 percent of Latinos in the sample reported having been treated with disrespect or looked down upon by medical staff, compared with only 9.4 percent of non-Latino white respondents.[74] Data from the 2000 National Survey of Early Childhood Health showed that many health-care providers hold stereotypical views of Latinos' child rearing practices and that Latino parents often feel that their health-care provider never or only sometimes takes time to understand their child's specific needs.[75] In a study that explored the effects of a ballot initiative designed to eliminate access to state-funded health services for undocumented immigrants in California, it was found that the rate of service utilization by Latino youth dropped by 26 percent after Proposition 187 received a majority of the "yes" votes.[76] This is a remarkable finding given the fact that this proposition never became law. Results of these studies indicate that such societal factors are likely to be barriers to help seeking for Latino parents.

Use of Services over Time

It is well established that Latinos use mental health services in low numbers. However, it is less well known that after the first visit to a mental health specialist, Latinos are unlikely to come back. The rate of attrition for mental health services among Latinos has been found in some studies to reach as high as 70 percent.[77]

There are many factors that may promote or diminish service utilization over time. Those factors could be divided into service characteristics, quality of care, and sociocultural norms and values. For example, a number of service characteristics such as the availability of culturally sensitive staff, bilingual clinicians or interpreters, doctors and staff of similar racial/ethnic background, and patient-friendly administrative procedures may increase the likelihood that the family will continue to use services.[78–80] Low English language proficiency (ELP) has been shown to be among the most significant access barriers to treatment for Latino children with health and mental

health disorders.[81] Given that at least 31 percent of Latinos who speak Spanish in this country either do not speak English well or do not speak it at all,[82] low ELP is a major barrier for Latino parents.

Studies have reported that racial and ethnic minority populations in this country believe that they receive mental health services of substandard quality compared to those received by nonminority populations.[83] Several studies using objective measures support these perceptions.[84,85] In a statewide, longitudinal study assessing the quality of publicly funded outpatient specialty mental health services in which the majority of participants were of ethnic minority background, Zima et al. found that clinics typically scored well below quality standards for most of the areas assessed, including service linkage with schools and PCPs, parental involvement, use of evidence-based psychosocial treatment, and patient protection.[86] Mental health care for children with disruptive disorders living in the inner city has been found to be highly fragmented and uncoordinated.[87] Based on these studies, it is reasonable to expect that low quality of services may be a significant factor in the high attrition rate in Latino child populations.

Sociocultural norms and values are also likely to play an important role in influencing families to stay in treatment. Two sociocultural constructs that have received empirical support in Latino populations are *Simpatía and Respeto*.[88] *Simpatía* means being kind, polite, and pleasant even in stressful situations. Avoiding hostile confrontations is also an important component. Latinos expect that the clinician is going to be polite, pleasant, and expressive. A reserved and nonexpressive clinician would normally not be well received by Latino patients or their families. Lack of *simpatía* could lead to decreased patient satisfaction, inaccurate reporting of history and symptomatology, nonadherence to therapy, poor follow-up and early drop out.[89] *Respeto* means "respect" and it is bestowed on professionals because of their position of knowledge and authority. Latinos also expect respect from the clinician, especially when the provider is younger than the parent. Unfortunately, this cultural value may lead patients and families to behave in an overly passive manner, for instance, not asking questions when instructions are unclear or questioning the clinician's diagnoses; all variables that would lead to high attrition rates.

SERVICE UTILIZATION PATTERNS

Table 6.1 presents some of the major systems available to Latino families. The list is divided into five categories: *Informal Support Network*; *School-Based*; *Primary Care*; *Mental Health Services*; and *Juvenile Justice System*.

There is some evidence indicating that in their quest for finding a solution to their child's difficulties, Latino families often consult and seek assistance from members of their nuclear and extended family first before reaching out to service providers.[90] It is not clear for what problems or in which circumstances would families need to continue their search for other sources of help beyond their social network. There are a number of other sources of support often used by Latino families, including community and religious organizations, folk healers, *botánicas* (herbal remedies) and

Table 6.1
Service Utilization Patterns

Service Categories				
Informal Support Network	**School-Based**	**Primary Care**	**Mental Health Services**	**Juvenile Justice System**
–Family and lay advisors	–Mental health clinic	–Referral services	–Pharmacological treatment	–Rehabilitation services
–Community/ religious organizations	–Individualized education plan (IEP)	–Pharmacological treatment	–Child and family therapy	–Counseling
–Promotores de salud	–Special accommodations (Section 504)	–Parent education	–Parent education	–Pharmacological treatment
–Botánicas	–After school program			

promotores de salud or health promoters.[91,92] However, it is likely that the use of these informal sectors of care vary according to country of origin and acculturation level.

Treatment and intervention for most Latino children with behavioral, emotional, and school problems are provided in schools or in primary care. Studies have consistently found that pharmacological treatment for behavioral and emotional disorders is often prescribed in primary care by practitioners without mental health training.[93] Latino children would be better served by specialized mental health providers. Unfortunately, access to a mental health practitioner is highly dependent on having health insurance with mental health coverage, a benefit that most Latino families do not have.[94]

The juvenile justice system is playing an increasingly important role in the mental health care of juveniles in the system.[95] Many Latino youth receive mental health services in this sector of care.[96] However, based on cultural norms and values (e.g., fear of stigma; lack of familiarity with mental health system), and socioeconomic and legal variables (e.g., lack of health insurance, residency status), schools appear to be the ideal setting for serving Latino children who exhibit behavioral, emotional, and/or learning disorders. The special role of schools in addressing children's mental health concerns is discussed in the next section.

SCHOOL-BASED MENTAL HEALTH SERVICES

Research suggests that low-income minority children and adolescents are more likely to seek mental health services from school-based health centers (SBHCs) or community-based providers, rather than through traditional hospital-based clinics or specialized mental health-care providers.[97–99] For example, Trina Anglin and

colleagues reported that up to 63 percent of students with access to SBHCs utilized their services, with female Latina students having the highest rates of use; emotional problems represented the largest diagnostic category among this population.[100]

In an effort to reduce service disparities among low-income families, many health-care professionals now advocate for funding and resources to be directed toward the development of school-based mental health services in order to promote health-care utilization in underserved communities.[101–103] This impending shift toward expanded school mental health (ESMH) programs may have the greatest potential impact among the populations that experience significant barriers to health-care access, such as low-income, urban, Latino children.[104]

SBHCs have been used to address a wide range of behavioral, academic, and social issues.[105] There is a growing body of literature demonstrating that SBHCs can produce positive treatment outcomes for numerous behavioral health problems among Latinos,[106] and can help reduce underutilization among low-income populations.[107] Susan Foster and colleagues conducted a national survey of mental health services in a sample of over 2,125 public schools and 1,595 school districts, and reported that one fifth of students received some type of school-supported mental health services. In addition, approximately 80 percent of schools in the sample provided some type of mental health service.[108] However, the prevalence of expanded school mental health programs serving Latino youth and families has not yet been well-documented.

FUTURE DIRECTIONS

The help-seeking behavior pathway model may be useful in generating studies to investigate factors that hinder or facilitate the use of services by low-income Latino families. Although research demonstrates that poverty can potentially hinder service use among low-income Latino families through its influence on financial variables that affect help-seeking (e.g., access to health insurance, ability to afford costly services, etc.), more research is needed to investigate how SES moderates the relationship between culture and health-care utilization among low-income Latino families. For example, what is the role of poverty in the development of Latinos' beliefs about health, illness, and mental health treatment? Some research suggests that immigrant Latinos may hold cultural health beliefs that differ from those that dominate the traditional American biomedical model of health and illness,[109] yet, it is unclear to what extent lack of education, marginalization, and poverty contribute to the development and maintenance of these beliefs. Research also suggests that more educated Latina mothers are better able to understand complex treatment plans for children with ADHD, and therefore may be more likely to use and adhere to treatment than Latina mothers with less education.[110,111] Thus, other factors associated with poverty (i.e., poor educational opportunities, low literacy rates, marginalization) may help shape the cultural beliefs that ultimately contribute to help-seeking behavior among low-income Latinos.

Much research has been conducted on the role of acculturation on health outcome for Latinos. However, no studies have been conducted on the role of acculturation in parental help-seeking behavior. It would be important to know whether thresholds for differentiating normal from abnormal child behavior vary as a function of acculturation among Latino parents. It would also be important to know if acculturation moderates the effects of factors that predict problem recognition. Do stigma and attitudes toward mental health services predict the decision to seek help and does the prediction vary as a function of different acculturation levels? Does increased knowledge about mental health and the mental health system lead parents to become more active in seeking help for their children? With regard to service utilization, under what conditions do familism or social networks facilitate or hinder use of professional services? Would improving certain service conditions such as availability of interpreters and culturally sensitive staff lead to a decline in patient drop out rates?

Research using this model may facilitate decision-making regarding health policy, and health-care administration and practice. For example, decision makers in health policy might be interested in determining whether the gap in service use is smaller in high-risk communities that offer school-based behavioral health services to Latinos and other minorities, as compared to communities that do not. This type of research might lead to policies that support the creation of SBHCs in all underserved communities. Health policy decision makers may want to identify ethnic-specific strategies for disseminating information about mental health disorders to promote the development of health beliefs that are more consistent with what is known about the causes and treatments for mental health disorders, while promoting respect for the individual's cultural values and traditional beliefs. Decision makers in health-care administration might want to determine the acceptability and feasibility of offering mental health services in nontraditional settings such as in churches and other community settings. Would services provided in these settings lead to an increase in adherence to treatment and a decrease in attrition? Direct service providers might test the acceptability and adherence to effective treatments for common mental health disorders as originally developed, versus modified versions of those same treatments that incorporate culturally sensitive content.

In summary, Latino children continue to lag well behind their nonminority counterparts in the rate of diagnosis and treatment for behavioral, emotional, and academic disorders. This chapter describes factors that are hypothesized to affect the help-seeking behavior of Latino parents who have children with behavioral, emotional, and/or academic disorders. Factors are integrated within the framework of a modified theoretical pathway model,[112] encompassing problem recognition, decision to seek help, and service utilization. The authors hope that this model will spur research on the causes of service disparities among Latino children.

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112. See note 12 above.

CHAPTER 7

Perceptions of Help-Seeking and Mental Health Service Use Among Parents of Head Start Children

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The 2001 Surgeon General's report on race, culture, and mental health states that ethnic minorities suffer from mental health disorders at approximately the same rate as nonminorities, but they do not seek or utilize services at the same rate.[1] Specifically, African American children tend to under-utilize outpatient mental health services compared to white Americans.[2] While African American children appear to be underserved by mental health service systems, they are over-represented in other service systems, including foster care and juvenile justice, and public institutions such as residential treatment centers and community mental health services.[3–6] Thus, research is necessary to understand why African Americans do not utilize services at the same rate as white Americans and what barriers might be perceived to children receiving early and effective interventions.

A number of factors have been suggested to explain the lower rates of mental health service utilization among African American children; most notably, barriers related to access and availability have been commonly cited in the literature.[7] However, less often discussed are attitudinal barriers toward mental health and service use that may be equally critical to determining timely service use. Cultural factors, such as race and low-income status, have been hypothesized to influence the attitudes and perceptions of parents toward mental health and service use, but these factors have not been examined thoroughly.[8] The purpose of this study is to examine low-income African American parents' perceptions of mental health services for preschool children in order to gain an understanding of how these perceptions might influence help seeking. The study uses in-depth qualitative interviews with parents of children enrolled in urban Head Start programs in the Detroit area.

BACKGROUND

Despite recent evidence that children's use of mental health services has almost doubled since 1986, ethnic minority children receive far fewer mental health services than white children.[9] According to a report funded by the Annie E. Casey Foundation, fewer black (19%) and Hispanic (14%) children receive services in comparison to whites (65%). The majority of children receiving services are adolescents aged 13–17 (51%), in comparison to children aged 6–12 (40%) and preschoolers (9%).[10] Research on the under-utilization of mental health services for African Americans has consistently pointed out that African Americans are less likely to have received care provided by mental health specialists, and less likely to have received services in outpatient and school settings.[11–14] The reasons for under-utilization have focused on various factors associated with help-seeking behavior, including instrumental and environmental factors such as socioeconomic status, lack of health insurance, and the inaccessibility and unavailability of services. Lack of heath insurance in particular is an accessibility barrier for African Americans, as nearly a quarter of African Americans are uninsured.[15] Also, research has shown that mental health services are not readily available in rural areas where higher proportions of African Americans live, particularly in the South.[16] In addition, in urban areas where services may be more readily available, service providers may not accept Medicaid or serve only high-need individuals who display severe, problems, thus rendering services unavailable to urban African Americans who are represented disproportionately in poor communities.[17]

However, these barriers may not be the only factors associated with help-seeking behavior. Research has shown that even when African Americans have health insurance, their levels of service use are still lower when compared to whites.[18] Specifically, attitudinal barriers associated with perceptions of mental health problems and service use may influence help seeking behaviors. Owens and colleagues found that of parents who reported barriers to mental health services, 20.7 percent reported structural constraints (e.g., too expensive, inconvenient, no transportation, unaware of where to go), 23.3 percent noted their perceptions of the mental health problem (e.g., problem not serious, decided to handle problems on own), and 25.9% cited negative attitudes toward services or the receipt of services as barriers (e.g., past negative experience, thought treatment would not help, stigma, did not know who to trust, child did not want to go).[19] Richardson uses social cognitive theory to understand how positive outcome expectations encourage the decision to engage in mental health service use. She reports that African American parents held disproportionately negative ideas and attitudes about the mental health profession and were twice as concerned about disapproval from family members, others knowing, and embarrassment about seeking services.[20] Research by Diala and colleagues found that African Americans had more negative views about the mental health field after receiving services when compared to whites.[21] In a study on attitudes of low-income Head Start parents toward seeking help with parenting, families were found to be less likely to believe in or seek out help than families with higher incomes.[22] Head Start families reported family, books and videos, telephone help-lines, and friends

as the most frequent sources of help. However, using data from the Epidemiological Catchment Area (ECA) study, Snowden found that African Americans were less likely than whites to report turning for assistance to a friend, family member, or religious figure.[23] Snowden also found that African Americans tend not to use informal help as a substitute for formal help, but in conjunction with formal help.[24]

In addition, varying expressions and explanations for illness may influence service use and treatment seeking. A study of treatment preferences for depression found that urban African American adults were more likely to prefer to "wait it out" rather than seek professional help for depression, perhaps perceiving symptoms as likely to spontaneously remit.[25] In relation to service use, Snowden found that folk symptoms and idioms are associated with voluntary help seeking among African Americans.[26] Studies investigating cultural perceptions of illness and etiology associated with children's mental health are needed. If culturally based explanations are prevalent, this may explain why there is a delay in the use of early preventive services and greater use of public services and institutions when symptoms are more severe. In part, the purpose of this study is to investigate whether cultural perceptions may play a role in determining help seeking patterns. Understanding how low-income, African American parents perceive mental health service use is important for early childhood mental health research because it informs researchers and professionals of possible intervention strategies that might effectively reach the most children within this segment of the population.

METHODS

Sample and Procedures

Respondents in this study were parents of preschool children enrolled at Head Start centers in Detroit, Michigan. Head Start is a federally funded program designed to augment the academic, social, health and mental health development of children from poor families with quality preschool programs that provide instruction and services to benefit several aspects of child development at ages 3 and 4. The sample consisted of 29 primary caregivers (27 mothers and 2 fathers), all of whom were African American and low-income. Based on available demographic information on parents at participating centers, there were equal numbers of male and female children, 88 percent of families met the federal government poverty income standards, about 40 percent had not completed high school, and the highest level of educational attainment was a high school diploma for about 50 percent of the parents. About 80 percent of the parents were single parents and over half of all mothers were teen parents. In addition to parents, a smaller sample of 10 Head Start teachers were also interviewed, however, only parent data are utilized in the present study.

Participation in the study was voluntary, whereby parents responded to flyers posted in Head Start centers. Study staff also recruited parents through referrals from classroom teachers. Trained graduate and undergraduate research assistants

participating in a yearlong community-based research and service learning internship conducted the interviews with parents (45–60 minutes per session). Parents were interviewed at their child's Head Start center in a private space (typically a conference room, unused classroom, or office) where confidentiality was assured. All of the interviews were audio taped with the permission of the parent. Parents were debriefed at the end of each interview and given contact information about the project and other community resources that provided more information about the interview topics.

Measures

The interview protocol was designed as an open-ended, semi-structured interview with the intent of initiating discussion related to several broad areas of parents' perceptions of child development, behavior problems, gender differences in behavior, risk and protective factors, and service utilization. We ended the interview with positive mood induction questions where parents could comment on their positive feelings about 3–5-year-old children.

At the beginning of the interview, parents were asked to think about a preschool-age child they knew that was not necessarily their own child. Parents could reference their own child, but were not asked to do so. We hoped that by not asking parents to reference their own child that it would elicit more honest and candid responses to the interview. Interviewers were trained to be nonjudgmental in their response to the answers that parents provided and were instructed to prompt parents for additional information or to provide clarifying statements that were nondirective and reflective of the meaning that parents derived from the questions.

Data Analysis

The audio taped interviews were transcribed verbatim into a text document format by undergraduate and graduate student research assistants and 25 percent were checked randomly for accuracy. Each interview was labeled specifically for the particular day and time of the interview and the type of interview (parents or teachers) was noted. Once the data was transcribed, it was formatted and loaded into ATLAS/ti, a qualitative software program that is used to organize data and aid in data analysis. The investigators conducted a two-stage coding procedure. The first stage of coding involved the development of a set of broad themes that reflected the research questions of interest. A total of 30 themes were developed (such as *environmental influence*, *origin of problems*, *service use,* and *potential solutions*) and definitions were developed for each theme to clarify the intended meaning and produce inclusion/exclusion criteria for the coders. The study investigators began by coding the data as a group and discussed the use of the codes extensively. Definitions for the themes were revised further to tighten the inclusion/exclusion criteria. Once consistency and understanding of the codes were established, two research assistants coded the remaining interviews independently. Codes were confirmed or revised under the supervision of the principal investigators (first and second authors) and queries were run using the ATLAS/ti

software. The queries used the codes to pull units of data relating to the broad themes.

Three pairs of individuals on the research team were formed to analyze the units using both open and axial coding of the data to capture embedded concepts and meanings.[27] The pairs then met to compare their findings under the supervision of the investigators. Further, findings were discussed in ongoing meetings with Head Start program personnel, in an attempt to check the validity of the distilled data. The concepts that emerged from these analyses were confirmed or revised based on these meetings and repeated for all of the queries. The final step was to use these concepts and their text examples to organize evidence for the research questions. The results of these analyses are reported below.

RESULTS

Qualitative axial coding and analysis yielded several themes. Parents identified various resources for children's emotional and behavioral problems, including informal help seeking, self-reliance, formal services, and community resources. Specifically, parents had a stronger preference for informal help seeking and self-reliance. While parents endorsed formal service use as a possible resource, they expressed concerns that reflect the structural and sociocultural realities of low-income, African American communities.

Informal Help-Seeking and Self-Reliance

In response to where parents might seek help for a child displaying behavioral and emotional problems, parents overwhelmingly identified informal resources over formal mental health services. Informal resources include talking to friends or family members. Parents also spoke of getting advice from other parents who might be dealing with the same situation they are experiencing. Head Start teachers were another important resource cited by parents. It should be noted that many Head Start teachers are former Head Start parents and therefore could be possible role models in the community. Parents often expressed the need for "advice" for helping their child. For example, one parent reported,

> If my child had, was violent, or depressed, or displaying bad verbal behavior, I would turn to a neighbor, another family member, uncle, aunts, grandparents, you could also go to a teacher, there's so many, a coworker. I really would go to them.

Positive role models also could include other members of the community, particularly when children's home environments are less than ideal.

> Positive role models. A lot of times a child can come from bad home where emotional abuse happened. But if they have a community or teacher or positive role models. A lot of times that positive role model can grab that child and can teach them, you know, when

> all the other brothers and sisters end up in jail. And this one child became an educated and successful adult, because of their positive role models.

The pastors and ministers also were cited often as important sources of advice. Spiritual guidance, expressed as going to church, was other ways in which religion and spirituality were important informal resources.

> With my family, because we go to church, so a lot of times if we're having problems, we can go to our pastor. You can ask him for advice, you know.

In addition to informal resources within the community, self-reliance in the form of "parent knows best" was a recurrent theme. This parent's response emphasizes the need to take care of one's own problems and not seeking advice or assistance outside the home.

> The only person I could see them asking would be their parents, like the current parents. I could never see myself asking a stranger for some advice on how to raise my son; you know that's like all instinct.

Also, parents talked about instilling certain "values" into the lives of their children as a way of dealing with emotional and behavioral problems. Some parents described what they themselves could do to mediate emotional and behavioral problems. These often were expressed through their perceptions of positive values and positive parenting practices. Not only did these values include moral values, but also parents emphasized the need for children to overcome their current situation, including poverty and high-risk neighborhood conditions, and to always strive to improve one's life.

> Well, yeah, um, I would think, regardless of where you live, good or bad community, you know, as long as you are there for your child, instill morals, go to church, positive things. Letting them know there's more to life than just here, where we live. You know, we're just here now, but when you get older you can become whatever you want. And if you choose to do better, fine. If you choose to stay, fine. But never become worse, always strive for better.

Formal Service Use

While parents typically endorsed informal resources and self-reliance for seeking help for children's emotional and behavioral problems, there was some discussion of the need to seek professional help. Several parents noted that they would only seek professional services as a secondary source of help or when a child displayed severe and consistent emotional or behavioral problems, and after other resources were attempted first.

> Number one thing would make this gentleman get better, is the parent have to get more involved. The parent not just getting involved in what he does, but get involved with him.

> Sit him down, talk with him, um, let him understand something, if not, seek some professional help, um, because of what the child have seen over the years . . . Um, professional help, you know, and really home training, home training would take the course.

One parent described the need for professional help to assess why a child may be displaying difficult behaviors. This parent viewed professional services positively as a way to diagnose the problem without putting the blame on parents or the child.

> I think if a child is showing violence or kinda withdrawn or is um, different things that they can do that sometimes its not just that parent that's doing something wrong, maybe something within the child. So I think if you're having these problems (with) your child, don't just naturally assume this is a bad child. You know, sometimes you need that professional advice to find out what it is.

Furthermore, when parents discussed the need for professional intervention it seems they were interested in seeking advice rather than obtaining medication or other formal interventions. In fact, no parent mentioned medication or psychotherapy specifically as sources of professional assistance they would seek out. In general, parents descriptions of formal services were vague and without detail. For example, specific services were not noted, nor were specific places where services might be obtained.

When parents were asked why they would not choose professional help first, they referenced many barriers, including lack of information about the availability of mental health services and an overall lack of formal resources in their neighborhoods. However, even when professional service may be available to them, many parents expressed feelings of distrust, skepticism, and fear of misunderstanding on the part of mental health professionals. Parents even questioned the competence of mental health professionals in truly being able to serve their children without stigmatizing them. For example, one parent stated:

> They don't know that much about mental health. They think that um, a child, they put children in boxes of good and bad and they don't understand that some children don't, they lack skills and need assistance. They don't understand.

Also, parents expressed concern that they would be blamed for their child's behavioral or emotional problems and that the impact of community and structural barriers faced by these families would not be recognized. Again, self-reliance was the preferred alternative, which would assure that parents would not be blamed and children would not be "taken away" from parents. For example, one parent stated,

> So just somebody who can actually give that kind of focus of help or psychological help. But then again, today's society is so afraid to do so because society is quick to take their kids. So it's a catch-22 thing. Like get help for my kid, then they're gonna blame me as the fault for it and then take my kids and I don't want that. So I do what is the best I know how. So society also has to let up on how much authority you can take from me.

Community Responsibility

In addition to informal and formal services, parents expressed a need for a community response to addressing the needs of children with emotional and behavioral problems. This response included structural changes in the social environment as well as enhanced community values such as cohesiveness, neighborly/village communication and involvement, safety, stability, and caring. For example, one parent stated,

> Ok, well . . . it goes back to getting involved, and looking at what's going on in the community, trying to put a halt to the situation, having development groups, having community involvement, having watch, neighborhood watch, having community awareness, police protection, just basically whole village involvement and to clean up the neighborhood, to clean up the community. And when we say clean up, let's go door to door, let's talk to families, let's see what's on families' minds, let's see what families are doing, what are their next steps. Are you shooting for the future or do you just want to stay in the past? And now, and now, are we going to get this neighborhood together? Are we going to live adequately or are we just going to live in dumps or are we going to live in good communities? Are we going to clean our areas up, not filthy? Get into the yards, let's clean things, now are we going to do this or are we going to stay right here? And that's definitely a big concern.

The theme of the "village" taking care of and looking after children was often repeated. The idea of the village extends the notion of informal help seeking, beyond family and friends to loose networks of parents and adults. However, in order for these systems to be effective, there needs to be greater sense of community and communication among its members. One parent summarized this idea in the following way:

> Yes, yes I do think it goes back to when I was talking about the village. If you would have or lived in a community of people that's just able to help one another um, we as generations coming up we need to be involved, we need to be involved, we need to help others, and helping others is not going to borrow nothing, but just helping means looking out, looking amongst what their children are doing. If the children are playing rough then go stop the children. If their doing something that you know that it's not right, stop them. Tell the parents, talk more. Nowadays, parents just run by each other. All they do is say hi and bye. The community is failing because there is no communication in the community, no communication.

DISCUSSION

A major goal of this study was to understand low-income, African American parents' perceptions of help seeking and use of children's mental health services. Several themes emerged from the data. First, a few parents endorsed the use of professional services, except for children and families experiencing severe problems. However, these endorsements lacked specificity and focused on advice and assessment rather than treatment modalities such as medication or psychotherapy. This finding is consistent with the literature that speaks to the under-utilization of services or the

delayed use of services when problems become too difficult to deal with on one's own. Parents also discussed the lack of available services and noted several barriers to service use, including not knowing where to go or whether or not services would be provided in a respectful and understanding manner. Stigmatization is a major fear of parents who don't want to be blamed for their children's behavior problems and don't want their children labeled as "bad" children. Parents' fears of labels also may stem from not wanting their children to be placed in special education or self-contained classes, which they view as a trajectory of future failure.[28] Furthermore, parents who may use socially undesirable discipline techniques like corporal punishment to deal with their children's behavior problems may fear that their children might be taken away from them. Thus, the environmental conditions that lead to stress among families, which may lead to less than desirable parenting, and subsequent emotional and behavioral problems in children create a "catch-22" for parents who may know that they need help, but fear the consequences of seeking formal services rather than embracing the possibility that services might actually help their children or even help them to become better parents. In other words, parents fear that formal services will focus on the individual behaviors and troubles of parents and children rather than acknowledge and address structural issues, including poverty, which may be at the root of the problem.

Informal sources of support, on the other hand, were referenced by parents in greater detail and included the use of spiritual leaders, friends, relatives, coworkers, and other parents for help and advice. Trust, level of comfort, and accessibility of these resources are likely to inform the decision to seek help first from within the community before seeking out professional services. Teachers also were trusted sources and were viewed as positive role models for parents in their Head Start community. While these informal resources can prove to be an invaluable first line of defense for dealing with children's behavior problems, there are limitations to this approach. First, these individuals likely are not trained in children's mental health, and the advice offered may or may not be good. In fact, it may be detrimental. For example, friends or family members may suggest punitive or authoritarian approaches to parenting, which are not responsive to children's emotional needs.[29, 30] The use of ineffective approaches provided by informal resources also may delay the onset of service use that may be beneficial to children.

However, rather than discourage the use of these natural helpers in the environment, a more useful approach may be to provide information and training to these community resources who are most likely to be approached for advice, such as Head Start teachers and ministers. One possible approach to the use of natural helpers that has demonstrated effectiveness is the community health worker model, which enlists indigenous members of a given population to channel information, social support, tangible aid, and referrals to external resources to individuals and groups within the community. The success of community health worker interventions are evident in the Centers for Disease Control and Prevention's (1994) two-volume directory of lay health advisor projects and programs in the United States.[31] These studies have been found to be particularly successful in racial and ethnic minority communities

(i.e., barbers and church members nominated by their pastors to encourage screening for hypertension among African Americans; migrant farm worker women served as *promotoras* to address the maternal and child health needs of families traveling in the Midwest and East Coast Migrant Streams). To date, this model has been used largely in the health arena, but could hold considerable promise in promoting effective parenting and positive mental health.

Parents also expressed concern about environmental conditions (e.g., drugs, violence, illegal dumping, and abandoned houses) and believe that children could be helped by communities taking greater responsibility for "cleaning up" the neighborhood. The concept of communal responsibility is congruent with popular notions of child well-being that evoke nostalgic feelings of the way things used to be when neighbors looked after one another and everyone knew whose child belonged to whom. Embedded in this concept is the notion of community empowerment and capacity building, where communities have the power and the ability to control their own destiny and future. Solutions for individual problems arise from collective action from within, and not necessarily from external political or economic forces or interventions. While this approach may be desirable and even advocated by community psychologists and social workers, poor communities of color should not bear the full burden of rectifying inequalities that are perpetuated by society at large. We can applaud and encourage the hope, and utilize the many strengths within poor communities of color, but at the same time, we must continue to work toward socially just policies and antipoverty approaches that will create structural changes to enhance a community's ability to help themselves. At the same time, we must also work toward eradicating the stereotypes of the poor and populations of color that maintain disparities in service use in formal settings.

While this study illustrates the importance of understanding parents' perceptions of help seeking and service use among poor, minority populations, the limitations of this study should be noted. First, the sample drawn for this study was not random and thus selection bias may have influenced the responses. It is possible that the sample consists of parents who were most willing to be interviewed and least likely to have children with mental health issues. Additionally, the sample is relatively small by the standards of quantitative research, but adequate for a qualitative study. Second, our data reflects parental perceptions and not actual behavior. In order to reduce bias and socially desirable responses, we did not ask parents directly about their own child or their past experiences with service use. Rather we assumed that parents would feel free to speak more candidly if they were asked questions about a hypothetical child they may know. Finally, our results may be biased by the use of university students as interviewers. Although these students also worked in the classrooms with teachers and children as part of a community service learning project for the entire academic year and parents had a number of opportunities to see and interact with the students, parents still may not have been comfortable interacting with students in the context of an interview or may not have wanted to appear lacking in competence around children's behaviors or parenting. Parents may have feared that information would be relayed back to teachers, despite assurances of confidentiality, or that their responses

would be tied to their own child's classroom behavior. Student interviewers were generally not from the Head Start communities we drew our sample from and their status as outsiders may have been a barrier to participation in the study or may have influenced parents' responses. Race and class differences between interviewers and parents may have also contributed to bias in responses.

Overall, the results of this study suggest that understanding parents' perceptions of help seeking and services has implications for the design of interventions for low-income, African American families. Barriers to service use associated with socio-cultural conceptualizations could be reduced through careful consideration of these perceptions in early prevention models of practice and intervention development. Increased access to preventive practices could have implications for reducing more serious problems that limits opportunities in adolescence and adulthood. For low-income, African American parents, we must start by changing perceptions through increased culturally appropriate and acceptable services that begin in early childhood.

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CHAPTER 8

IMMIGRANT STATUS, POVERTY, AND CHILD HEALTH

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Children of immigrants are growing in numbers and face greater economic hardships than children of U.S. natives.[1,2] In 2000, one in five children in the United States had a foreign-born parent, and one in four low-income children was an immigrant's child.[3] While, in the past, poverty rates among children of immigrants were lower than among children of natives, the situation has been reversed. Currently, 22 percent of children of immigrants under the age of 18 live in poverty compared to 15 percent of children of natives and 10 percent of non-Hispanic white children.[4] This substantial economic disadvantage would be expected to produce corresponding health and healthcare disparities, considering a well-documented relationship between poverty and poor health.[5,6] However, the picture is mixed. Overall mortality and morbidity risks are lower among immigrant children and adults than among their native counterparts.[7–12] On the other hand, children of immigrants fare worse on some measures of well-being such as parent-reported health status,[13,14] and they have lower healthcare utilization rates.[15]

Despite growing interest in the well-being of children in immigrant families, the literature is still limited. A prior in-depth assessment of health status and adjustment of children of immigrants[16] relied on data from the mid-1990s, and a more current study is now needed. Recent health comparisons of children of immigrants and children of natives focus on access to health care and/or include only a single indicator of physical health and a few indicators of mental and social well-being, for example, negative behaviors and school and extracurricular activities.[17,18] A comprehensive immigrant–native comparison including multiple indicators of health and health care use has recently been conducted only for adults;[19] a similar study on children is warranted. Furthermore, little attention has been given to diversity of the immigrant population. Even treatment of the large, and the most economically vulnerable,

Hispanic/Latino population is sparse and lacking systematic research.[20,21] Finally, past studies might have underestimated immigrant disadvantage by including in the definition of "immigrant" children with one foreign-born and one U.S.-born parent. Children with both parents foreign-born may be more vulnerable than those whose at least one parent is a U.S. native.

The goal of this study was to examine the relationship between child health, immigrant status, and poverty. Specifically, we aimed to compare the extent of health-related disadvantage among poor children based on immigrant vs. native status. We defined immigrant children as having both foreign-born parents and native children as having at least one U.S.-born parent. Our analysis is based on a nationally representative sample of U.S. children. We include multiple health/health-care indicators and examine the role of immigrant background by racial/ethnic status as well as parental region of origin.

THEORETICAL FRAMEWORK

It is clear that poverty and health are strongly related.[22,23] Poverty leads to poor health outcomes, and it can also result from poor health. In general, access to health care, which may depend on socioeconomic resources, plays a relatively small role in population health, but medical care saves individual lives, decreases suffering, and improves functioning. Poverty can put children at risk of poor health regardless of family native background. However, the intersection of two or more kinds of social disadvantage (e.g., poverty and minority status) is likely to exacerbate the situation. To what extent children from immigrant families experience the burden of minority and socioeconomic disadvantage in health is yet to be shown. Several perspectives should be considered.

Economic and Political Migration

Many immigrants seek economic opportunities in the United States and a chance to attain higher standards of living. Some immigrants were economically disadvantaged before entry to the United States and their disadvantage continues in the United States because of low-pay employment, discrimination, and segregation.[24] This group tends to consist of emigrants from less developed and/or economically troubled countries (e.g., Mexico). In the United States, they face economic, legal, and linguistic barriers to health care, resulting in under-utilization of medical services and reducing their chances for optimal health. Refugees are another highly vulnerable population. Coming from conflict and poverty stricken regions of the world (e.g., Africa), they may have special health needs (e.g., dietary, mental health) which are often not adequately addressed because of access-related and communication barriers.[25,26] That said, economic and political immigrants are often better off in the United States than they would have been in their home countries, and, thus, relative poverty may not affect them as much as U.S. natives.

Immigrant Selection and Assimilation

A potential advantage that immigrants have vis-à-vis U.S. natives, at least at baseline or time of entry to the United States, is their relatively low prevalence of disease and disability.[27] People who migrate tend to be healthy based on logistic (e.g., travel, employment) and legal requirements of immigration (e.g., health screening component of visa application). However, the health status of immigrants is likely to change with length of stay and each new generation born in the United States.[28,29] Some immigrants may be able to attain higher health status during their stay in the United States due to the advanced American health-care system or their assimilation into the "health" culture of American society. For example, families may take advantage of availability of vaccinations and get children protected against disease. Other immigrants' health may worsen in the course of assimilation because of the health risks embedded in the American culture (e.g., fast food consumption, inactive lifestyles) or because of limited access to health-care.

Cultural Diversity

Finally, it is important to keep in mind that immigrants come from various cultures, which continue to shape their health-related attitudes and behaviors.[30] Health consciousness may be high in some immigrants and they will seek health services and/or pursue healthy lifestyles despite their limited resources and barriers faced within the healthcare system (e.g., communication). For example, Cubans, who come from a system of socialized medicine, which has made great strides toward disease eradication and health promotion, may have good health habits and use medical services on a regular basis. Asians may practice holistic health and use complementary/alternative medicine, following their traditional cultures. As noted above, these attitudes may change during the assimilation process—with positive or negative consequences for health.

HYPOTHESES

Our central goal was to assess how poor children of immigrants fare in terms of health and use of healthcare vis-à-vis their native counterparts. We expected that overall health and health-care use would be lower among children of immigrants than among the natives because of the additional burden/barriers associated with immigrant and minority status. However, this relationship was expected to be moderated by racial/ethnic status; that is, racial/ethnic minority natives were expected to have the same or worse outcomes than children of immigrants. Also, we expected some variation within the immigrant population based on length of U.S. stay and parental place of origin. The effects of length of stay were thought to be positive and negative, as explained above, and thus, possibly balance each other out. Children of immigrants from less developed countries were expected to fare worse than children of immigrants from advanced societies. The former group was expected to fare worse while the latter group was expected to fare better than U.S.-native children.

METHODS

Data

In this study, we used data from the National Health Interview Survey (NHIS), a multipurpose health survey conducted annually by the National Center for Health Statistics (NCHS), Center for Disease Control and Prevention.[31] The survey is based on a probability sample and personal household interviews. Using appropriate weighting procedures, results based on these data are generalizable to the U.S. population. The weights were calculated by NCHS staff to produce estimates consistent with the population estimates by age, sex, and race or ethnicity, based on projections from the 2000 U.S. Census. In addition to basic sociodemographics and an extensive health component, the NHIS contains information on the respondent's place of birth by region. This information is more detailed than in any other national health survey.

We used 3 years of data, 2001, 2002, and 2003, in the study. A preliminary study showed no significant changes of the study variables over time. We combined the 3 years of data to increase the reliability of estimates and the power of tests for some of the smaller population subgroups.

Data were derived from two NHIS files. Sociodemographic infomation, health insurance status, and general health status were derived from the Person File (household head report) while data regarding specific health conditions were derived from the Sample Child File. A total of 80,400 children under 18 years of age were identified based on the Person File. There were 54,596 children (68.2%) whose parents had valid birthplaces and who, hence, were eligible for the study. For most of the variables from the Person File, the overall percentage of unknown values was small, usually less than 1 percent. However, 25.4 percent of the cases had missing family income information or the respondents stated that their combined family income was either less than $20,000 or $20,000 or more without providing additional detail. Therefore, poverty status, which is based on family income, also has a high nonresponse rate. Also, 3.5 percent of cases were missing parental education data.

A total of 38,477 children were obtained from the Sample Child File, with 25,741 (66.9%) children whose parents had valid birthplace and who, hence, were eligible for the study. The unknown or missing rates for learning disability, and attention deficit-hyperactivity disorder/attention deficit disorder (ADHD/ADD) were 19.1 percent and 12.9 percent, respectively. Cases with missing values were excluded from computation.

Measures

Our dependent variables included health status, health insurance, and health-care use indicators. Our main independent variables were immigrant status and poverty status. Other covariates included age, gender, race/ethnicity, and parent education.

Health Status

General health status is parent-reported health status based on a question in the survey that asked respondents, "Would you say (child's name)'s health in general is excellent, very good, good, fair, or poor?" Parents also reported change in child's health status by responding to the question, "Compared with 12 months ago, would you say (child's name)'s health is now better, worse, or about the same?" In addition, we examined indicators of the most common childhood health problems: asthma, allergies (hay fever, other allergies), a learning disability, and ADHD/ADD.[32,33] If they were ever told their child had asthma, a learning disability, or ADHD/ADD was indicated with an affirmative response to the question, "Has a doctor or other health professional ever told you that {child's name} had {condition}?" Had asthma attack in past 12 months is based on the question, "During the past 12 months, has {child's name} had an episode of asthma or an asthma attack?" A similar question was asked about hay fever and other types of allergies. In addition to general health status and specific conditions, we examined prescription medication use based on the question, "Does {child's name} now have a problem for which he/she has regularly taken prescription medication for at least 3 months?" and for school-aged children (5–17 years), number of missing school days in the past 12 months.

Health Insurance

NHIS respondents were asked about their health insurance coverage at the time of interview. For children, types of insurance were classified as follows: private (obtained directly through employer or workplace, purchased directly, or through a local or community program), Medicaid (and/or other State-sponsored health plans including State Children's Health Insurance Program, or SCHIP), other coverage (e.g., military or other government programs), and uninsured (including persons only covered by Indian Health Service, or IHS, or a plan that pays for one type of service such as accidents or dental care).

Health Care Use

We used several indicators of health-care utilization: usual source of health care, last health-care visit, number of emergency room (ER) visits, and last dental visit. Respondents were asked about the place where they go most often when the child is sick, with the following response categories: clinic or health center, doctor's office or HMO, hospital ER, hospital outpatient department, "some other place," and "doesn't go to one place most often"; we used a dummy-coded variable indicating lack of usual source of healthcare (the last response category). Respondents were also asked if the child saw a health professional and had two or more ER visits in the past 12 months. In addition, respondents were asked about the child's last dental visit using a question, "About how long has it been since (child's name) last saw or talked to a dentist? Include all types of dentists, such as orthodontists, oral surgeons, and all other dental specialists, as well as dental hygienists." Responses were categorized as follows: "6 months or less," "more than 6 months but not more than 1 year ago," "more than

1 year, but not more than 2 years ago," "more than 2 yrs, but not more than 5 years ago," and "more than 5 years ago." We dichotomized the variable as "in the past 12 months" vs. "more than 1 year ago."

Immigrant Status and Length of Stay

Immigrant status is measured by parental place of birth: U.S. versus foreign-born. Immigrant children are defined as having both foreign-born parents; native children are defined as having at least one U.S.-born parent. We also use a detailed parental region of birth variable. The NHIS region of birth variable categorizes all respondents into one of 12 categories according to the CIA online World Factbook.[34] Due to a small number of cases in some categories available for our analysis, we combined some regions and used the following five categories of detailed parental region of birth: (1) United States, (2) Mexico, Central America, Caribbean Islands, and South America, (3) Europe and the former USSR, (4) Asia, and (5) "Elsewhere." In addition to parental place of birth, we examined length of stay in the United States, which is measured in NHIS using the following time intervals: "less than 1 year," "1 year, less than 5 years," "5 years, less than 10 years," "10 years, less than 15 years," and "15 years or more." We combined these categories into: "less than 5 years," "5 to 10 years," and "11 or more years."

Poverty Status

The poverty status variable is based on adult respondents report of family's income (total combined income before taxes from all sources for the previous calendar year), information supplied either as a dollar amount or as an interval estimate. This variable is the ratio of family's income to the corresponding year's poverty threshold defined by the U.S. Census Bureau, considering the family's size and number of children. In our study, we dichotomized poverty status as "less than 200 percent of the poverty threshold" and "equal or more than 200 percent of the poverty threshold." We will refer to the former group as "poor" or "near poor" and to the latter group as "not poor"[35] (or, sometimes, "higher income"). For the demographics table, we list the original four levels of poverty status: "less than 100 percent of the poverty threshold," "100–199 percent," "200–299 percent," and "equal or more than 300 percent."

Sociodemographic Covariates

Demographic variables include age, gender, race/ethnicity, Hispanic heritage, and education. Race/ethnicity is categorized as follows: non-Hispanic white, non-Hispanic black, Hispanic, and other. Hispanic ethnicity is classified as: Mexican/Mexican-American; Puerto Rican, Cuban/Cuban American, and Dominican (Republic); Central/or South American; and "other." Parent education is defined as the highest level of school completed for the parent with the higher level of education.

Analysis

We computed percentage distributions with standard errors for all of the categorical variables. Estimates with relative standard errors of greater than 30 percent were considered unreliable[36] and were identified and indicated with an asterisk (*) in the tables. For binary outcomes, logistic regression models were used to assess the effects of independent variables, adjusted for other sociodemographic covariates. For categorical and ordinal outcomes, multinomial and cumulative logistic regression models were used instead. Outcomes in subpopulations were assessed using the same statistical models.

All analyses were performed using SAS-callable SUDAAN Version 9.0.1 (Research Triangle Institute, NC). All estimates were weighted using the U.S. Census-based weights derived by the NHIS. Specifically, the data in 2001 and 2002 used weights derived from the 1990 U.S. Census-based postcensal population estimates, and the data in 2003 used weights derived from the 2000 U.S. Census-based postcensal population estimates.[37]

FINDINGS

Sample

Table 8.1 shows the distribution of sociodemographic variables for the total sample and for the native and immigrant children subsamples. The sample consisted of 54,596 children including 13,100 (23.9%) children from immigrant families. The children of immigrants were somewhat younger than the native children. The majority of the native children were non-Hispanic white (80%) whereas the majority of the immigrant children were Hispanic (60%). Many more immigrant children (56%) than native children (23%) were "poor" or "near poor" (family poverty level, or FPL < 200%), which is consistent with other recent reports.[38–40] Parents of the native children tended to have higher education levels than those of the immigrant children. Over 75 percent of parents of the native children completed more than high school/GED education, compared to only 45 percent in the immigrant group. Only 4 percent of parents of the native children had below high school education, compared to 36 percent in the immigrant group. These differences may be due, in part, to differences between the U.S. and foreign systems of education (e.g., vocational training opportunities in lieu of high school in other countries).

We also examined the distribution of the immigrant children by parental region of birth and of all children by Hispanic ethnicity. About 60 percent of the immigrant children had parents who were born in Mexico, Central America, or the Caribbean Islands. Children of South East Asians were the second largest group (10%). Single-digit percentages were observed for all other regions of birth. In regard to Hispanic ethnicity, over 70 percent of the native and the immigrant children were Mexican/Mexican American. More native (16%) than immigrant (7%) children were Puerto Rican, Cuban/Cuban American, and Dominican (Republic), whereas more immigrant (18%) than native (7%) children were Central or South American.

Table 8.1
Sociodemographic Characteristics of US Children by Immigrant Status, 2001–2003

Selected Characteristic	Percent (standard error)		
	All ($n = 54,596$)	**US Native Children[a] ($n = 41,696$)**	**Immigrant Children[b] ($n = 13,100$)**
Age			
0–4 years	28.47 (.27)	28.04 (.31)	30.70 (.49)
5–11 years	39.04 (.25)	38.78 (.28)	40.37 (.47)
12–17 years	32.49 (.27)	33.18 (.30)	28.93 (.46)
Gender			
Male	51.44 (.23)	51.48 (.26)	51.19 (.51)
Female	48.56 (.23)	48.52 (.26)	48.81 (.51)
Race/ethnicity			
Hispanic	16.55 (.42)	8.20 (.28)	59.51 (1.20)
Non-Hispanic white	69.46 (.54)	80.37 (.47)	13.23 (.80)
Non-Hispanic black	8.76 (.32)	9.36 (.36)	5.66 (.46)
Non-Hispanic other	5.23 (.21)	2.07 (.13)	21.60 (.94)
Family's federal poverty level			
<100%	9.25 (.31)	6.60 (.28)	23.73 (.98)
100–199%	18.42 (.38)	15.88 (.41)	32.41 (.87)
200–299%	19.60 (.35)	20.00 (.38)	17.57 (.64)
≥300%	52.73 (.57)	57.52 (.59)	26.30 (1.05)
Parents' education			
Less than high school or GED	9.53 (.30)	4.32 (.19)	36.31 (1.04)
High school or GED	20.14 (.33)	20.44 (.38)	18.36 (.62)
More than high school or GED	70.34 (.43)	75.24 (.41)	45.33 (1.05)
Child's living status			
Lives with single parent	1.93 (.08)	1.87 (.09)	2.23 (.17)
Lives with both parent	96.37 (.12)	96.36 (.14)	96.37 (.23)
Does not live with parent(s)	1.70 (.08)	1.77 (.09)	1.40 (.14)
Family size			
≤4	54.07 (.41)	56.44 (.45)	41.68 (.81)
>4	45.93 (.41)	43.56 (.45)	58.32 (.81)
US region of residence			
Northeast	17.95 (.36)	18.00 (.39)	17.78 (.86)
Midwest	23.97 (.48)	26.48 (.54)	10.95 (.84)
South	35.12 (.52)	36.38 (.59)	28.60 (1.06)
West	22.96 (.51)	19.13 (.54)	42.67 (1.25)

Note: (1) Values in the cell are weighted mean (standard error) of frequency in percent. (2) SUDAAN Proc Descript was used in estimation. Estimates were adjusted for age based on the 2000 U.S. standard population.

[a] At least one parent is US-born.

[b] Both parents are foreign-born or a single parent is foreign-born.

Poverty, Immigrant Status, and Health

Our main findings are presented in Tables 8.2–8.5. A preliminary analysis showed that immigrant length of stay was not associated with any of the key variables; therefore, we excluded it from further analyses.

Immigrant-Native Status

In Table 8.2, we compare the health and health-care indicators by immigrant-native and poverty status. As expected, the vast majority of children in both groups were in good, very good, or excellent health; less than 2 percent of children were reported to have fair or poor health. Health status was associated with poverty status. In particular, the children from "not poor" families (FPL $\geq$ 200%) showed better health than those from "poor" or "near poor" families, regardless of immigrant status. Among the natives, 51 percent of the children who were "poor" or "near poor" reported excellent health compared with 63 percent of the higher income children, and 1.6 percent of the children who were "poor" or "near poor" reported poor or fair health versus 1 percent of the higher income children. The native children were reported to have better health than the immigrant children in "not poor" families. However, immigrant status had no effect on health status in the "poor" or "near poor" families. Interestingly, the health advantage due to higher incomes was smaller among the immigrants than among the natives. On the other hand, the immigrant children, regardless of poverty status, were less likely than the native children to report worse health and more likely to report better health than a year ago. For example, among children who were "poor" or "near poor," 27 percent of the immigrant children reported better health than a year ago compared with only 22 percent of the native children.

In terms of chronic health conditions, the native children were roughly twice as likely as the immigrant children to have been told they had asthma ($\sim$12% vs. $\sim$6%) and to report an asthma attack in the past 12 months ($\sim$5% vs. $\sim$2%). A similar native disadvantage vis-à-vis the immigrant children was observed for prevalence of hay fever and respiratory allergy. Poverty status was associated with a higher likelihood of having asthma only in the native children; about 13 percent of the children who were "poor" or "near poor" reported having asthma compared with 11 percent of the children who were "not poor." In the immigrant children, poverty status was associated with a *lower* likelihood of having an asthma episode, respiratory allergy, or food or skin allergies. For example, 6 percent of the immigrant children who were "poor" or "near poor" reported respiratory allergy compared with 9 percent of their higher income counterparts.

A learning disability and ADHD/ADD were the most prevalent in the native children who were "poor" or "near poor" (9% and 5%, respectively for a learning disability and ADHD/ADD) compared with the other native and immigrant children (e.g., 3% and 1% in the immigrant children who were "poor" or "near poor"). Poverty status was not associated with having a learning disability or ADHD/ADD in the immigrant children.

Table 8.2
Health and Health Care of US Children by Immigrant Status and Federal Poverty Level (FPL

	US Native Children		Immigrant Children	
Variable	**FPL < 200%**	**FPL ≥ 200%**	**FPL < 200%**	**FPL ≥ 200%**
General health status				
Excellent	51.00 (.99)A	63.23 (.53)aB	50.81 (1.66)A	58.22 (1.35)bB
Very good	32.26 (.58)A	25.92 (.43)aB	32.34 (.81)A	28.72 (.79)bB
Good	15.17 (.51)A	9.89 (.23)aB	15.27 (.85)A	11.88 (.59)bB
Fair	1.37 (.09)A	.84 (.05)aB	1.38 (.12)A	1.03 (.08)bB
Poor	.20 (.03)A	.12 (.02)aB	.20 (.03)A	.15 (.02)bB
Health better, about the same, or worse than 12 months ago				
Better	21.38 (.83)a	20.81 (.40)a	26.55 (1.32)b	25.15 (1.33)b
About the same	77.02 (.77)a	77.53 (.42)a	72.23 (1.24)b	73.54 (1.25)b
Worse	1.61 (.12)a	1.66 (.10)a	1.21 (.11)b	1.30 (.12)b
Ever been told that_had asthma	12.81 (.65)aA	11.03 (.32)aB	5.86 (.67)b	6.95 (.79)b
Had an asthma episode in past 12 months	5.54 (.44)a	5.27 (.23)a	1.73 (.33)bA	3.07 (.49)bB
Had hay fever in past 12 months	9.66 (.56)a	9.84 (.35)a	6.51 (.77)b	7.65 (.79)b
Had respiratory allergy in past 12 months	13.12 (.74)a	13.37 (.35)a	5.71 (.70)bA	8.50 (.94)bB
Had food/digestive or eczema/skin allergy in past 12 months	12.54 (.75)a	12.31 (.32)	6.09 (.73)bA	10.58 (.88)B
Ever told_had a learning disability	8.82 (.63)aA	5.93 (.28)aB	3.01 (.46)b	2.06 (.39)b
Ever told_had ADHD/ADD	5.43 (.55)aA	4.08 (.25)aB	1.01 (.24)b	1.16 (.30)b
≤5 missing school days in past 12 months (age 5–17)	77.55 (1.08)aA	82.81 (.45)aB	89.84 (1.10)b	87.57 (1.34)b

(*continued*)

Table 8.2
(*continued*)

Variable	US Native Children		Immigrant Children	
	FPL < 200%	**FPL ≥ 200%**	**FPL < 200%**	**FPL ≥ 200%**
Prescription medication for 3+ months for a current health problem	15.17 (.76)aA	13.29 (.35)aB	4.78 (.63)b	6.21 (.77)b
Health insurance coverage	61.21 (1.17)A	93.50 (.31)aB	56.72 (2.21)A	89.93 (.87)bB
Private coverage	11.61 (.79)A	.69 (.12)B	10.34 (1.68)A	1.06 (.28)B
Medicaid	5.77 (.71)aA	2.47 (.23)aB	1.37 (.31)bA	.46 (.15)bB
Other coverage	21.41 (.95)aA	3.33 (.19)aB	31.57 (1.75)bA	8.55 (.80)bB
Uninsured				
Saw/spoke to health professional in past 12 months	91.36 (.60)aA	94.01 (.22)aB	87.26 (1.05)bA	92.25 (.74)bB
Has usual place of health care when sick	95.66 (.39)aA	98.21 (.14)aB	92.47 (.91)bA	96.71 (.51)bB
Two or more ER visits in 12 months	91.63 (.52)aA	94.53 (.23)B	93.71 (.72)b	94.18 (.75)
Saw/talked to dentist in past 12 months (age 5–17 years)	78.80 (1.24)A	88.28 (.57)B	78.86 (1.96)A	87.04 (1.50)B

Note: (1) Values in the cell are mean (standard error) of frequency of "yes" (event) in percent. (2) SUDAAN Proc Rlogist and Proc Multilog were used in computation of logistic, cumulative logistic, and multinomial regression models. Estimates were adjusted for age, gender, race/ethnicity, and parents' education. *P* values < .05 are considered statistically significant. (3) Different lower-case letters in the same FPL group in a row indicate means are statistically different between two immigrant status groups. (4) Different upper-case letters in the same immigrant status group in a row indicate means are statistically different between two FPLs.

* indicates the estimate has a relative standard error of greater than 30% and should be used with caution as they do not meet the standard of reliability or precision.

Disparities were also observed for school attendance and prescription medication use. The native children who were "poor" or "near poor" had the lowest school attendance: 78 percent missed five or fewer school days in the past 12 months, compared to 83 percent of the native children who were "not poor," and 88–90 percent of the immigrant children. Furthermore, the native children who were "poor" or "near poor" were most likely of all the groups to have taken prescription medication for 3 months or longer: 15 percent of those children reported using prescription medication compared to 13 percent of the native children who were "not poor" and 5–6 percent of the immigrant children. No differences were observed among the immigrant children's prescription medication use based on poverty status.

In regard to health insurance coverage, disparities were even more striking than for health indicators, with the immigrant children who were "poor" or "near poor" experiencing the greatest disadvantage. About a third of immigrant children who were "poor" or "near poor" were uninsured, compared with a fifth of their native counterparts, and only 9 percent and 3 percent, respectively, of the immigrant and the native children who were "not poor." Medicaid coverage rates were similar between the immigrant status groups, though, of course, they differed based on poverty level; e.g., 12 percent of the native children who were "poor" or "near poor" had Medicaid versus less than 1 percent of their "not poor" counterparts. While the rates of private insurance coverage were similar for the native and the immigrant children who were "poor" or "near poor," the rate was somewhat lower for the immigrant children who were "not poor" (90%) versus their native counterparts (94%).

Despite the varying rates of health insurance coverage across the study groups, the vast majority of children saw or spoke to a health professional in the past 12 months and reported having a regular source of health care (vs. not going to the same place most of the time). The immigrant children who were "poor" or "near poor" reported the lowest rate of a medical encounter and a regular source of healthcare (87% and 93%, respectively), followed by their native counterparts (91% and 96%), and their "not poor" immigrant (92% and 97%) and native (94% and 98%) counterparts. Two or more ER visits in the past 12 months were also reported for the vast majority of children. Although the immigrant children who were "poor" or "near poor" had a somewhat higher rate of reporting two or more ER visits (94%) than their native counterparts (92%), their rate was not different from the rates for the immigrant and the native children who were "not poor." Finally, the rates of a dental visit in the past 12 months varied by poverty level but not by immigrant status. About 79 percent of the native and the immigrant children who were "poor" or "near poor" reported a dental visit within the past year compared with more than 87 percent of their "not poor" counterparts.

Region of Birth Comparisons

Table 8.3 shows a comparison of the health status and health-care indicators based on parental region of birth. We refrained from including poverty status as a stratification variable, as we expected few observations in some variable categories. Also, some of the estimates do not meet our reliability standard (see Methods) and should

Table 8.3
Health and Health Care of US Children by Parental Region of Birth

Variable	US Native Children	Immigrant Children			
		Mexico and CA/CI/SA[a]	Europe[b]	Asia[c]	Else[d]
General health status					
Excellent	60.05 (.47)	58.60 (1.54)	51.13 (3.11)#	53.07 (3.32)#	62.06 (4.62)
Very good	27.76 (.41)	28.55 (.86)	32.34 (1.42)#	31.35 (1.63)#	26.63 (2.67)
Good	11.10 (.23)	11.69 (.68)	15.07 (1.55)#	14.14 (1.55)#	10.31 (1.78)
Fair	.96 (.06)	1.01 (.08)	1.37 (.18)#	1.27 (.18)#	.88 (.18)
Poor	.13 (.02)	.14 (.02)	.19 (.04)#	.18 (.03)#	.12 (.03)
Health better, about the same, or worse than 12 months ago					
Better	20.90 (.39)	24.37 (1.22)#	22.29 (3.19)	30.53 (3.27)#	28.78 (3.91)#
About the same	77.45 (.41)	74.27 (1.13)#	76.19 (2.91)	68.47 (3.12)#	70.13 (3.71)#
Worse	1.66 (.10)	1.36 (.13)#	1.53 (.30)	1.00 (.17)#	1.09 (.21)#
Ever been told that_had asthma	11.43 (.30)	5.67 (.61)#	6.89 (2.19)#	6.21 (1.28)#	9.44 (2.41)
Had an asthma episode in past 12 months	5.30 (.21)	2.43 (.48)#	*2.13 (1.17)#	2.71 (.80)#	*2.89 (1.30)
Had hay fever in past 12 months	9.77 (.31)	6.99 (.77)#	*4.74 (1.89)#	8.23 (1.65)	*7.09 (2.26)
Had respiratory allergy in past 12 months	13.26 (.33)	7.19 (.71)#	8.52 (2.32)#	7.61 (2.02)#	*6.25 (2.25)#
Had food/digestive or eczema/skin allergy in past 12 months	12.24 (.30)	7.97 (.79)#	7.71 (1.83)#	11.99 (2.14)	*5.70 (1.99)#

Ever told_had a learning disability	6.50 (.27)	2.93 (.42)#	*1.87 (1.12)#	*.55 (.35)#	*1.67 (1.19)#
Ever told_had ADHD/ADD	4.34 (.26)	1.17 (.25)#	*.79 (.56)#	*.61 (.39)#	*1.39 (1.08)#
≤5 missing school days in past 12 months (age 5–17)	81.66 (.43)	90.57 (1.06)#	85.04 (3.37)	92.50 (1.71)#	86.03 (4.35)
Prescription medication for 3+ months for current health problem	13.69 (.31)	5.24 (.55)#	5.51 (1.93)#	5.29 (1.14)#	*5.57 (2.04)#
Health insurance coverage					
Private coverage	88.84 (.40)	85.00 (1.19)#	90.56 (2.73)	89.92 (2.30)	83.81 (3.32)
Medicaid	1.69 (.18)	1.23 (.19)#	*3.44 (1.49)	*.98 (.41)	*2.60 (1.24)
Other coverage	3.29 (.29)	1.13 (.24)#	*.36 (.30)#	*.26 (.12)#	*1.23 (.74)#
Uninsured	6.18 (.25)	12.65 (1.10)#	5.64 (1.85)	8.84 (2.16)	12.36 (2.94)#
Saw/spoke to health professional in past 12 months	93.52 (.22)	90.49 (.81)#	91.13 (2.40)	89.52 (2.06)	93.79 (1.94)
Has usual place of health care when sick	97.80 (.14)	96.25 (.52)#	94.71 (1.86)	96.83 (.0087)	95.44 (1.69)
Two or more ER visits in 12 months	93.97 (.22)	94.27 (.69)	95.00 (1.51)	95.13 (1.50)	95.83 (1.67)
Saw/talked to dentist in past 12 months (age 5–17 years)	86.51 (.54)	85.62 (1.54)	89.88 (4.17)	81.87 (4.01)	95.11 (2.72)#

Note: (1) Values in the cell are mean (standard error) of frequency of "yes" (event) in percent. (2) SUDAAN Proc Rlogist and Proc Multilog were used in computation of logistic, cumulative logistic, and multinomial regression models. Estimates were adjusted for age, gender, race/ethnicity, and parents' education. *P*-values < .05 are considered statistically significant.

[a] includes Mexico, Central America, the Caribbean Islands, and South America.

[b] includes Europe and Russia and other former USSR areas.

[c] includes East Asia South-East Asia and the Indian Subcontinent.

[d] includes the Middle East, Africa, and other countries and regions.

* indicates the estimate has a relative standard error of greater than 30% and should be used with caution as they do not meet the standard of reliability or precision.

# indicates the mean under a specific foreign born region is significantly different from that in the US native group.

be interpreted with caution. Generally, the results indicate similarities among the immigrant groups in how they compare to the native children. For example, for specific health conditions and use of prescription medication, the immigrant children from the various regional backgrounds had a similarly low prevalence compared to the children of natives—roughly a half of the native rate or lower. However, the immigrant children from European and Asian backgrounds had worse health than the native children, while the children who had parents from Mexico, Central and South America, and the Caribbean Islands had the same health status as the native children. When change in health status was considered, more immigrant children who had parents from Mexico, Central and South America, the Caribbean Islands, and Asia reported better health than the native children, while the children of European parents had the same improvement in health as the native children. The immigrant children who had parents from Mexico, Central and South America, and the Caribbean Islands were less likely than the native children to have health insurance and a regular place of health care and to have seen/talked to a health professional in the past 12 months; other immigrant groups did not differ from the natives on these indicators. On the other hand, school attendance (missing 5 or fewer school days) was higher among the children who had parents from Mexico, Central and South America, and the Caribbean Islands (91%) and from Asia (93%), compared with the native children (82%).

Immigrant versus Native Black Children

Table 8.4 compares the native white and black non-Hispanic children to the immigrant children. Estimates for all children as well as children who were "poor" and "near poor" are shown for each racial group. The results again indicate that the native children had a higher prevalence of various health problems and worse school attendance than the immigrant children. However, there were significant racial disparities among the native children. The prevalence of asthma, asthma attacks, food/skin allergies, and prescription medication use was higher among the black children than among the white children. General health status was also lower among the black children, and especially low among the black children who were "poor" or "near poor." On the other hand, hay fever, respiratory allergies, and ADHD/ADD were more prevalent among the white children. Interestingly, the native white children were somewhat more likely to report worse health and less likely to report better health than a year ago compared with both the native black children and the immigrant children.

In contrast to health status, the immigrant children were less likely to have health insurance than the white or the black children. The percentage of children who were uninsured was especially high among the immigrant children who were "poor" or "near poor"—35 percent versus 21 percent among their native white and black counterparts. A similar immigrant disadvantage was noted for medical encounter, regular place of health care, and ER and dental visits. That is, the immigrant poor children were less likely than their native white and black counterparts to have seen/talked to a health professional in the past 12 months, to have a regular place of health care, to have two or more ER visits in the past 12 months, and to have

Table 8.4
Health and Health Care of US Children by Immigrant Status and Race

			US Native Children			
	Immigrant Children		Non-Hispanic White		Non-Hispanic Black	
Variable	**Total**	**FPL < 200%**	**Total**	**FPL < 200%**	**Total**	**FPL < 200%**
General health status						
Excellent	54.72 (.96)	48.04 (1.53)	62.04 (.52)#	53.32 (1.21)#	49.17 (1.42)#&	40.56 (1.74)#&
Very good	30.52 (.59)	33.72 (.75)	26.61 (.43)#	31.38 (.69)#	33.04 (.71)#&	36.23 (.82)#&
Good	13.41 (.47)	16.50 (.83)	10.35 (.23)#	13.88 (.59)#	16.10 (.75)#&	20.87 (1.65)#&
Fair	1.19 (.08)	1.51 (.12)	.88 (.05)#	1.23 (.09)#	1.47 (.12)#&	2.03 (.25)#&
Poor	.17 (.02)	.23 (.04)	.13 (.02)#	.18 (.03)#	.21 (.03)#&	.31 (.05)#&
Health better, about the same, or worse than 12 months ago						
Better	27.78 (.87)	28.72 (1.20)	19.88 (.43)#	20.55 (1.03)#	26.81 (1.19)&	22.76 (2.11)#
About the same	71.08 (.82)	70.20 (1.14)	78.37 (.44)#	77.78 (.95)#	71.99 (1.13)&	75.77 (1.95)#
Worse	1.14 (.09)	1.08 (.10)	1.76 (.11)#	1.67 (.14)#	1.20 (.10)&	1.47 (.20)#
Ever been told that __ had asthma	6.99 (.56)	6.53 (.70)	10.66 (.33)#	12.63 (.79)#	15.11 (.97)#&	14.22 (1.76)#
Had an asthma episode in past 12 months	2.58 (.33)	1.66 (.30)	5.11 (.23)#	5.25 (.53)#	7.30 (.69)#&	7.54 (1.30)#
Had hay fever in past 12 months	6.66 (.52)	5.96 (.65)	10.42 (.34)#	10.34 (.70)#	7.89 (.78)&	7.81 (1.43)
Had respiratory allergy in past 12 months	6.65 (.54)	5.11 (.59)	13.94 (.37)#	14.23 (.91)#	11.87 (.92)#&	8.00 (1.38)#&
Had food/digestive or eczema/skin allergy in past 12 months	8.80 (.61)	5.73 (.67)	12.17 (.35)#	12.81 (.93)#	15.30 (1.02)#&	13.22 (1.81)#
Ever told __ had a learning disability	2.01 (.23)	2.73 (.38)	6.74 (.31)#	9.10 (.78)#	6.20 (.58)#	10.97 (1.51)#
Ever told __ had ADHD/ADD	.79 (.15)	.78 (.19)	4.87 (.30)#	5.94 (.72)#	3.25 (.45)#&	4.43 (.92)#

(*continued*)

Table 8.4
(continued)

	Immigrant Children		US Native Children			
			Non-Hispanic White		Non-Hispanic Black	
Variable	**Total**	**FPL < 200%**	**Total**	**FPL < 200%**	**Total**	**FPL < 200%**
≤5 missing school days in past 12 months (age 5–17)	91.29 (.73)	91.57 (.89)	80.31 (.50)#	76.01 (1.39)#	86.41 (1.15)#&	80.81 (2.28)#
Prescription medication for 3+ months for a current health problem	4.46 (.39)	3.79 (.47)	14.70 (.36)#	15.98 (.97)#	12.29 (.90)#	15.38 (1.61)#
Health insurance coverage						
Private coverage	83.84 (.85)	51.76 (1.74)	89.91 (.41)#	63.40 (1.44)#	86.65 (1.21)#&	58.13 (2.86)
Medicaid	1.99 (.30)	11.01 (1.29)	1.48 (.16)#	10.80 (.87)	2.05 (.38)	13.14 (1.88)
Other coverage	1.13 (.20)	1.72 (.34)	2.82 (.28)#	5.04 (.73)#	5.05 (.83)#&	7.68 (1.73)#
Uninsured	13.04 (.74)	35.50 (1.63)	5.79 (.29)#	20.76 (1.21)#	6.25 (.69)#	21.05 (3.09)#
Saw/spoke to health professional in past 12 months	88.91 (.59)	83.82 (1.15)	93.98 (.24)#	91.76 (.70)#	92.79 (.67)#	92.11 (1.25)#
Has usual place of healthcare when sick	94.25 (.47)	88.44 (1.05)	98.16 (.14)#	96.31 (.40)#	97.08 (.38)#&	94.87 (.97)#
Two or more ER visits in 12 months	95.11 (.43)	94.33 (.61)	93.89 (.25)#	91.62 (.68)#	92.59 (.75)#	93.31 (.90)#
Saw/talked to dentist in past 12 months (age 5–17 years)	82.87 (1.19)	73.77 (2.05)	87.82 (.55)#	79.56 (1.45)#	83.90 (1.74)&	81.34 (2.85)#

Note: (1) Values in the cell are mean (standard error) of frequency of "yes" (event) in percent. (2) SUDAAN Proc Rlogist and Proc Multilog were used in computation of logistic, cumulative logistic, and multinomial regression models. Estimates were adjusted for age, gender, race/ethnicity, and parents' education. *P*-values < .05 are considered statistically significant.

# indicates the mean of a native parent subgroup (non-Hispanic white or non-Hispanic black) is significantly different from that in the immigrant group.

& indicates the means of two native groups (non-Hispanic white and non-Hispanic black) are significantly different.

* indicates the estimate has a relative standard error of greater than 30% and should be used with caution as they do not meet the standard of reliability or precision.

seen/talked to a dentist in the past 12 months. Although the black children generally fared worse in terms of health care than the white children, the black and the white children who were "poor" or "near poor" appeared equally disadvantaged.

Hispanic Ethnicity

Finally, we compared children of various Hispanic backgrounds based on native-immigrant status (Table 8.5). We found that despite lower prevalence of various health problems, the Mexican/Mexican American immigrant children had lower general health and more limited access to health care than their native counterparts. For example, 45 percent of the Mexican/Mexican American immigrant children were uninsured versus 21 percent of their native counterparts. They were also less likely to have seen/spoken to a health professional and dentist in the past 12 months and to have a regular place of health care than the Mexican/Mexican American children from native families. Similar patterns but fewer differences were noted between the immigrant and the native Puerto Rican, Cuban/Cuban American, and Dominican children. Interestingly, the immigrant children of Central/South American heritage were more likely to report better health now than 12 months ago than their native counterparts. However, they were more likely than the natives to be uninsured and less likely to have a regular source of health care.

DISCUSSION

Our findings complement the current literature on the health and health care of children of immigrants in the United States. Notably, our findings are consistent with a 1998 report, which showed that children of immigrants generally have better health status and fewer health problems than U.S.-born children.[41] Our results, thus, do not support the immigrant disadvantage in health status that is reported in two recent studies.[42,43] While those studies focused on mental and social well-being, our emphasis was on specific medical conditions and overall health. It is possible that children of immigrants are still "protected" by immigrant selection (process in which the healthy individuals migrate), and thus show fewer specific health problems. On the other hand, children of immigrants are less likely to see medical providers and, therefore, may be less likely to be diagnosed with a certain medical condition. Future longitudinal studies that assess children of immigrants at baseline, or entry to the United States, and follow them over time, in terms of both health and health-care assessment, may be able to show the effects of immigrant selection versus health-care utilization on the health status of children of immigrants.

Our results also support previous studies which showed that children of immigrants are more likely to lack health insurance[44–47] and access to health and dental services.[48,49] We were able to take a step further by looking more closely at the contribution of poverty, parental region of birth, and racial/ethnic background to the health status and health care of children from native and immigrant families. Our study provides more evidence that the intersection of two or more types of disadvantage, for example, poverty and immigrant or racial and/or ethnic minority status,

Table 8.5
Health and Health Care of US Children by Immigrant Status and Hispanic Ethnicity

	US Native Children				Immigrant Children			
Variable	**(A)**	**(B)**	**(C)**	**(D)**	**(A)**	**(B)**	**(C)**	**(D)**
General health status								
Excellent	49.26 (1.43)	53.07 (2.45)	59.00 (4.11)	52.94 (3.44)	40.86 (1.17)#	53.68 (2.87)	53.78 (2.19)	46.27 (5.23)
Very good	29.73 (.83)	28.34 (1.11)	25.79 (2.00)	28.39 (1.47)	31.93 (.73)#	28.10 (1.29)	28.06 (1.02)	30.66 (1.64)
Good	19.13 (.86)	16.97 (1.39)	13.94 (1.99)	17.04 (1.90)	24.58 (.98)#	16.64 (1.57)	16.59 (1.27)	20.95 (3.29)
Fair	1.67 (.16)	1.43 (.18)	1.13 (.20)	1.44 (.23)	2.32 (.20)#	1.40 (.19)	1.39 (.16)	1.87 (.42)
Poor	.22 (.04)	.19 (.04)	.15 (.03)	.19 (.04)	.30 (.05)#	.18 (.04)	.18 (.03)	.24 (.07)
Health better, about the same, or worse than 12 months ago								
Better	24.36 (1.23)	27.36 (2.29)	18.66 (3.18)	22.95 (2.65)	26.99 (.94)	28.09 (2.61)	32.49 (2.11)#	24.96 (5.08)
About the same	73.64 (1.15)	70.93 (2.10)	78.56 (2.63)	74.89 (2.37)	71.26 (.89)	70.25 (2.40)	66.16 (1.98)#	73.10 (4.58)
Worse	2.00 (.22)	1.71 (.26)	2.78 (.63)	2.16 (.37)	1.75 (.19)	1.65 (.28)	1.35 (.20)#	1.94 (.54)
Ever been told that…had asthma	10.20 (.81)	17.83 (2.01)	11.60 (2.43)	10.43 (2.13)	4.55 (.47)#	15.96 (1.90)	7.07 (1.00)	*5.32 (1.76)
Had an asthma episode in past 12 months	3.74 (.48)	8.83 (1.76)	*2.61 (1.14)	*4.26 (1.29)	1.33 (.26)#	4.61 (1.19)#	1.74 (.40)	*3.66 (1.57)
Had hay fever in past 12 months	8.07 (.75)	5.36 (1.18)	*4.67 (1.44)	12.56 (2.46)	5.66 (.57)#	4.18 (1.13)	6.28 (.96)	*5.64 (1.97)#
Had respiratory allergy in past 12 months	9.85 (.88)	9.24 (1.53)	7.77 (2.19)	7.90 (1.73)	5.59 (.52)#	5.63 (1.37)	5.30 (.86)	*3.03 (1.38)#
Had food/digestive or eczema/skin allergy in past 12 months	8.69 (.67)	12.40 (1.84)	10.53 (2.58)	15.32 (2.68)	5.14 (.45)#	5.01 (1.29)#	7.58 (1.14)	7.42 (2.29)#

Ever told_had a learning disability	5.68 (.72)	10.06 (2.01)	*4.30 (1.87)	*3.84 (1.61)	2.69 (.41)#	5.10 (1.32)#	2.90 (.75)	*4.22 (2.48)
Ever told_had ADHD/ADD	3.13 (.52)	5.25 (1.17)	*4.09 (1.78)	*1.27 (.73)	.69 (.15)#	*2.19 (.96)#	*1.45 (.54)	*3.13 (1.91)
≤5 missing school days in past 12 months (age 5–17)	82.61 (1.25)	77.37 (3.26)	89.69 (3.46)	74.37 (4.09)	90.11 (.77)#	88.59 (2.33)#	88.92 (1.66)	83.63 (4.83)
Prescription medication for 3+ months for a current health problem	8.10 (.66)	14.17 (1.86)	7.32 (1.94)	7.98 (2.19)	3.65 (.33)#	5.52 (1.77)#	4.78 (.93)	*6.23 (2.66)
Health insurance coverage								
Private coverage	66.95 (1.33)	74.89 (2.66)	76.96 (3.84)	79.25 (3.25)	44.02 (1.47)#	64.54 (3.16)#	56.06 (2.38)#	62.54 (5.54)#
Medicaid	9.38 (.97)	9.00 (1.35)	*3.76 (1.56)	*5.54 (1.77)	9.64 (.82)	13.19 (2.48)	7.68 (1.07)#	*5.62 (2.55)
Other coverage	3.21 (.49)	4.15 (1.10)	*3.96 (1.94)	*4.08 (1.44)	1.39 (.26)#	*4.26 (1.38)	1.42 (.36)	*.38 (.41)
Uninsured	20.46 (1.34)	11.96 (1.92)	15.33 (3.25)	11.13 (2.29)	44.95 (1.40)#	18.00 (2.43)#	34.84 (2.32)#	31.45 (5.35)#
Saw/spoke to health professional in past 12 months	88.90 (.73)	92.69 (1.37)	90.77 (2.96)	94.55 (1.53)	80.57 (1.00)#	88.26 (1.92)	88.36 (1.25)	88.50 (3.05)
Has usual place of healthcare when sick	93.24 (.68)	98.08 (.80)	96.37 (1.65)	96.75 (1.24)	88.62 (.85)#	92.78 (1.29)#	88.33 (1.49)#	91.77 (3.49)
Two or more ER visits in 12 months	94.54 (.56)	91.44 (1.53)	95.04 (1.86)	93.83 (1.51)	95.22 (.52)	92.04 (1.61)	93.43 (.93)	88.28 (2.97)
Saw/talked to dentist in past 12 months (age 5–17)	74.89 (1.76)	72.22 (4.11)	74.24 (6.93)	81.55 (5.80)	68.50 (1.52)#	80.25 (4.52)	74.35 (2.97)	81.86 (5.26)

Note: (1) Values in the cell are mean (standard error) of frequency of "yes" (event) in percent. (2) SUDAAN Proc Rlogist and Proc Multilog were used in computation of logistic, cumulative logistic, and multinomial regression models. Estimates were adjusted for age, gender, race/ethnicity, and parents' eductation. *P*-values < .05 are considered statistically significant. (3) Column headings are as follows: (A) Mexican & Mexican American; (B) Puerto Rican, Cuban/Cuban American & Dominican (Republic); (C) Central or South American; and (D) Others.

# indicates two means under the same ethnic subgroups are significantly different.

* indicates the estimate has a relative standard error of greater than 30% and should be used with caution as they do not meet the standard of reliability or precision.

is associated with an especially high risk of having poor health and limited access to health care. However, considering specific constellations of statuses is crucial to identify the most vulnerable groups on various health-related outcomes. For example, children from low-income and Mexican/Mexican American immigrant families are the most vulnerable among U.S. children in regard to health care, while black children from low-income native families have the lowest health status. These findings provide specific direction for public policy and interventions as to which groups to target to improve the health status and health-care access among U.S. children.

There are some methodological differences between our study and the previous studies, which may have contributed to some variation in findings. First, the studies use different data sources and samples. Our estimates of health and health-care indicators are consistent with other reports using recent NHIS data, including any variations by racial/ethnic status.[50] Thus, we have confidence in our analyses. A second source of variation among the current studies (including our findings) is the definition of immigrant status. Some of the previous studies have defined immigrant status of children based on parental U.S. citizenship status or have considered an immigrant family one in which at least one parent was foreign-born.[51,52] We used parental place of birth as an indication of immigrant status and defined immigrant family as one where both parents are foreign-born, and thus be potentially most vulnerable.

Interestingly, while focusing on the potentially most vulnerable group, we found that group showing relatively few health problems. At the same time, a more in-depth analysis by parental region of birth and by race and ethnicity showed considerably more variation in health status among children from immigrant families. This leads us to believe that specific ethnicity and culture play an important role in how health is assessed. That is, ratings of health may be higher in some cultures and lower in other cultures. Culturally based somatization of health and illness is widely discussed in the literature; for example, Hispanic adults have been shown to provide lower self-rated health scores than Anglo adults with similar objective measures of health.[53]

Our study has several limitations. The data are cross-sectional providing only a snapshot of the health situation of U.S. children at one point in time. A longitudinal design would be more powerful to observe the effects of poverty and immigration on the health of U.S. children. At least, our data are based on 3 survey years, and, as such, reflect a broader time span. We are also concerned about possible selection bias—that due to the sampling procedures, illegal immigrants and individuals with the lowest income and the poorest health are likely to be excluded from the survey. Thus, the data probably under-represent the two populations of most interest in this study: poor children and children of immigrants. In addition, the foreign-born population is confined to a limited number of regional categories, which may contain little to a great deal of cultural variation (e.g., Mexico, Central America, and the Caribbean Islands). Although more data are needed to describe this variation, some general patterns emerge from this study based on the broader immigrant categories. Finally, our study was limited in scope and focused on several variables of interest. Additional analyses are possible with these data. For example, other indicators of health and

health care can be examined (e.g., other health conditions, immunizations, health behaviors, or specialist visits).

All in all, our study provides additional evidence regarding the health status and health care among U.S. children based on immigrant status, family income, and racial/ethnic background. Future work should continue focusing on multiple health and health-care indicators and on various subpopulations of children to pinpoint more precisely where the greatest disparities exist and to design appropriate interventions. Cultural diversity and generational changes in the immigrant population must also be considered in further research, public policy, and clinical work.

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CHAPTER 9

IMMIGRANT CHILDREN IN POVERTY

Uma A. Segal, Zubin N. Segal, and Anu R. Diwakaran

Census 2000 indicates that one of four people in the United States was born outside its borders, with substantial numbers having entered after the liberalization of immigration laws in 1965, consequently, U.S. society is becoming increasingly aware of ethnic and cultural differences between immigrants, particularly those of color, and the native-born populations. Interest in understanding attitudes, values, religions, and behaviors is reflected in the burgeoning literature on immigrants and refugees. Social service agencies have often had to mediate between immigrants and U.S. institutions as newcomers learn to adapt to their new environments. In the process, the environment has begun to become sensitized to the diversity of the new arrivals.

Less focus has been placed on the systematic understanding of the socioeconomic levels of these immigrant groups and their implications for adaptation and achievement. Based on the allocation of immigration visas, there have been a variety of legal immigrant streams that have entered the United States in the last few decades. While earlier immigrants of the 1960s were, primarily of a professional stream, current streams are more likely to include large numbers entering through family reunification processes. These individuals and groups may not have the human capital and skills that are readily transferable into the fast-paced technological society. Consequently, the promised "land of milk and honey" may not be so for them.

Two additional populations to the United States, refugees and undocumented immigrants, may find that they are frequently on the fringes of society—the former for a significant portion of their lives, and the latter, almost for their entire stay in the United States. Thus, a large segment of the immigrant group, particularly the newer immigrants of the last decade, is likely to be marginalized. Without the requisite English language competencies, education, and usable job skills, many hover at poverty levels.

The census data and the records of the continuing inflow of newcomers, furthermore, suggest that a large number of immigrant families are entering with dependent children.[1] Although the importance of cultural competence cannot be overemphasized and is relevant for understanding these populations, as significant is recognition that immigrants in poverty face unique difficulties—perhaps distinct from those of the native-born population—and their children may be especially vulnerable.

This chapter explores implications of immigrant child poverty for academic success, mental health, and health-care access. Following institutional review board approval, elementary quantitative data from a local pediatric health clinic, Glennon Care Pediatrics, provide examples of the current and relevant experience of immigrant families in poverty. Guidelines for intervention are presented.

FOREIGN-BORN POPULATION

The 2003 population survey of the U.S. Census[2] indicates that of the 286 million residents in the United States, approximately 34 million (12%) are foreign born. Of the foreign born, 4.6 million are from Europe, 8.4 million from Asia, 17.8 million from Latin America, and 2.7 million from other regions, including Africa. Estimates suggest that approximately 9.3 million, in addition, are in the nation without the requisite papers.[3] Newcomers to the United States enter under a variety of conditions. Early migrants of the nineteenth and early twentieth centuries came as volunteer immigrants, indentured laborers, or as slaves. Most however, were considered "legal immigrants," particularly in the absence of any legislation. Present-day immigrants may be categorized as voluntary immigrants (legal or undocumented) or as refugees (and asylees). Several legal voluntary immigrants or refugees, after a minimum length of residence in the country, choose to apply for U.S. citizenship.

The 1965 Immigration and Nationality Act (INA), despite minor modifications, continues to set the guidelines for annual quotas of immigrants into the country, with a family-sponsored preference limit of 226,000 and for employment-based preference immigrants of at least 140,000. The 2006 quota for family-sponsored preference, however, is 480,000. The INA, furthermore, allocates another 55,000 diversity visas for individuals from countries not represented by the above quotas.[4] A substantial number of legal immigrants include those not subject to these numerical limits—relatives of U.S. citizens and children born abroad to permanent residents. In 2004, this number was approximately 407,000.[5]

Among those who voluntarily migrate to the United States are immigrants without the requisite papers, the undocumented population. While there is no valid method of counting undocumented immigrants, estimates suggest a number as high as 9.2 million,[6] and it is believed that this number grows at a rate of 500,000 individuals annually.[7] Even more recent estimates report numbers as high as 12 million.[8] These are people who are in the United States without governmental approval and are often described as economic refugees, but are not so recognized by the United Nations High Commissioner for Refugees. Although undocumented immigrants lack the legal documentation to be residing in the United States, they may have entered the country

legally or illegally. Despite perceptions of undocumented immigrants being those who slip across borders without appropriate documentation, the Immigration and Naturalization Service stated that a large proportion (about 41%) of all undocumented immigrants, particularly from Asian countries, are "overstays" who fail to return to their homelands when the period of their visas expires.[9]

Refugees and asylees, unlike immigrants, are usually involuntary migrants. The United States has always been a refuge for those fleeing from persecution and, traditionally, has the largest number of the world's refugees.[10] According to the definition presented in the 1951 convention and the 1967 protocol setting forth the mandate of the United Nations High Commissioner for Refugees, refugees are persons who are outside their homelands and are unable to return because of fear of persecution. The U.S. president, in consultation with Congress, can establish annual numbers and allocations of refugees based on the current political climate of the world. In recent years, these annual numbers have been as high as 91,000 in 1999 and as low as 70,000 in 2005 and 2006.[11] Asylees differ from refugees in that they usually enter the United States on their own volition without prior approval. Once within the United States, they apply for asylum, which may or may not result in an admission under refugee status. They are detained until a determination is made, at which time, they are either legally admitted into the country as refugees or are repatriated to their homelands. Refugees may apply to adjust their status to permanent resident after a year.

In throwback fashion to earlier migration periods of the early twentieth century, the nation is beginning to see three more groups of migrants—victims of human smuggling, victims of human trafficking, and mail-order brides. Those smuggled into the country pay a substantial price to enter the country clandestinely, and once in the United States find they are burdened with debt and have few employment opportunities. Victims of human trafficking, on the other hand, continue to be exploited for illicit reasons and are enslaved to those who bring them into the country.[12] Finally, the mail-order bride market is burgeoning, with 590,000 Web sites catering to a growing clientele.[13] Mail-order brides are usually women from developing countries who register with a catalogue or Web site their intent to marry foreign men. Usually there is no period of courtship, and marriages take place in absentia, with the man having "shopped" for the wife who fits his needs. These women, then, enter the country legally as the wives of U.S. citizens.

CHILDREN OF IMMIGRANTS

Children of immigrants, either by birth or by migration, are the fastest growing segment of the children population in the United States. While most immigrant families include both citizen and noncitizen parents, more than 70 percent of the children of immigrants are citizens. Immigrants compose approximately 11 percent of the total population in the country; however, immigrant children under the age of 6 years are 22 percent of the child population, and, overall, one in five children under the age of 18 years is in an immigrant family. Furthermore, 4.7 million of these children have undocumented immigrant parents, and about 1.6 are, themselves,

undocumented.[14] Census data indicate that of the 36 million and 37 million people living below the poverty line in 2003 and 2004 respectively, 20 percent were foreign born; 80 percent of the foreign born in poverty was not naturalized.[15] Thus, children of immigrants, particularly of recent immigrants and of undocumented immigrants are more likely to be living in poverty than are children of native-born parents. Furthermore, immigrant children more likely than native-born children to (1) be poor, (2) be at risk for poverty even if their parents work full time, (3) be in poverty even with parents with high school degrees, and (4) be poor despite living in two-parent homes.[16]

The American Psychological Association (APA) in 1998 adopted the APA Resolution on Immigrant Children, Youth, and Families, continues in 2006 to recognize the unique issues faced by this group in the United States.[17] Research cited in the document supports its statements that

- the experience of immigration is especially intense for the psychological and social well-being of children
- the unique stresses, prejudice, and poverty experienced by immigrants places their children at risk not only for health, emotional, and behavioral problems but also for learning and academic difficulties
- children of service workers from Asia and Haiti and migrant farm workers from Mexico and Central or South America often enter the migrant stream to work with their parents; few states set minimum age for farm labor
- health prevention, mental health, and social services are infrequently used, and
- executive and legislative initiatives periodically limit immigrants' civil rights and access to public benefits.

In addition, children of immigrants must early learn to become bicultural, for they must successfully function in the dominant American culture during the day, yet return to the cultural norms of their parents in the evening. Most must learn to negotiate their surroundings in a language that is not spoken in their homes.[18] Despite these difficulties many children face, immigrant families often come with significant strengths that enable them to navigate the morass of barriers. Children of immigrants, more often than children of native-born parents, are likely to live in two-parent families and are more likely to be born healthier.[19] Further, as most immigrant families come to the United States to pursue the *American Dream* and experience a second lease on life, they imbue their children with the importance of hard work and the significance of education. In fact, at least until adolescence, most tend to do better in school than the children of native-born parents.[20]

ACADEMIC SUCCESS

A 2001 issue of the *Harvard Educational Review* focused specifically on immigrant children, and studies revealed much that is generally understood, that low English language proficiency, difficulties associated with adaptation, discrimination, poverty, and

low teacher expectations can have significant influence on academic achievement.[21] On the other hand, children in various immigrant groups differ in their levels of achievement; with children of Mexican immigrants frequently performing more poorly than do children of Asian or European immigrants. However, many of the former are highly resilient, and many overcome tremendous hurdles in order to succeed.[22]

MENTAL HEALTH

The experience of many immigrants and almost all refugees has been fraught with turmoil. Stereotypes about immigrants abound and range from the negative to the overwhelmingly positive, often ascribing to immigrants characteristics they do not possess. Furthermore, those who are political refugees bring with them a burden of horrendous experiences that others cannot begin to fathom and that may have resulted in major depressive and post traumatic stress disorders.[23] Many have been left with psychosocial problems that are compounded by the social, economic, and cultural distance between them and the U.S. society. This combination of difficulties has not only affected their personal adjustment but has wreaked havoc with long-established family roles and traditional patterns of interaction.

Studies of the mental health of immigrant children provide mixed results. While a number of studies suggest that children in immigrant families are at higher risk for mental health problems than are the children of U.S.-born parents[24] another has found that although foreign-born children were twice as likely as the native-born counterparts to be in poverty, the mental health and behavioral problems they evidenced were significantly lower.[25]

HEALTH AND HEALTH-CARE ACCESS

Concomitant with poverty is lack of adequate health insurance, and, hence, health-care access. The uninsured rate of immigrants (33.7%) is about 2.5 times that of native-born residents (13.3%); however, when broken further, it is clear that newer immigrants are highly vulnerable, with those who are not naturalized having an uninsured rate of 44.1 percent.[26] Socioeconomic status is a strong determinant of child well-being and is related to physical and mental health development, and frequently children of low-income immigrant families face substantial health disparities from those of their more affluent counterparts.[27]

U.S. health policy, which allows health coverage for many, but not for all, has particular implications for those in poverty, those who are near poverty, and those of low socioeconomic status and income, and those who are self-employed as are many immigrants. The last group is least likely to be able to afford private insurance coverage, yet it is ineligible for means-tested coverage, such as Medicaid. In addition, most immigrants are ineligible for public benefits in the first five years of their residence in the United States, making them more likely to leave curable illnesses untreated. Implications of health policy for immigrants are not limited to issues of coverage A number of other cultural and educational concerns confound their access

to health-care services. Health policy must focus not only on who is covered but also on how services are utilized. Currently, general access to health-care services is fraught with problems for many immigrant groups, and the access problems are exacerbated by the implementation of the 1996 Federal Welfare Reform law (H.R. 3734). Responsibility and financial risk for immigrants have moved from the top level of government (federal) to the lowest level (county).[28] Under this structure, each county must ensure that its policies in delivering services reflect awareness of the unique needs of immigrant groups. Another essential component of effective health-care policy is research effort that recognizes the interaction of race, ethnicity, nativity, and health.[29] Health policy must also be driven by how, when, and why health services are used—or not used—because of a mix of cultural effects.

Invariably, the most vulnerable and dependent members of any group have access to the least resources. Policy makers must take into account the particular needs of children, the elderly, and those with disabilities among the immigrant populations. Multicultural awareness and policies that address the diversity of issues must be integrated into health-care policy so that not only is lack of insurance removed as a barrier to health service access, but so are cultural factors. In California, for example, many low-income women are unaware of their eligibility for Medi-Cal (California's equivalent of national Medicaid) and healthy-family programs, and an even larger proportion of immigrant women are unaware of, or intimated by, the system. Not only is there a high uninsured rate among immigrants in California, but even those who are eligible for public health care do not seek it because of the morass of paperwork required to qualify for eligibility and the unfounded fear of deportation. Women and children, more often than men, are likely to deprive themselves of health-care services under such conditions.[30] In addition, immigrants may be more suspicious of different treatment methods, uncomfortable with interaction patters with health-care providers. It is most important that those who are responsible for providing these services understand culturally based perceptions of medical care and physicians as well as the role of traditional medicine and how it dovetails with modern medicine. It is essential, further that translators be bicultural, for they must be able to adequately translate not only the language but also the meanings of events and communication, for a number of phenomena are unique to specific immigrant groups and their experience of illness and treatment must be understood within the cultural context.

EXPLORATORY STUDY OF PARENTAL PERCEPTIONS

To explore the experience of low-income immigrant families and to compare them with that of low-income U.S. native families, a pilot study sought responses from parents regarding their perceptions of their needs. The study began after it received Institutional Review Board approval from the two collaborating organizations—the University of Missouri-St. Louis and St. Joseph's Hospital in St. Charles, Missouri.

All parents who brought their children to a public pediatric health clinic (Glennon Care Pediatrics at St. Joseph's Hospital) over a 1-month period, were invited to participate in the study by anonymously completing a 15-minute, Likert-type

questionnaire regarding their economic, social, physical, psychological, and health needs. Parents were recruited while they and their children were awaiting the physician in the examination room. After giving informed consent, they anonymously placed completed questionnaires in a sealed box. In the event that parents were unable to read or needed a translator, the questionnaire was read to them. It was estimated that approximately 20 percent of the patient pool of the clinic is of an immigrant group, and an average of 125 families are seen in the clinic on a weekly basis. Thus, 500 subjects were anticipated for inclusion in the study, however, only 289 subjects were treated at the clinic in the month of February 2006. Of the 289 potential subjects, 235 completed the questionnaire for a response rate of 81.3 percent.

Demographic information can be found in Table 9.1 which is presented based on immigrant status: 170 subjects self-identified as American (whose parents were born in the United States), 17 are second generation (who were born in the United States but whose parents are immigrants), and 30 are immigrants.

While there is a wide range in the ages, the highest concentration in age is from 21–30 years for all backgrounds. In addition, female respondents far outnumber male respondents in each group. Among the American subjects, the majority of respondents had some college education. The majority of second generation respondents had a high school diploma, and the majority of immigrants had less than a high school education. Most American subjects were from single households (never married), second generation subjects had more respondents that were married than were single (8:5), and immigrant subjects also had a greater ratio of married to single (10:8) families. The majority of American subjects had household with one child, while second generation subjects were more likely to have two children in their households, and immigrants had an equal number of respondents with one and two children in the family. Most American subjects earned $10,000 a year or less, the largest number of second generation respondents earned either $10,000 or between $21,000 and $30,000, and the majority of immigrants reported an annual income of between $11,000 and $20,000.

Data from the 35 item Likert-type questionnaire were coded and, when the factor analysis method of data reduction was applied, resulted in four underlying perceptual dimensions (factors) that could be identified as reflecting (1) antisocial behavior, (2) perceptions of helplessness, (3) perceptions of low levels of belongingness, and (4) poor financial resources. The three subject groups—Americans, second generation, and immigrants—were compared across the four dimensions. The analysis of variance procedure (ANOVA) was applied to the factor scores to statistically assess intergroup differences along the four factors that emerged. Using average perceptual dimension scores, a relative index was created for each dimension and for each group (Figure 9.1). These results are also supported by descriptive measures of surrogate variables for each of the perceptual dimensions.

Although the results of the ANOVA revealed that only Helplessness was statistically significant at $p \leq 05$, with the second generation evidencing more such feelings than either the American or the immigrant groups, because of the pilot nature of the study, it was considered important to also present the direction of other observed differences. A review of the directionality, rather than the magnitude, of the findings indicates

Table 9.1
Ethnicity $N = 235$[a]

Demographics	American	2nd Generation	Immigrants	Total
Ethnicity				
White	151	11	9	170
African American	15	1	5	21
Hispanic	2	3	9	14
Asian	0	0	6	6
Middle Eastern	0	2	0	2
Other	3	0	1	2
Total	170	17	30	217[a]
Age				
Less than 18 years	3	0	1	4
18–20 years	18	1	2	21
21–30 years	92	10	15	115
31–40 years	41	3	9	53
40 and above	19	3	2	24
Total	171	17	29	217[a]
Gender				
Male	17	6	5	28
Female	153	9	23	185
Total	170	15	28	213[a]
Education				
Less than high school	29	4	10	43
High school diploma	53	10	6	69
Some college	63	3	5	71
College diploma	26	0	7	33
Total	171	17	28	216[a]
Family Income				
$10,000 or under	49	6	4	59
$11,000–$20,000	41	2	10	53
$21,000–$30,000	35	6	4	45
$31,000–$40,000	20	1	1	22
$41,000 and above	19	1	3	23
Total	164	16	22	202[a]
Marital status				
Single, never married	75	5	9	89
Married	47	8	11	66
Partnered	14	1	2	17
Separated	7	1	6	14
Divorced	25	2	2	27
Widowed	3	0	0	3
Total	169	17	30	216[a]
Number of children				
0	1	0	0	1
1	67	3	7	77
2	48	5	10	63
3	29	3	7	39
4 or more	12	4	3	19
Total	157	15	27	199[a]

[a]Missing data when totals do not equal 235.

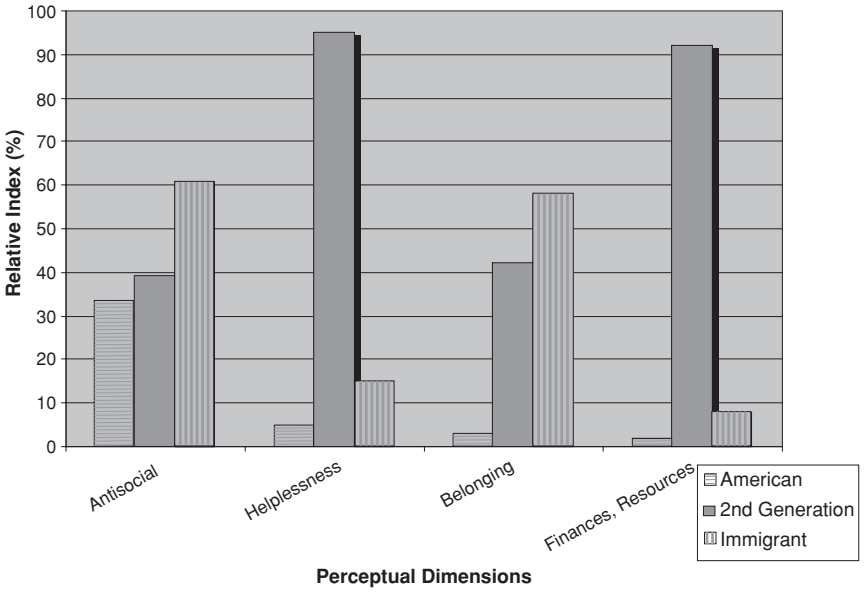

Figure 9.1
Latent Perceptual Demensions: A Relative Assessment

that self reported perceptions of Helplessness (95%) and poor Finances/Resources (92%) are evidenced most often by second generation Americans. In addition reports of Antisocial Behaviors (61%) and low levels of feelings of Belonging (58%) are felt the greatest by immigrants in the study.

Statistically, second generation Americans in this sample evidence a much greater degree of helplessness than either Americans or immigrants. This could be a result of the pressures associated with trying to maintain a bicultural identity. Coping with pressures and prejudices of not truly belonging to either group may force these subjects to feel incapable of fulfilling both sets of expectations. In contrast, regardless of their economic status, both immigrants and Americans may have clearly defined backgrounds, traditions, and support systems to negotiate daily stresses. In addition, the second generation American may not be aware of available supports or available societal resources. This seems to be reflected, also, in the direction of the financial concerns, as the second generation perceives this to be a greater problem than do members of the other groups. That the direction of the antisocial behaviors and low levels of feelings of belonging is greater for the immigrant group than for the others should not be surprising. Literature suggests that the stresses of acculturation and/or adaptation can take their toll and express themselves in behaviors that are less than acceptable (such as domestic violence, substance abuse, or gambling) and perceived social distance from the members of the host country, particularly those living in the neighborhood, may result in feelings of isolation.

Clearly this pilot study is limited by the size and selectivity of the sample, as well as by the self-report data and the results should be viewed with extreme caution. However, it is interesting to note that, in general, despite differences in immigrant status, subjects in poverty report similar types of experience.

SUMMARY AND CONCLUDING REMARKS

With President George Bush's proposal for a temporary worker program for undocumented immigrants, which as of the Friday, June 2, 2006 preceding the writing of this paper, found disagreement between the House and the Senate, the fate of many immigrants and immigrant children is in the forefront of the U.S. public's consciousness. A number of options are proposed to handle the issue of illegal immigration. Specifically, they can be put on a route to citizenship, they should leave the country and reapply to enter legally, or they and their employers would be subjected to greater penalties than currently exist.

Recent estimates suggest there are approximately 12 million undocumented immigrants, the majority who come from Mexico and most who live in poverty. However, with the increased current focus on this group of immigrants, it is easy to forget that this is not the only immigrant population in poverty. Seven and a half million documented immigrants are also living in poverty; their children, who are not identified as immigrants as most (80%) are born in the United States and are citizens, are also poor, increasing the numbers exponentially. The social services must be especially aware that although this group of immigrants and their children is underrepresented in the client pool, this is not because of an absence of need or a private trough of resources.

Traditionally people of countries outside the borders of the United States have either believed it unacceptable to utilize resources outside their personal networks or the societies from which they have come have no services and supports to offer them. Thus, the concept of seeking assistance is alien to them, and many suffer without approaching social services for the help for which they are eligible. While the social services must be applauded for their increasing focus on learning about cultural differences and their effects on the client-worker relationship, they must also recognize that a disproportionately low number of immigrants in poverty actually seek their services. The profession must proactively reach out to immigrant populations in poverty to prevent longer-term difficulties in adaptation among the second generation such as those evidenced in the pilot study undertaken for this chapter.

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Child Poverty in America Today

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Edited by Barbara A. Arrighi and David J. Maume

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To our children
Eiler, Elena, and Megan
and
Meghan and Allison
Our concern for their welfare piqued our interest in the welfare of all children

Contents

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First, we wish to thank all of the contributors to the four volumes for the exceptional caliber of their research. Their dedication and commitment to understanding the causes of child and family poverty is remarkable. It has been a pleasure to work with such a fine group of scholars. It is noteworthy, too, that more than a few of the contributors endured family emergencies and/or experienced personal crises during the research and writing phase, yet remained committed to the project. For that, we are grateful.

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Introduction

David J. Maume and Barbara A. Arrighi

> People agree with everything I say. They say, yes, it is unfair *they* don't get as much per pupil as our children. Then they say, tell me one thing. Can you really solve this kind of problem by throwing money at it? And I say, you mean, can you really buy your way to a better education? It seems to work for *your* children.
>
> Jonathan Kozol, Marx Lecture at Columbia University, Teachers' College 2002

CHILDREN AND EDUCATION

Any discussion of the educational system in the United States has to consider several factors. First, is public education in the United States sufficient to maintain a literate middle-class, a condition required for a republic? That is, are young people who finish the twelfth grade critical thinkers, able to discern logical arguments and not easily swayed or manipulated by political chicanery? Second, is public education sufficient so that young people can move onto higher education seamlessly, without remedial courses, and complete a four-year degree successfully within four years? Third, is the relationship between the educational system and the economic system synergistic so that a young person (who does not wish to pursue a bachelor's degree) can obtain a high school diploma and find a job that will enable s(he) to be self sufficient, even in a "global economy?" Fourth, does the educational system equalize the playing field between the haves and the have-nots?

Unfortunately, the gap between the lives of the children of the poor and children of the well off is glaring and well documented. Education, purportedly the "great equalizer" is part of the matrix of inequality. Children of the well off are sometimes home schooled and privately tutored, poolside.[1] Poor children who are academically behind and eligible for tutoring under the No Child Left Behind Act must wait for

funding to be appropriated. While poor children struggle to pass state and federal proficiency tests,[2] well-connected parents are buying internships for their children at their private school silent auctions.[3] Middle-class and well-off parents have the means to flee public school systems for private schools. Meanwhile school systems in poor areas are finding it more difficult to muster support for school tax levies.

Employers are able to evaluate the state of the educational system by the literacy skills prospective employees exhibit when they come through the corporate doors; however, now the corporate doors can be in India or China. For example, although I.B.M. laid off thousands of employees in the United States it increased the number of its employees in India from 9,000 in 2004 to 43,000 in 2006, about 13 percent of its global workforce, and not just service workers.[4] In its India Research Lab, a hundred employees have Ph.Ds. If corporations can find whatever they need off shore—well educated, motivated, docile, less expensive labor—in order to provide the highest profits to share holders as well as top executives, what incentive is there for them to boost the education of U.S. children? As more and more corporations are making a greater share of their profits outside the United States rather than in the United States and investment gurus are encouraging investors to buy overseas stocks, how effective can school systems be in their appeal for funding? And what is left for young people in the United States? Almost half of all workers earn $13.25 or less an hour, $26,784.00 or less a year.[5] Thirty million low-wage workers earn less than $8.70 an hour.[6]

Parents of public school children who do not have the means to flee public schools might have been encouraged by the upward trend in the standardized state test scores earned by their children individually and schools collectively. However, the too-good-to-be-true test scores seemed to be just that. Evidence suggests that states have simplified the tests to facilitate high rates of passing and therefore, "comply" with the No Child Left Behind directives. For example, according to state test results of fourth graders in Idaho, 90 percent of students were proficient in math; however on the federal test only 41 percent were proficient. States in which discrepancies between state and federal testing were found include: New York, North Carolina, Alabama, Texas, and Tennessee.[7] If students are not proficient in reading and math, can they be good stewards of the republic they inherit?

Can simplified state tests be reconciled with the National Academy of Sciences' report that sagging educational standards threaten the U.S.'s "strategic and economic security?"[8] Concerns abound. At present, even the most advanced twelfth graders in the United States "... perform poorly relative to their peers on international tests." Nicholas Kristof, *New York Times*, editorial writer, showed his daughter's third grade homework to teachers in China who evaluated it as comparable to their first grade work. In China, most students take advanced biology and calculus compared to less than 18 percent of U.S. students.[9] Some argue that the state of U.S. education is related to U.S. decline in technological advances. For example, The Economic Strategy Institute, reported that in 2000 the United States was the leader of broadband internet, but now ranks 16th. And 21 percent of the world's telecom equipment is manufactured in the United States today, down from 40 percent.[10]

Self-interest could be key to motivating corporate leaders (not living abroad or in gated communities) who might otherwise think the problem isn't theirs to fix. On the one hand, Bill Gates expresses grave misgivings about the state of U.S. education vis-à-vis other countries. On the other hand, his concerns provide justification for Microsoft's outsourcing of American jobs. Statistics that are of interest to all and especially the corporate class include the following: High school graduates are less likely to commit crime; increasing high school completion rates by 1 percent can reduce justice system costs by $1.4 billion annually; a one-year increase in average years of schooling can reduce murder and assault by almost 30 percent and car theft by 20 percent; the average 45-year-old high school drop out is in poorer health than the average 65-year-old high school graduate (the former translates into higher health-care costs for taxpayers to bear).[11] Although the well-off can send their children to private schools to ensure a *quality* education and a safe environment away from poverty, at some point in time, the lives of the well-heeled and the *other* will intersect because the *other* performs the jobs the well-off don't want to do and can afford to pay the *other* to do.

If, as the evidence has suggested, the playing field is not level for children in poverty, then it isn't rocket science to understand the importance of starting education earlier for these children. Yet, while other countries are investing more in their children, the United States has been backpedaling. For example, in 1996, while the United States was dismantling decades of welfare assistance for families and children living in poverty, Quebec was implementing subsidized day care for 4-year-olds. Four years later Quebec extended its programs to infants.[12] Britain, considered somewhat of a laggard when it comes to early childhood education and child care, has instituted a program for 3- to 4-year-olds.[13] If other countries are capable of early childhood education and care, why not the United States? Some argue that early childhood education is a better investment than having kids try to "catch up" later. If a child falls behind in the fundamentals the likelihood of future academic success decreases.[14]

The Children's Defense Fund reported that 3-year-olds living in poverty knew half the words as other kids their age, but by first grade they had lost ground and knew only a quarter of words that other first graders knew.[15] In a similar study by the Economic Policy Institute it was reported that the average cognitive score for high-SES kids was 60 percent above kids in the lowest SES group.[16] There is evidence that kids from disadvantaged backgrounds suffer "summer set back"—they tend to forget what they learned in the previous academic term because of a lack of stimulation over the summer.[17] Adding fuel to the argument others have found that children who experience high-quality care have "... greater mathematical ability, greater thinking and attention skills, and fewer behavioral problems than children in lower quality care."[18] Sheila Kamerman, testifying before the U.S. Senate, made the point that early childhood education and care programs "enhance children's development and prepare them for primary school ... [and] ... are increasingly viewed as a 'public good.'"[19]

While the federal government ignores the gorilla in the room, several states have implemented universal prekindergarten programs. For example, Georgia introduced

a universal, voluntary program and expanded the program to 4-year-olds. Oklahoma, Florida, and New York have all developed prekindergarten programs; however, New York's program has not been fully funded. Maryland plans a universal program for 4-year-olds in 2007 and cities, like Chicago and Los Angeles are "on board," and making preschool available for all 3- and 4-year-olds.[20]

The bottom line is: The educational system does not exist in a vacuum. It is connected to the political and economic and as such is not neutral. Decades ago, Bowles and Gintis argued that the "structure of social relations in education not only inures the student to the discipline of the work place, but develops the types of personal demeanor, modes of self-presentation, self-image, and social-class identification which are the crucial ingredients of job adequacy."[21]

In other words, children from lower socioeconomic backgrounds are intertwined in a matrix of negative physical and social factors—food insecurity, dilapidated housing, violent neighborhoods, lead paint poisoning, lack of health and dental care, asthma, perhaps homelessness—education is some nebulous thing vying for their attention. Kids living in impoverished families live in the practical world, a concrete world—their lives revolve around scrounging money for rent, food, gas, heat, water, clothing—struggling to satisfy what Maslow refers to as the basic physical needs of food, clothing, and shelter.[22] According to Maslow's perspective, humans can't achieve beyond the concrete level until the basics are assured. Children living in poverty arrive at school prepared for "concrete" thinking, not the abstract—what Bordieu calls "symbolic mastery" that children of higher socioeconomic status (SES) are prepared to tackle.[23] Because higher SES families have a surplus of resources to ensure their basic physical needs, their children are able to turn their attention to higher-level thinking. The educational system is bifurcated—one for the haves and one for the have-nots, one that reproduces Harrington's two Americas. Will it safeguard the republic?

The pursuit of diplomas is consistent with wider cultural messages that emphasize striving and hard work as the primary route to a higher quality of life. Certainly, when the public considers ways to eliminate or reduce poverty, their first inclination is to provide better schooling to those who need it most. And many social scientists have completed studies that show schools do in fact, improve the skills of the less-advantaged.

Other social scientists, however, have long been interested in how family circumstances predict educational attainment. This research agenda is consistent with the notion that schools are bureaucratic institutions that protect the interests of educators, and reproduce current inequalities. Although purportedly predisposed to prepare everyone for success in adulthood, schools instead identify students who exhibit values and behaviors consistent with the future-oriented, disciplined, and acquisitive nature sought in the labor market. Such students are rewarded with good grades and receive favorable treatment from teachers. Students who fall short of this ideal are weeded out over time, and their lack of success in school (and by implication, their lack of success later in life) is attributed to internal deficiencies that preclude them from taking advantage of the "promise" offered to them.

The diverse articles in this volume fit within this debate and extend it as well. For example, at the very beginning of the life cycle, researchers are increasingly focused on the child-care experiences of children, especially those whose families receive public subsidies for care. Deborah A. Phillips and Marcy Whitebook examined the quality of care offered by licensed, center-and home-based child-care programs operating in low- and middle-income neighborhoods in the Oakland area. They found that the standards for licensure among home-based care providers pertained more to safety standards, in contrast to licensed centers that had to meet additional standards regarding the number and educational skills of teachers. Consequently, children's literacy scores were higher in center-than home-based day care, a quality gap that interacted with the socioeconomic status of the neighborhood in which care was offered. The authors are concerned that given the cumulative nature of education, these prekindergarten differences may widen when children enter school.

Indeed, Dylan Conger's analysis shows that within-school decisions also contribute to variation in educational outcomes. Using data from New York City public schools, she found that a nontrivial 11–12 percent of the total racial/ethnic segregation of students was attributable to within-school decisions to cluster students of similar racial and ethnic background in the same classroom. The outcome of this decision is hardly benign, as Conger further shows that segregation varies positively with the poverty status of children, and negatively with standardized test scores.

Despite the fact that many classrooms are segregated by race, ethnicity, and social class, there is some evidence that schools are effective in fulfilling their mission. Annie Georges drew from the *Early Childhood Longitudinal Study*, a nationally representative sample of 1998–1999 kindergarten class, to examine students' math achievement. Although her data largely confirmed that scores on standardized math tests were lower among students from disadvantaged families, she also found that students' fall-to-spring *gain* in math skills was the same irrespective of income and education of their parents. Although Georges expected the *type* of instruction (drills and worksheets versus group-learning) to have an effect on math achievements she did not find it. Rather, she concluded that, "... children below poverty benefit more from formal classroom instruction than children who are not in poverty." Georges' research provides more evidence for earlier classroom education for children living in poverty.

Edward B. Reeves reports similar findings in his analyses of data on Kentucky schools, a state where there exists an almost "... 'iron law' linking student [social-economic status] and education outcomes." After being one of the first states in the nation to implement comprehensive educational reform in 1990, Reeves analyzed current performance data among more than 700 elementary schools to assess the impact of reform efforts. Like Georges, Reeves found that point-in-time correlations between academic achievement and poverty rates among schools were negative and significant. But, when he examined the 7-year *change* in test scores, he found no correlation with the poverty status of the school. Reeves suggested that state and federal mandates have elevated expectations of what students should know, and students in *all* schools have responded by improving their performance in the classroom.

Sandra Mathison's chapter is a treatise on state and federal mandates that focus on testing students to determine educational effectiveness. In a provocative essay, she argues that testing (at all levels of education) is a mechanism by which weak students are identified and weeded out of schools. Students who remain in school generate higher tests scores for their schools and districts, enabling educators in these districts to claim that their superior effectiveness entitles them to increased financial support for their efforts. Readers who have little memory of standardized tests in their own educational experience, will no doubt be surprised by Mathison's first table showing the typical testing experience today for children between grades K-12. Further, today's students take more "high-stakes tests" that determine their futures and those of their educators. For example, districts are increasingly relying on ninth-grade proficiency tests to determine who should graduate from high school. Students of color and those from disadvantaged backgrounds are at higher risks of failing these tests and dropping out. After doing so, high schools are composed of better test-takers producing higher school-wide scores (and greater claims to teaching effectiveness from administrators). Those who fail these tests in the ninth grade often drop out and later acquire a GED certificate, allowing educators to further claim that they are not neglecting the educational needs of the poor.

Yet, Richard K. Caputo maintains the GED certificate is not equivalent to a high school degree, and instead GED recipients are more like high-school dropouts when measured by their success in the labor market. Using data from the 1997 *National Longitudinal Survey of Youth* he analyzed the correlates of several education outcomes, including dropping out, getting a high school diploma, or attaining the GED. Like other authors in this volume, he found that socioeconomic status determined attainment; however, that finding did not hold up when he controlled for social and behavioral problems of the adolescents. Importantly, however, he found that the quality of educational experiences in elementary school had a strong effect on attainment in later years, and that these factors also varied by race and ethnicity.

The remaining authors in this volume considered links between schools and other community institutions to determine how schools might fulfill their "promise." For example, Jason M. Smith argued that extracurricular activities provided students with role models and experiences that fostered their success in high school. Using data from the *National Education Longitudinal Study*, he contrasted inactive students with those who were involved in extracurricular activities such as sports, plays, band, or other school clubs. He limited his sample to students who attended high-poverty schools and found that active students had a significantly higher graduation rate than nonactive students. This finding is particularly important given community tendencies to cut funding for extracurricular activities in tight budgetary times. Such a course of action may disproportionately affect the graduation chances of poor students thereby reproducing current inequalities in the area.

Youth employment is the focus of attention for Constance T. Gager, Jacqueline C. Pflieger, and Jennifer Hickes Lundquist, especially in conjunction with students' socioeconomic status. The authors drew on the *Survey of Adults and Youth*, a survey funded by the *Robert Wood Johnson Foundation.* They found that the youth labor

market largely paralleled the adult labor market, in that employment rates are higher for white youths who come from families of higher socioeconomic status. Because youth employment fosters behavioral change and introduces youths to key gatekeepers in the community, it can potentially reinforce and accentuate the skills learned in school. Thus, it is noteworthy that these authors conclude that "... policies are needed that specifically target job training for youth, especially those in urban neighborhoods."

Finally, Judith Hennessy considers the role of education of welfare reform as it affects single mothers. After reform legislation was passed in 1996, welfare recipients were required to "earn" their benefits by developing plans to become self-sufficient. Most states defined this as requiring women to work and only a few states allow women to attend college as part of their plans to be self-sufficient. Hennessy interviewed workingwomen and those in college to determine how they made sense of their choices. She found that low-income student mothers had to wrestle with the prevailing definition that women were "successful" when they were working, but that this often conflicted with the care of children. Moreover, these women realized that education offered the "promise" of a better life in the future, but welfare officials measured their own success by the number of women who were working and no longer drawing welfare. Thus, working women got better benefits and more support from welfare offices, yet student mothers couched their choices as striving to fulfill the "promise" that linked educational attainment with future productivity.

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CHAPTER 1

What Do Public Child Care Dollars Buy? It Depends. . . .*

Deborah A. Phillips and Marcy Whitebook

Concern about the school achievement gap between children of low-income families and other children is the focus of much research, discussion, and policy. The facts are startling. Young children just entering school from the lowest quintile of family income score at about the 30th percentile of their cohort's academic achievement, while those from the top quintile of income enter school scoring at about the 70th percentile. Disadvantages arise early in life, and poorer children do not arrive at the school door as prepared for academic learning. Because of the cumulative nature of education, moreover, children in or near poverty levels almost never catch up to the educational proficiency of their wealthier counterparts and often drop out as early as ninth grade. That fact runs to the foundations of socioeconomic inequality in America and of disparities in later life chances—for healthy living, for living wages, for secure, and for productive citizenship.

Facts of this nature have led to a virtual explosion of interest in early education. The policy response has consisted primarily of efforts to prepare 4-year-olds for school so that "no child is left behind." This includes federal initiatives to upgrade standards and training for Head Start teachers, exponential growth in state investments in pre-k programs—focused primarily on low-income children, and increasing pressures to document the long-term educational impacts of these investments. These initiatives have fueled a dramatic shift from viewing early care and education settings for 4-year-olds as part of the long-standing child care system and thus focused on ensuring an adequate supply of care to support parental employment to approaching them as a new educational environment that must be of sufficiently high quality to support the early learning of young children.

Over the next decade, it is likely that a growing proportion of 4-year-olds will move into pre-k programs given state expansion in this area. At the same time, consistently

high rates of maternal employment starting in infancy (accompanied by increasingly stringent work requirements associated with welfare reform) will continue to place large demands on the non-pre-k, non-Head Start segment of the early care and education market, namely community-based profit and nonprofit child-care centers and home-based programs, as well as informal child-care arrangements. In stark contrast to the discussion around education for 4-year-olds and the federal Head Start program, efforts to improve the quality of child care remain largely under the radar screen of policy discussion and thus sporadic and poorly or inconsistently funded.

This uneven attention to the developmental environments of early care and education settings flies in the face of evidence that the trajectory of early learning begins well before the fourth year of life and that the vast majority of children spend this vitally important developmental period in child care, as distinct from pre-k and Head Start or Early Head Start, settings.[1] Large-scale studies over the last two decades have shown that most community-based child care is of mediocre quality and that these programs compare unfavorably to pre-k and Head Start settings.[2] Moreover, research has highlighted a perverse juxtaposition of circumstances regarding low-income children. Specifically, while low-income children benefit more than their advantaged peers from high-quality early childhood programs,[3] they are less likely to attend high-quality early care and education arrangements. This has been found repeatedly for home-based arrangements, whether licensed or not. With regard to center-based arrangements, there is some evidence that very low-income children can receive higher quality center-based care than children with modestly higher incomes when they have access to programs, such as Head Start, with strict income eligibility requirements.[4] Thus, the poorest of the poor may actually receive some of the best and some of the worst center-based care this country has to offer, whereas, in home-based settings, they tend to receive poor quality care.[5]

This study was designed to examine the full range of early care and education services available in one community—Alameda County, California—to families with different levels of income and/or access to public subsidies: licensed center-based care, licensed family child-care homes, and license-exempt home-based care.[6] The findings presented here focus on the first two sectors. They provide an in-depth look at the quality of services offered in child-care programs receiving public subsidies, and in programs not receiving subsidies. Nonsubsidized programs were divided into two groups: those located in low-income neighborhoods and those located in middle-income neighborhoods. As such, this research informs pressing questions about the extent to which existing early care and education programs that serve children from different socioeconomic groups, including those receiving subsidized care, provide them with the high-quality experiences, resources, and interactions that will prepare them for formal schooling.

METHODS

The sample for these findings reported in this paper consists of licensed, center- and home-based child care programs operating in low- and middle-income neighborhoods

and serving subsidized and nonsubsidized children in Alameda County, California. This site was selected because it has a diverse local child-care market and population of families using care. It also represents a relatively "high end" site with regard to having a strong record of developing initiatives to improve the quality of early care and education and to offer child-care workers incentives to pursue professional development. In addition, it is important to note that California, unlike many states, uses both contracts and vouchers to support care for low-income children in centers. As noted below, the contract mechanism is accompanied by added requirements for the centers regarding quality of care. Thus, the findings in this report are most appropriately approached as a good case scenario of the quality of care experienced by low-income children.

The final sample consisted of 102 programs, 42 centers, and 60 licensed family child-care homes. All participating programs had been in operation for at least 9 months prior to being observed and we sought the participation of programs that provided care not only for preschoolers, but also for infants and toddlers. The centers consisted of 20 programs receiving state contracts to serve low-income children (all considered low-income subsidized and including part-day State Preschools [$n = 4$] or Head Start programs [$n = 5$] and full-school-day programs funded by the State Department of Education [$n = 2$]), 5 additional centers serving 25 percent subsidized children through vouchers (and thus added to the contracted programs to create 25 low-income, subsidized centers), 8 centers in low-income neighborhoods that served fewer than 25 percent subsidized children (the low-income, nonsubsidized subgroup), and 9 centers in middle-income neighborhoods that served fewer than 25 percent subsidized children (the middle-income, nonsubsidized subgroup). The homes were similarly characterized by the neighborhood in which they resided and whether they enrolled 25 percent or more subsidized children. The final sample consisted of 23 low-income, subsidized homes, 19 low-income, nonsubsidized homes, and 18 middle-income, nonsubsidized homes.

All programs were visited by observers trained to reliability between February and August 2001. The observers assessed the quality of the child-care environments using the Early Childhood Environment Rating Scale-Revised Edition (ECERS-R)[7] for preschool rooms in center-based settings, and the Infant and Toddler Environment Rating Scale (ITERS)[8] for infant and toddler rooms. The Family Day Care Environment Rating Scale (FDCRS)[9] was used for licensed home-based settings. These instruments cover a wide range of characteristics of the child-care environment, ranging from learning activities to personal care routines. Scores range from 1 to 7, with 1 indicating care that is inadequate and 7 indicating excellent care. An observational measure of ratios and group size was obtained in conjunction with the ECERS-R, ITERS, or FDCRS observations.

In addition, a more detailed measure of caregiver–child interactions was obtained using a modified version of the Observational Record of the Caregiving Environment (ORCE) used in the NICHD Study of Early Child Care.[10] This instrument, named the Child-Caregiver Observation system (C-COS), captured the one-on-one interactions between caregivers and the children in their care. Specific behaviors coded

include verbal interaction, stimulation of age-appropriate learning, and the sensitivity of the interactions. Finally, the Caregiver Interaction Scale[11] was used to capture more global ratings of the providers' harshness, sensitivity, and detachment toward the children in their care; it captures more emotional-affective qualities of caregiving. Observer reliabilities were obtained as part of preobservation training and assessed periodically during data collection. Reliabilities were .93 for the Caregiver Interaction Scale, .79 for the C-COS, .91 for the ECERS-R/ITERS, and .87 for the FDCRS.

Adult literacy was assessed using the Documents scale of the Tests of Applied Literacy Skills (TALS), developed by the Educational Testing Service to assess performance on English literacy tasks that adults typically encounter at home, at work, and in day-to-day activities. The Documents scale specifically assesses the knowledge and skills required to locate and use information contained in various formats, including job applications, payroll forms, transportation schedules, tables, and so forth.[12] These skills are relevant to being familiar with child-care regulations and safety procedures, participating in training, finding information in a phone book or through written materials (e.g., written emergency procedures), and completing forms such as Individual Education Plans for children with special needs. Scores on TALS scales range from 0 to 500, with scores below 275 representing limited literacy proficiency and scores between 276 and 325 considered the minimum literacy needed for success in today's labor market. The mean score on the document scale for a large, nationally representative sample of U.S. adults is 267.[13]

FINDINGS

Where Are the Children?

The demographics of center- and home-based arrangements tell different stories about the distribution of low-income children across programs serving different populations of families. Over 80 percent of the centers (83%), but only 48 percent of the licensed family child-care homes in our sample served at least one subsidized child. Many of the centers that did serve this population enrolled very few subsidized children. For example, 10 of the 35 centers with subsidized children—5 in low-income and 5 in middle-income neighborhoods—had fewer than 8 percent subsidized children. At the same time, 13 centers, all in low-income neighborhoods, served 75 percent or more subsidized children. It thus appears that low-income children were dispersed across subsidized (25% subsidized children) and nonsubsidized centers and across centers in low- and middle-income neighborhoods, perhaps as a result of children using vouchers to purchase center care in programs without large numbers of subsidized children. At the same time, centers with large concentrations of subsidized children were located in low-income neighborhoods. It is important to note that these patterns may be specific to our sample which, by design, over-represented centers with state contracts relative to those accepting children with vouchers.

Because licensed family child-care providers were asked to estimate the family income level of the children in their care, we were able to examine the distribution

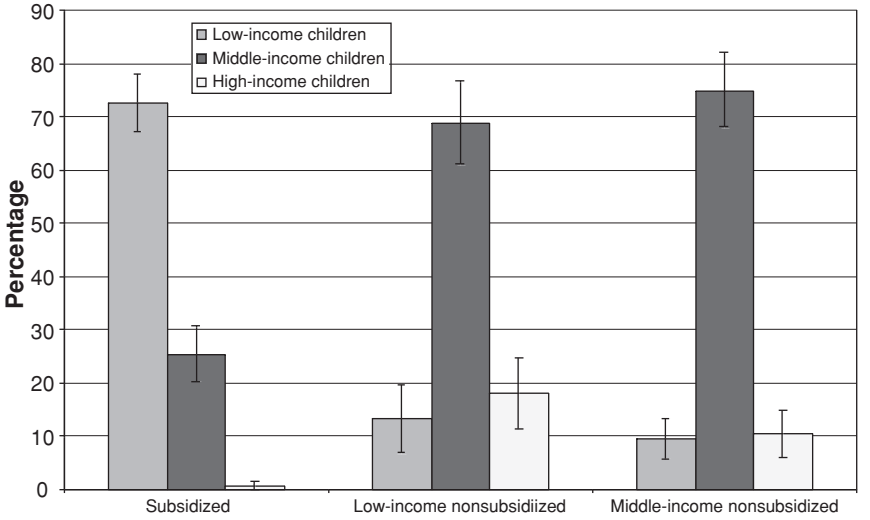

Figure 1.1
Family Income of Children in Licensed Family Child Care, by Income Subsidy Groups
Note: **Bars indicate standard errors of the means. Bars that do not overlap indicate statistically significant differences. For example, low-come children are significantly more likely to be in subsidized programs than are middle- or high-income children.**

of children, by family income, across groups of providers defined by neighborhood income and receipt of subsidies. As shown in Figure 1.1, in contrast to center care, low-income children appeared to be more concentrated within some segments of the home-based market. Specifically, subsidized providers in low-income neighborhoods had the largest percentage of children from low-income families (73%) ($F(2, 55) = 44.97$, $p < .001$). Providers in middle-income neighborhoods enrolled mainly children of middle- and high-income families (86%). Interestingly, nonsubsidized providers in low-income neighborhoods also enrolled primarily children of middle- and high-income families (87%), perhaps driven by economic necessity given the difficulty that low-income families have in covering the full cost of care when they do not receive subsidies.

In sum, many more centers than homes provided care for subsidized, low-income children and these children were somewhat dispersed across contracted and non-contracted centers in low- and middle-income neighborhoods. Within the family child-care sector, in contrast, low-income children were over-represented in homes in low-income neighborhoods and in which at least 25 percent of the children received subsidies to defray the cost of care.

Because we did not collect data on the income or subsidy status of individual children in the centers, as we did in the homes, we are not able to provide data on the overall distribution of low-income or subsidized children across centers and homes in our sample. However, a study conducted by the state of California in 2000 revealed

that about 55 percent of children receiving subsidies were in center-based care. About 17 percent were in licensed family child care. The remainder were in license-exempt care. Among children attending subsidized licensed care, 63 percent were in the contracted programs with higher standards. It appears, therefore, that within the regulated sector of child care, children receiving subsidies are disproportionately enrolled in center-based programs, as compared to licensed homes. Large numbers of these children, however, are in care that operates beyond the regulatory system altogether.

What Quality of Care Are Low-Income Children Receiving?

Associations between quality of care and the income of the enrolled children varied by type of care. Among center-based programs, those serving at least 25 percent subsidized children and those serving fewer subsidized children provided comparable levels of care and education, as did centers in low- and middle-income neighborhoods. There were only two exceptions to this conclusion. First, as shown in Figure 1.2, subsidized centers in low-income neighborhoods had better ratios of teachers to preschool-age children (but not to infants) than did other centers ($t(65) = 2.09$, $p < .05$). Second, nonsubsidized centers in low-income neighborhoods ($M = 3.81$) were observed to provide significantly poorer quality in the area of personal care routines (e.g., diapering and feeding) than other centers (subsidized $M = 4.8$,

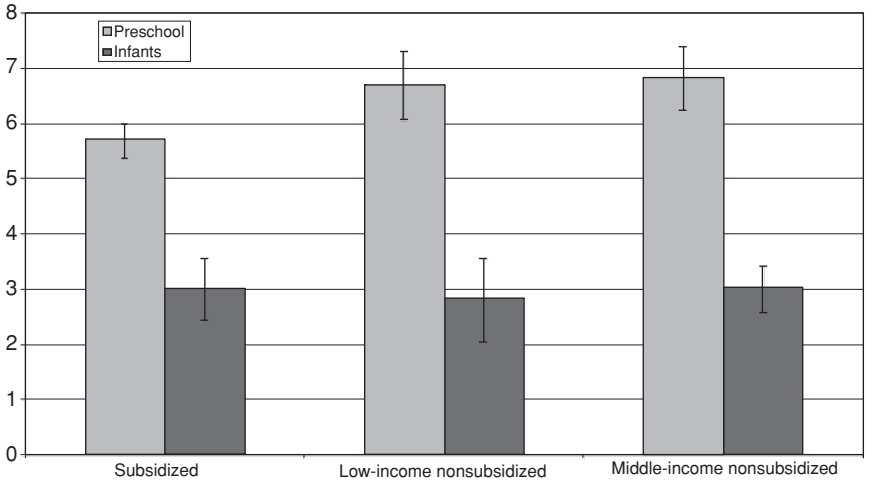

Figure 1.2
Child:Teacher Ratios, by Income and Subsidy Status of Center
Note: **Bars indicate standard errors of the means. Bars that do not overlap indicate statistically significant differences. For example, there is no significant difference in child to adult ratios for infants across income and subsidy groups, but subsidized centers have significantly better preschool child to adult ratios than nonsubsidized centers.**

middle-income, nonsubsidized $M = 5.0$, $F\,(2, 66) = 3.15$, $p < .05$). Thus, in low-income neighborhoods, subsidized centers had a slight edge over nonsubsidized centers on these basic indicators of safe and appropriate care.

In licensed family child-care homes, both the income level of the neighborhood and the subsidy status of the home predicted dimensions of child care quality that are strongly associated with developmental outcomes. Specifically, homes in middle-income neighborhoods offered more sensitive caregiving ($M = 3.30$) than did those in low-income neighborhoods ($M = 2.96$, $t(57) = 2.06$, $p < .05$). Homes in middle-income neighborhoods also offered greater opportunities for social development ($M = 4.9$) than did homes in low-income neighborhoods ($M = 4.1$, $t(46) = 2.04$, $p < .05$). Observed learning activities, based on the Family Day Care Environment Rating Scale, were of significantly higher quality in nonsubsidized homes in both low-income ($M = 3.96$) and middle-income neighborhoods ($M = 3.90$) than in subsidized homes in low-income neighborhoods ($M = 2.99$, $F(2, 57) = 4.47$, $p < .02$) (see Figure 1.3). This pattern of findings is of concern in light of the high concentration of children from low-income families in subsidized family child-care homes.

Children's access to providers and teachers with higher levels of adult literacy was also inequitably distributed by income.[14] Specifically, middle-income, nonsubsidized providers had significantly higher scores on the TALS than did low-income, nonsubsidized and low-income, subsidized providers (332, 299, and 275, respectively; $F(2, 95) = 11.3$, $p < .001$). When examined by type of care, this finding was driven

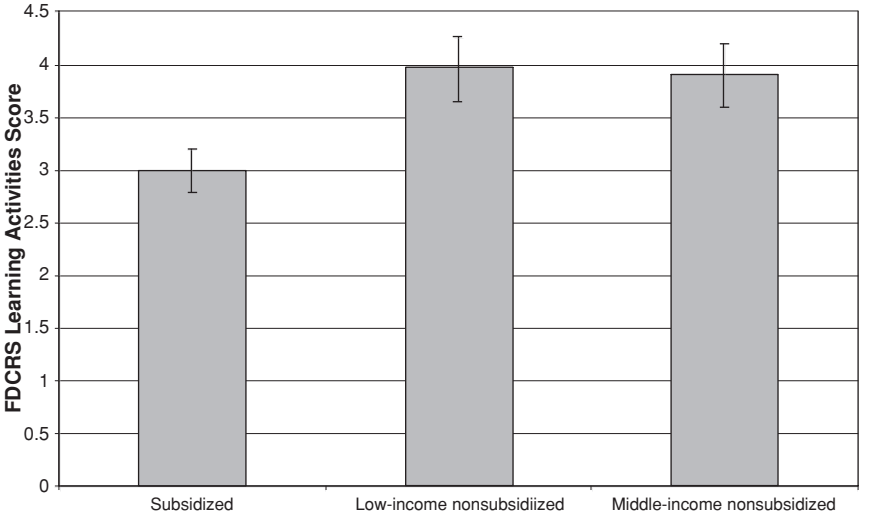

Figure 1.3
Mean Learning Activity Scores, by Income and Subsidy, for Licensed Family Child Care
Note: **Bars indicate standard errors of the means. Bars that do not overlap indicate statistically significant differences. For example, Subsidized providers have significantly lower FDCRS learning activities scores than either nonsubsidized group.**

Table 1.1
Literacy Scores by Income-Subsidy Group and Type of Care

	N	TALS Mean (SD)	PPVT-III Mean (SD)
Home Licensed			
Subsidized	6	263 (84)	90 (7)
Low-income nonsubsidized	15	313 (49)	92 (22)
Middle-income nonsubsidized	12	329* (31)	98 (11)
Centers			
Subsidized	41	277 (47)	90 (11)
Low-income nonsubsidized	12	282 (54)	98 (33)
Middle-income nonsubsidized	12	335* (33)	100 (11)

*Starred groups are significantly different than Subsidized Centers (Games-Howell post-hoc test).

largely by centers. Teachers in subsidized centers had significantly lower TALS document scores ($M = 277$, $SD = 47$) than did teachers in middle-income centers ($M = 335$, $SD = 33$) and than providers in nonsubsidized middle-income homes ($M = 329$, $SD = 31$, respectively). Nevertheless, the lowest TALS scores were found among subsidized home providers in low-income neighborhoods ($M = 263$, $SD = 84$) and, as can be seen in Table 1.1, the trend among home-based providers was the same as among center-based teachers, with the lowest averages in subsidized care and the highest in middle-income nonsubsidized care. The sample size of home-based providers may have been insufficient to obtain statistically significant differences.

In sum, we found large inequities in the quality of care that low-income, subsidized children received within the licensed child-care market based on whether they attended a center- or home-based program. Within the center market, low-income children were much more likely to receive care of comparable quality regardless of the neighborhood location of the center or its status as a subsidized (i.e., contracted or having 25% subsidized children) center, than was the case in the home-based sector. In fact, subsidized centers in low-income neighborhoods were characterized by higher ratios and better personal care routines than other centers. In contrast, homes serving 25 percent subsidized children and in low-income neighborhoods provided significantly poorer quality care than other homes, notably in the critical areas of sensitive caregiving, support for social development, and learning activities. This pattern of results mimics prior evidence that in center-based care the odds that children from a low-income family will receive quality care may not deviate greatly from the odds for children from higher-income families, but that low-income children typically receive poorer quality care than their higher-income peers in home-based care settings.

DISCUSSION

These findings highlight the fact that public child-care subsidies are not buying equitable care across sectors of the system for low-income children and that public

dollars are frequently purchasing substandard care. This appears to be especially true in family child care homes where low-income children are highly concentrated in homes based in low-income neighborhoods that provide care for subsidized children. This evidence suggests that, as a growing share of public child care dollars are shifted away from contracted arrangements with centers (that often involve more stringent quality standards), it is essential to examine not only differences in quality of early care and education for children receiving and not receiving subsidies, but also for low-income children receiving care in different kinds of settings given the vastly different experiences they appear to receive.

In California there are two sets of state policies that place our findings in context. The first has to do with the stringency of regulations that apply to different sectors of the child-care market. To access subsidies in home-based care, providers are not required to meet any more stringent requirements than those set forth by the state licensing agency. Those requirements are minimal, focused mostly on CPR and other safety issues, but with little focus on child development. Though providers are encouraged to participate in professional development, and many do, there is nothing that mandates that they must do so. With regard to centers, the situation is more complex. Centers receiving vouchers are not required to meet standards for teacher education or ratios beyond those set by licensing, but centers contracted with the state must employ more teachers per children and teachers, for example, must complete 24 units of early childhood plus 16 units of general education at the college level in contrast to the 12 units required by licensing.

The second issue relates to the incentive structures to serve subsidized children that are built into the varying generosity of reimbursement rates, particularly as they relate to per child expenditures. Contracted programs predate the voucher system and the spending levels are set through a complicated reimbursement system that has failed to grant adequate cost of living increases for many years. In contrast, rates paid to centers and homes accepting vouchers are based on periodic market rate surveys. As a result, many contracted centers actually receive lower reimbursement rates per child than voucher centers even though they must meet higher standards. Subsidies for home-based providers who accept vouchers are generally considered more ample, if still falling short, than those in center care. In practice, then, there is a stronger incentive to provide home-based care to subsidized children supported with vouchers than to provide contracted center-based care for these children. Given the higher quality of care that these children receive in centers (perhaps especially in contracted centers with their higher standards, although our sample did not permit a direct comparison of contracted and voucher-based centers), from a developmental perspective this is perverse financial incentive system.

Within the world of K-12 education, inequities among and within school-districts have been deemed unacceptable, leading to court challenges and other policy interventions. While disparities continue to exist, there is a prevailing belief that they should be remedied. This sensibility is less prevalent in the world of early care and education, in large part because concern focuses on access to care, rather than on ensuring that all children attend developmentally supportive programs. To the extent

that policy debate focuses on low-income children, its emphasis is on the many children who qualify for subsidies but cannot access them due to limited supply.

The evidence reported here paints a stark picture of inequities in access to quality care and education among children from low-income families that are likely to perpetuate inequities in school readiness not only between low- and higher-income children, but within the most disadvantaged group of children in our society. Today, multiple voices are arguing that the earliest postnatal years are essential to future success and, accordingly, that efforts to address the hard realities of unequal life chances among children before rather than after they enter school are the most cost-efficient target for gaining greater socioeconomic opportunity throughout the life course. To these arguments, we add a strong recommendation that the time has come to apply the same expectations and goals to the early care and education field that we currently apply to K-12 education and, increasingly, to preschool programs. A broad, inclusive reassessment of the kinds of opportunities for young children that public dollars are purchasing is long overdue.

NOTES

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CHAPTER 2

WHICH SCHOOLS HAVE THE MOST SEGREGATED CLASSROOMS? A LOOK INSIDE NEW YORK CITY SCHOOLS

Dylan Conger

Relative to research on the racial segregation of students across neighborhoods and schools, far less is known about patterns in racial segregation across classrooms within schools. Most of the research on classroom segregation consists of now-dated studies that narrowly focus on the effect of tracking programs on segregation between white and black students in relatively small samples of high schools.[1] There are two notable exceptions that use recent, large sample, datasets to ask and answer broader questions about patterns in within-school segregation, including which racial groups are most segregated, how severe within-school segregation is relative to across-school segregation, and how within-school segregation varies across grade levels, substate and subcity districts, and over time.[2] These two studies, one relying on the census of North Carolina public school students and the other on the census of New York City (NYC) public-elementary and middle-school students, reveal that in addition to experiencing high rates of segregation across schools, students of all races are further isolated within their schools. Yet relative, and partially due to the extremely high rates of across-school segregation in both areas, within-school segregation is quite low. It also varies across racial groups: In NYC, Hispanics and blacks are more segregated within their schools than are Asians and whites, a result that differs from across-school segregation patterns where white students tend to be a highly segregated group.

This chapter aims to build on these two studies by focusing on the variation in classroom segregation across schools where classroom assignment decisions are made. Using data on NYC public elementary schools, the chapter answers the following two questions: (1) What is the variation in within-school segregation across schools? and (2) What distinguishes schools with highly segregated classrooms from those with more integrated classrooms? To answer question one, a measure of classroom segregation is computed for each racial group in each school for two elementary

school grades (first and fifth) in two school years (1996–1997 and 2000–2001) and the resulting distributions are observed. As noted above, within-school segregation in general, and the variation across schools in particular, is an under-explored topic, primarily due to the lack of large sample studies with data at the classroom level and to the shortcomings of segregation indexes when applied to contexts where the subunit sizes (classrooms) are small and the number of subunits and the minority shares vary widely across larger units (schools). One contribution of this paper is to compute a measure of segregation for each school that corrects this inadequacy of standard segregation measures and allows for comparisons across schools with different numbers of classrooms and minority shares.

To answer question two, I compare the student characteristics and resources of schools at the top and bottom of the distribution in within-school segregation. To be clear, the purpose of this exercise is purely descriptive. I do not offer a behavioral model of within-school segregation, one that determines the underlying motivations behind principals' classroom assignment decisions. Yet, by examining the differences between the most and least segregated schools, this chapter lays the foundation for further investigation of why some schools are more segregated than others. Unlike school assignments, which are largely driven by family residential choices and central administrative decisions, classroom assignments are determined by school-level administrators, with some input from parents, district-level administrators, and other school personnel.[3]

As with racial segregation across schools and neighborhoods, segregation across classrooms could result from race-related preferences or discrimination. For instance, parents may want their children placed with co-race peers, independent of the educational attributes of those peers. Yet, principals are likely motivated by more pedagogical choices, such as whether to separate students according to their prior academic ability, English language proficiency, and special needs. Given racial differences along these characteristics, a school that employs such sorting practices is likely to have higher rates of racial segregation across classrooms than one that does not.[4] Decisions about whether to segregate students by educational characteristics or by race may, in turn, be influenced by the resources of the schools, including the experience and education of the teachers, the size of the school, and the funding available. At the very least, if classroom racial segregation is driven by the composition of the students and the resources available, highly segregated and highly integrated schools should differ along these characteristics. The goal of this chapter is to uncover such differences. While a considerable amount of research has explored the possible correlates of racial segregation across neighborhoods, and to a lesser extent schools, very little work has taken an empirical look inside schools.[5]

This analysis raises two important questions. First, why study within-school segregation when so little progress is being made to integrate schools? Indeed, recent national trends in school segregation show a growth in black/white segregation in Southern schools during the late 1980s and 1990s, reversing gains made during the previous decade.[6] In addition, NYC has among the highest levels of white and black school segregation in the nation.[7] Yet when the implicit definition of integration, that

between black and white students, is broadened to consider other racial groups, mixed race schools are fairly common in the city. Almost 63 percent of the elementary and middle schools in NYC served at least 20 percent of two racial groups in school year 2000–2001. Most commonly, these duo-racial schools were comprised of Hispanic and black or Hispanic and white students. One-third of the schools in 2000–2001 contained at least 10 percent of three different racial groups, the typical combination being Asian, Hispanic, and white. What is more, the city experienced modest declines in school segregation for all racial groups except Asians between school years 1995–1996 and 2000–2001.[8] Thus, though school integration is far from complete, there are certainly enough mixed-race schools in the city to warrant concerns about the potential for within-school segregation.

Second, if schools become integrated, why should educators be concerned about segregation within schools? Two reasons, which correspond with the two goals of racial integration, stand out. The primary purposes of integration are to equalize educational resources across racial groups (including the educational preparation of the peers students are exposed to) and to increase interracial contact, which in turn is expected to foster positive inter-racial relations. Through complete school desegregation, students will be exposed to other racial groups in their schools and to the same school-wide resources and peer groups. Yet a multiracial school, with perfectly segregated classrooms, could significantly erode these goals of school desegregation. To the extent that teacher and peer quality varies within a school, racial segregation across classrooms could contribute to significant disparities. Moreover, inter-racial contact may be quite limited in multiracial schools since students have been found to self-segregate across the lunch tables, playgrounds, and extra curricular activities of the same school.[9] In fact, the classroom could be the only environment during or outside of school hours that students from different ethnic groups are truly required to socialize.

MEASURING WITHIN-SCHOOL SEGREGATION

To describe patterns in within-school segregation, I use the same unevenness measure that is used in the earlier studies of within-school segregation: the gap-based segregation index (S). Though the S is not as popular an unevenness index as the Dissimilarity index for example, it is easy to interpret and has the advantageous feature of being decomposable into within- and across-schools components.[10]

To compute the S, one begins by calculating the exposure index (E), an index that captures the probability of contact between two dichotomous groups in a given context, such as a classroom, school, or neighborhood. For illustration, I will discuss the exposure rate of Hispanic to non-Hispanic students. The classroom exposure rate of Hispanics to non-Hispanics (E_c) is the percentage non-Hispanic in the average Hispanic student's classroom, simply the weighted average of classroom percentage non-Hispanic where the weight is the number of Hispanics in each classroom. An equivalent exposure rate can be calculated at the school level (E_s), providing the likelihood that a Hispanic student will come into contact with a non-Hispanic student in school.

The degree of exposure between groups is determined both by the share of the groups in the population and the extent to which they are segregated across classrooms and schools. If Hispanics are evenly distributed across classrooms and schools, then the classroom and school exposure rate of Hispanics to non-Hispanics should equal the school district share of non-Hispanics. Deviations from perfect integration can be measured with the *S*, which normalizes the exposure rate to its theoretical maximum, the share of non-Hispanics in the larger unit. The formula for classroom segregation in a school district is written as: $S_d = (P_d - E_c)/P_d$, where P_d is the percentage non-Hispanic in the district. The *S* ranges from 0 (perfect integration) to 100 percent (perfect segregation) and measures the percentage gap between the exposure of two groups to one another in a smaller unit (e.g., classroom, school) and the maximum exposure possible in the larger unit (e.g., school, school district).

The *S* can also be computed for an individual school (S_c) where instead of using the school district share of non-Hispanics as the maximum exposure possible, we substitute the school share of non-Hispanics as follows: $S_c = (P_s - E_c)/P_s$, where P_s is the percentage non-Hispanic in the school. Correspondingly, the *S* for an individual school measures the percentage gap between the exposure of two groups to one another in their classrooms and the maximum exposure possible at the school.

While the theoretical boundaries of the *S* are 0 and 100, the minimum and maximum values for a given school depend upon the number and size of the classrooms along with the minority share. The reason for this variation is that the number of students in one group is rarely perfectly divisible into the number of classrooms, consequently preventing a school from achieving a perfectly even or uneven distribution. Consider a school with two classrooms of 20 students each and five Hispanic students. If the administrators in this school sought to segregate all the Hispanic students, they would have to create a classroom of five Hispanic and 35 non-Hispanic students. While possible, such a classroom configuration would likely raise eyebrows and result in large inefficiencies. Instead, this segregation-maximizing school would place the five students in a classroom of 20, resulting in a Hispanic to non-Hispanic classroom exposure rate of 75 percent and a segregation level of 14.3 percent, nowhere near the 100 percent value that would indicate complete segregation of Hispanics.[11] Given practical class sizes, schools with small minority shares and small numbers of classrooms are less able to achieve high segregation values on the *S* and other unevenness indexes than other types of schools. The minimum segregation possible for a given school is less sensitive to these constraints. This index inadequacy, which all unevenness indexes are subject to, prevents trustworthy comparisons of schools with varying minority shares and classrooms.

To address these issues, I compute two levels of segregation for each school in addition to the implicit boundaries of 0 and 100. The first is computed after assigning students to their classrooms in an effort to minimize segregation (Min *S*) and the second is computed after assigning students to their classrooms in an effort to maximize segregation (Max *S*). Both assignment mechanisms assume existing numbers and sizes of classes so as to represent the upper and lower bounds a principal could obtain given practical classroom configurations. Using the minimum and maximum boundaries, I

Table 2.1
Student and School Characteristics by Race, 5th Grade, 2000–2001

	All	Hispanic	Black	White	Asian
Number of students	77,654	29,524	26,601	12,023	9,228
% of all students	100.0	38.0	34.3	15.5	11.9
% of students who are:					
Poor/Near poor	85.2	93.9	92.0	50.6	81.3
Limited English Proficient (LEP)	8.0	14.5	1.6	3.4	11.7
Part-time special education (PTSE)	8.4	9.6	8.1	9.0	4.1
Average test scores					
Math	0.00	–0.18	–0.26	0.09	0.72
Reading	0.00	–0.17	–0.19	0.55	0.45
Average school characteristics					
Enrollment	816	897	773	694	842
% teachers 5+ years experience	53.8	52.0	50.9	60.3	59.7
% teachers with masters degrees	75.3	73.1	71.4	83.6	82.8
Expenditures (in thousands)	$10.4	$10.4	$10.7	$10.1	$9.6

Note: (i) average school characteristics are measured as the weighted mean of school level variables where the weights are the number of students in total or in each racial group in the school. (ii) The sample of 5th graders includes students from 665 schools.

then create a standardized version of the segregation index (S^*) which normalizes the observed segregation level to these alternative benchmarks as follows: $S^* = (S - \text{Min } S)/(\text{Max } S - \text{Min } S)$. S^* has no intuitive interpretation but it allows for comparisons of within-school segregation across schools while taking into account variation in the capability of each school to reach the theoretical boundaries of the index. This index correction does not address the additional concern that the segregation of students across classrooms may fall within the realm of a random allocation, a possibility I am currently exploring elsewhere.[12]

DATA AND SAMPLE

Data on students and their schools were obtained from the NYC Department of Education. For each first through fifth grade student in school years 1996–1997 through 2000–2001, the dataset includes sociodemographic (e.g., race, eligibility for free or reduced price lunch) and educational variables (e.g., test scores, performance on English language test) as well as indicators of the schools and classrooms to which students are assigned. Using these school and classroom codes, I calculate the racial composition of students' classrooms and schools. This study also uses information on expenditures and teacher characteristics from two NYC school-level databases: the Annual School Reports and the Student Based Expenditure Reports.

For most of the analyses reported in this chapter, I rely on the fifth grade in 2000–2001, which consists of almost 78,000 students in almost 600 schools. Differences in other grades and years, where observed, are noted in the text. As shown in Table 2.1,

NYC's students are incredibly diverse: while most students are Hispanic (38%) or black (34%), there are also sizeable shares of white (16%) and Asian (12%) students.[13] Most students (85.2%) qualify for the federally subsidized lunch program and are considered poor (up to 130% of federal poverty level) or near poor (between 130% and 185% of poverty level). Approximately 8 percent of students score below the 40th percentile on the Language Assessment Battery, designating them as Limited English Proficient (LEP) and eligible for bilingual education or English as a Second Language services. An equivalent percentage of students receive part-time special education (PTSE) services for relatively mild disabilities, such as speech impediments and dyslexia. Reading and math tests scores are standardized to a mean of 0 (as shown in the table) and a standard deviation of one.

Students in this fifth grade cross section attended 655 schools. The average student attended a school where approximately 54 percent of teachers have taught for at least 5 years, and over three-quarters have obtained master's degrees. The average level of per pupil spending across the 655 schools is approximately $10,400.

The additional columns in the table show the extent to which these measured student and school characteristics vary by racial group. Notably, white students are the least poor among all racial groups at a rate of only 50.6 percent. Hispanic and Asian students have the highest LEP rates and Asians have the lowest rates of participation in special education programs. Consistent with national trends, black and Hispanic students score lower on standardized tests than Asian and white students. Students from each racial group also attend different types of schools: white and Asian students attend schools with slightly more experienced and educated teachers on average, yet they also attend schools with lower overall spending. Interestingly, black and white students attend smaller schools than Hispanic and Asian students.

RESULTS

A necessary first step in exploring variation in segregation across schools is to examine the overall levels of within-school segregation in the entire school district. Table 2.2 provides these levels of within-school segregation and the levels of across-school segregation for comparison. The table indicates that for every racial group, an additional amount of segregation occurs within schools leading to higher levels of total classroom segregation. For instance, Hispanic fifth graders are 5.2 percent less exposed to non-Hispanics in their classrooms than in their schools and 33 percent less exposed to non-Hispanics in their schools than in the district. In total, Hispanics are 37.9 percent less exposed to non-Hispanics in their classrooms than in the school district and within-school sorting processes accounts for almost 14 percent (5.2/37.9) of this total classroom segregation.

Though within-school segregation is generally trumped by across-school segregation, the relative severity varies by race. The maximum within-school segregation across all racial groups is among Hispanics at 5.2 percent (accounting for 14% of total segregation). In contrast, within-school segregation of whites is 2.8 percent (accounting for only 6% of total segregation). The amount of within-school segregation is similar for Asian and black students (approximately 4%), but the portion of total

Table 2.2
Within- and Across-School Segregation (S), 5th Grade, 2000–2001

	Within-School	Across-School	Total
Hispanic			
Component	5.2	32.7	37.9
% of total	13.7	86.3	100.0
Black			
Component	4.0	45.7	49.7
% of total	8.0	92.0	100.0
White			
Component	2.8	41.9	44.7
% of total	6.3	93.7	100.0
Asian			
Component	3.6	28.0	31.6
% of total	11.4	88.6	100.0

Table reads: Hispanic 5th graders are 5.2% less exposed to non-Hispanic 5th graders in their classrooms than in their schools and 32.7% less exposed in their schools than in the school district. The total classroom segregation between these two groups is 37.9%, 13.7% (5.2/37.9) of which can be attributed to within-school segregation.

classroom segregation accounted for by within-school segregation is much higher for Asians than for blacks, 11 percent and 8 percent respectively. Though not shown in the table, cross-racial classroom exposure rates indicate where integration across schools and classrooms occurs; it disproportionately occurs between black and Hispanic students on the one hand and between white and Asian students on the other, though Asian students tend to be fairly integrated with all three other racial groups. Overall, black and white students are highly segregated from one another across schools and classrooms.[14]

Variation in Within-School Segregation Across Schools

The previous analysis indicates that most of the segregation between racial groups occurs across schools and that once students reach the same school, within-school segregation is quite rare. Yet the experience of the average student in the district could mask variation experienced by students in different schools, where assignment decisions are made. Table 2.3 shows the variation in observed within-school segregation (S) across schools in 2000–2001, along with the distributions in the minimum (Min S), maximum (Max S), and standardized segregation (S^*).

The average segregation levels are very similar to those reported at the district level yet schools vary in the extent to which they segregate their classrooms. For instance, while the average level of within-school Hispanic segregation from non-Hispanics is 6.1 percent, it ranges from one school with 0 percent segregation to another school with 86.7 percent segregation. Despite this wide range, as indicated by the median

Table 2.3
Observed, Minimum, Maximum, and Standardized Within-School Segregation Across Schools, 5th Grade, 2000–2001

	Mean	Median	75th %tile	Min	Max
Observed Segregation (*S*)					
Hispanic	6.1	3.6	7.4	0.0	86.7
Black	5.6	3.4	6.8	0.0	81.0
White	4.6	3.2	5.8	0.0	36.4
Asian	4.2	3.1	5.6	0.0	32.5
Minimum (Min *S*)					
Hispanic	0.2	0.1	0.2	0.0	2.8
Black	0.3	0.1	0.2	0.0	3.3
White	0.4	0.1	0.2	0.0	3.8
Asian	0.3	0.1	0.2	0.0	3.4
Maximum (Max *S*)					
Hispanic	67.5	80.1	94.2	3.5	100.0
Black	59.1	65.5	93.2	1.6	100.0
White	63.0	75.5	91.9	2.5	100.0
Asian	56.9	62.9	89.1	1.6	100.0
Standardized Segregation (*S**)					
Hispanic	9.7	5.7	11.6	0.0	100.0
Black	11.7	6.6	13.3	0.0	100.0
White	9.5	5.5	11.7	0.0	100.0
Asian	10.6	6.1	12.0	0.0	100.0

Note: (i) Schools with fewer than two students of the racial group in question were not examined, which resulted in different numbers of schools used for each type of racial segregation. (ii) Standardized segregation is calculated as follows: $S^* = (S - \text{Min } S)/(\text{Max } S - \text{Min } S)$.

of 3.6 percent and the 75th percentile of 7.4 percent, the overwhelming majority of schools have relatively low levels of within-school segregation. For each racial group, three-quarters of the schools have a segregation level below 7.4 percent. On a scale that ranges from 0 to 100, these averages and 75th percentiles are remarkably modest.

As described in the measurement section above, the minimum (Min *S*) and particularly the maximum segregation (Max *S*) possible for a given school are substantially influenced by the minority share as well as the number and size of the classrooms in the school. Though most schools are able to reach a minimum quite close to 0 as shown in Table 2.3, the same is not true for maximum obtainable values. In fact, the average maximum obtainable value does not exceed 67.5 percent and, as indicated by the minimum values on the maximum obtainable segregation, some schools are unable to exceed 3.5 percent segregation of Hispanics, 2.5 percent segregation of whites, and 1.6 percent segregation of Asians and blacks.

Given these constraints, the standardized segregation (*S**) provides a more accurate assessment of the variation in within-school segregation across schools. Once practical

minimum and maximum obtainable values are taken into consideration, the average segregation levels double in most cases and the minimum and maximums have the natural reference points of 0 and 100 percent. Yet still, as indicated by the 75th percentiles, most of the schools do not exceed 13.3 percent segregation. On a true scale that ranges from 0 to 100, the overall level of within school segregation is not exceedingly high for most schools. In addition, once more practical boundaries on the segregation index are employed, the relative segregation of the racial groups changes: black and Asian students show higher rates of within-school segregation than Hispanic and white students on all moments of the distributions.

Results for the first grade and for both the first and fifth grades in an earlier school-year (1996–1997) show similar distributions on observed, minimum, maximum, and standardized within-school segregation. Some differences are worth noting. For instance, the standardized segregation averages for each racial group were higher in the earlier year and, in both school years, the averages were higher for younger elementary school students.

Differences Between Highly Segregated and Highly Integrated Schools

Despite the relatively low levels of within-school segregation for most schools, some schools have markedly high levels of segregation. Ultimately, we are interested in understanding why some schools are more segregated than others. As a first step toward this goal,Table 2.4 considers the characteristics of the most and least segregated schools for each racial group. Specifically, the characteristics of schools in the top quartile (at or above 75th percentile) and the bottom quartile (at or below 25th percentile) of each distribution in standardized within-school segregation (S^*) are provided. Along with the average characteristics of each group, the table provides the results of a two-sample hypothesis test of these averages. For instance, schools in the bottom 25 percent of the Hispanic segregation distribution average 30.7 percent Hispanic students and schools in the top 25 percent of the distribution average 38.9 percent Hispanic, a difference that is statistically significant at the 1 percent level.

The results indicate that the racial composition of the students in the school correlates with classroom segregation, though the correlations are not always statistically significant and not always in the same direction. Overall, the presence of Hispanic and black students tends to associate with higher levels of classroom segregation for all racial groups, while the presence of white and Asian students tends to associate with lower levels of segregation. There are some exceptions, for instance, the racial composition of the school seems to have no relationship to black segregation. In fact, the black share is lower in schools with high levels of black segregation than it is in schools with low levels of black segregation, a difference that is, nevertheless, statistically insignificant.

In addition to the racial composition of the students, other student attributes distinguish high from low segregating schools. The more segregated schools tend to have higher shares of students who are poor or near poor, though the differences

Table 2.4
Characteristics of Schools at Top and Bottom Quartile of Within-School Standardized Segregation (S^*) Distribution, 5th grade, 2000–2001

	Hispanic		Black		White		Asian	
	0%–25%	75%–100%	0%–25%	75%–100%	0%–25%	75%–100%	0%–25%	75%–100%
% of 5th graders who are:								
Hispanic	30.7	38.9[a]	31.5	36.5	28.0	38.3[a]	31.0	38.9[b]
Black	38.3	38.5	43.0	37.9	15.0	31.6[a]	17.3	27.9[a]
White	17.2	13.6	14.3	16.5	36.1	16.9[a]	27.9	24.2
Asian	13.4	8.7[b]	10.8	9.0	20.6	12.8[a]	23.3	8.8[a]
Poor/near poor	79.1	83.6[c]	82.7	83.0	67.8	79.2[a]	72.8	76.0
LEP	4.4	10.0[a]	4.4	9.3[a]	5.1	7.0[b]	6.7	6.4
PTSE	9.6	8.0[a]	8.7	8.5	9.6	8.7	8.8	8.8
Average test scores								
Math	0.08	–0.06[b]	0.02	–0.04	0.34	0.15[a]	0.31	0.12[a]
Reading	0.07	–0.07[b]	0.02	–0.05	0.30	0.15[a]	0.25	0.15
Average school characteristics								
Enrollment	600	760[a]	621	725[a]	644	817[a]	625	800[a]
% teachers 5+ years experience	55.3	52.5[c]	54.1	54.5	61.7	55.7[a]	59.2	56.4
% teachers masters degrees	75.5	73.2	74.0	74.3	83.3	78.4a	79.3	79.2
Expenditures (in thousands)	$11.3	$10.7[b]	$10.9	$10.9	$10.2	$10.4	$10.5	$10.4

Note: (i) LEP = Limited English Proficient, PTSE = Part-time special education. (ii) Tests of significance refer to a test of the difference between schools in the bottom and top quartiles of the distribution ($a = p < .01$; $b = p < .05$; $c = p < .10$). (iii) Schools with fewer than two students of the racial group in question were not examined, which resulted in different numbers of schools used for each type of racial segregation. The total number of schools used for each analysis is as follows: Hispanic (143 schools in each quartile); black (133 schools in each quartile); white (78 schools in each quartile); Asian (83 schools in each quartile).

are only statistically significant in segregation of Asians and whites. The presence of LEP students also associates with higher rates of segregation for all but Asians. The more segregated schools also tend to have far lower average reading and math test scores than the less segregated schools; however, not all the differences are statistically significant. Special education rates are slightly lower in the more segregated schools for Asians but not for any other group.

Overall, schools with the most segregated classrooms tend to be larger. Yet the most and least segregated schools appear to differ little in measured resources: while schools with more Hispanic and white segregation have relatively less experienced and less educated teachers and schools with more Hispanic segregation have relatively lower expenditures, no statistically significant differences exist among the other types of segregation.

Similar analyses were conducted using the first grade and using the earlier school year, 1996–1997. The differences observed in Table 2.4 for the fifth grade in 2000–2001 were in the same direction but generally more pronounced, more likely to be statistically significant, and more consistent across the racial groups in the earlier year and in the younger grade. For instance, schools with higher levels of black segregation across classrooms also tended to have fewer whites and more qualified teachers in the other cross sections. The share of students in part-time special education programs also tended to be higher in schools that were less segregated than in schools that were more segregated, though the difference was not always significant at conventional levels.

CONCLUSIONS

This chapter adds to a relatively limited literature exploring patterns in within-school segregation. Answers to the two questions posed in the introduction move us in the direction of better understanding the severity, consequences, and causes of classroom segregation.

Previous studies have focused almost exclusively on measuring within-school segregation at the district or subdistrict level, to the neglect of measurement at the school-level where classroom assignment decisions are made. One reason is that the segregation level obtainable for an individual school is substantially influenced by the minority share and classroom configurations, preventing reliable comparisons of classroom segregation across schools. This study creates a segregation measure for each school using more realistic boundaries than the theoretical boundaries of 0 and 100 percent. Even after these constraints are taken into account, most schools appear not to be segregating at very high levels. In fact, three-quarters of all schools do not exceed a segregation of 14 percent on the standardized segregation index, which has boundaries of 0 and 100 percent. In addition, within-school segregation has declined in recent years and tends to decrease as students reach the end of elementary school. In short, the average levels of within-school segregation at the elementary school level are not extreme, the variation across schools is not extensive, and there is no evidence of a growing problem.

There are, however, a handful of schools with highly segregated classrooms. In order to determine what might be different about these schools, I compared them to very integrated schools on the composition of the students and the resources of the schools. Though some of the comparisons are not statistically significant at conventional levels in the fifth grade 2000–2001 cross section, across both the first and fifth grade cross sections in 2 years, schools with more segregated classrooms tend to have more Hispanic, black, poor, LEP, and low-achieving students, all relatively disadvantaged groups. In somewhat of a departure from this trend, the more segregated schools also have lower shares of students receiving part-time special education services. Highly segregated schools are also typically larger and have less qualified and experienced teachers. Thus, the less endowed schools that already serve disadvantaged populations appear also to be the most segregated. To the extent that racial segregation prevents positive interethnic relations and inhibits academic achievement, this is an unfortunate reality.

Whether segregation in these schools is a byproduct of these school characteristics or whether these characteristics are themselves driven by the existing levels of segregation has not been determined here. Yet, the distinct differences in high- and low-segregated schools suggests that classroom sorting practices on nonracial characteristics, such as into bilingual education, ability grouping, and compensatory education programs, may contribute to racial segregation across classrooms. They also suggest that schools with greater resources, including higher teacher-to-pupil ratios and more experienced teachers, may be less likely to segregate students along racial or educational characteristics. In order to sufficiently isolate the sources of classroom segregation, a causal model that incorporates underlying preferences and motivations, and that provides conditional expectations would be necessary. In the meantime, the observations in this chapter suggest many possibilities worth exploring further.

It is important to keep in mind that this study highlights the experience of a somewhat unique public school system. NYC is the largest school district in the country and home to markedly high levels of school segregation and a rare diversity of students. Research that explores classroom segregation in less urban, less multiracial, and less segregated school systems, such as that conducted in North Carolina, is important for understanding within-school segregation in all environments and all types of students.

Additionally, the emphasis here on students' first five years of school is important given the impact of early education on later experiences. However, the isolation of students in junior and high schools has been found to be much higher.[15] And although most of the existing research on tracking and segregation already focuses on high schools, further work is required to identify the existence, persistence, and consequences on a large scale.

Finally, this study uses a popular segregation index, which like other indexes has its limitations. While useful when units and minority members are numerous, such indexes limit reliable comparisons of within-school segregation across school districts and schools. Further research devoted to modifying these indexes or exploring alternative sensitivity analyses as was done in this study would help tremendously in

further analysis of segregation in units smaller than neighborhoods and large schools districts.

NOTES

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2. Charles T. Clotfelter, Helen F. Ladd, and Jacob L. Vigdor, "Segregation and Resegregation in North Carolina's Public School Classrooms," *North Carolina Law Review* 81.4 (2003): 1463–1511; Dylan Conger, "Within-School Segregation in an Urban School District," *Educational Evaluation and Policy Analysis* 27.3 (2005): 225–244.

3. There is very little research on how classroom assignment decisions are made. Personal correspondence by the author with several principals and teachers as well as at least one study of principals in a small sample of schools suggests that while principals often decide how to group students, their decisions are sometimes influenced by school district personnel, teachers, parents, and students. See David H. Monk, "Assigning Elementary Pupils to Their Teachers," *The Elementary School Journal* 88.2 (1987): 167–187.

4. For research on the possible effects of educational sorting practices (including ability grouping, compensatory education, bilingual/ESL instruction, and special education) on racial segregation see Janet Eyler, Valerie J. Cook, and Leslie E. Ward, "Resegregation: Segregation Within Desegregated Schools." In Christine H. Rossell and Willis D. Hawley (Eds.), *The Consequences of School Desegregation* (Philadelphia, PA: Temple University Press, 1983); Meier, Stewart Jr., and England, 1989; Kevin G. Welner, *Legal Rights, Local Wrongs: When Community Control Collides With Educational Equity* (New York: State University of New York Press, 2001); Tamela McNulty Eitle, "Special Education or Racial Segregation: Understanding Variation in the Representation of Black Students in Educable Mentally Handicapped Programs," *Sociological Quarterly,* 43.4 (2002): 575–605.

5. For research on school segregation see Gary Orfield and John T. Yun, *Resegregation in American Schools* (Cambridge, MA: The Civil Rights Project, Harvard University, 1999); Sean F. Reardon, John T. Yun, and Tamela M. Eitle, "The Changing Structure of School Segregation: Measurement and Evidence of Multiracial Metropolitan-area School Segregation, 1989–1995," *Demography,* 37.3 (2000): 351–364; Hamilton Lankford and James Wyckoff, "Why are Schools Racially Segregated? Implications for School Choice Policies." In Janelle T. Scott (Ed.), *School Choice and Diversity: What the Evidence Says* (New York: Teachers College Press, 2005).

6. Orfield and Yun, *Resegregation in American Schools*.

7. Erica Frankenberg and Chungmei Lee, *Race in American Public Schools: Rapidly Resegregating School Districts* (Cambridge, MA: The Civil Rights Project, Harvard University, 2002); John R. Logan and Deirdre Oakley, *The Continuing Legacy of the Brown Decision: Court Action*

and School Segregation, 1960–2000, (Albany, NY: Lewis Mumford Center for Comparative Urban and Regional Research University of Albany).

8. Conger, "Within-School Segregation in an Urban School District."

9. Janet W. Schofield and H. Andrew Sagar, "Peer Interaction Patterns in an Integrated Middle School," *Sociometry* 40.2 (1977): 130–138; Charles T. Clotfelter, "Interracial Contact in High School Extracurricular Activities," *Urban Review* 34 (March 2002): 25–46.

10. For other applications of the *S*, see Barbara S. Zoloth, "Alternative Measures of School Segregation," *Land Economics* 52.3 (1976): 278–291; Charles Clotfelter, "Public School Segregation in Metropolitan Areas," *Land Economics* 75(1999): 487–504.

11. Exposure rate (E_c) is calculated as [(5*0.75) + (0*1)]/5 and segregation (Ss) is calculated as (0.88–0.75)/0.88.

12. For a discussion of indexes that use the random allocation of students as a lower bound, see William J. Carrington and Kenneth R. Trokse, "On Measuring Segregation in Samples with Small Units," *Journal of Business and Economic Statistics* 15.4 (1997): 402–409 and Christopher Winship, "A Reevaluation of Indexes of Residential Segregation," *Social Forces* 55.4 (1977): 1058–1066.

13. The Department of Education identifies five categories of race: white, black, Hispanic, Asian, and Native American. Although these categories combine race, ethnicity, and linguistic origin, the term "race" is used for simplicity.

14. For instance, the average black fifth grader shares a classroom with 67% black, 24% Hispanic, 5% white, and 4% Asian students. The average white fifth grader shares a classroom with 53% white, 16% Asian, 20% Hispanic, and 10% black students.

15. Clotfelter, Ladd, and Vigdor, "Segregation and Resegregation in North Carolina's Public School Classrooms."

CHAPTER 3

Family Poverty, Classroom Instruction, and Mathematics Achievement in Kindergarten

Annie Georges

Current education policies view quality instruction, student testing, and holding schools and students accountable as the levers for improving learning of mathematics, reading, and increasingly science. To that end, state and federal policies require instruction to de-emphasize lectures, encourage understanding of concepts, and develop skills in problem solving and reasoning skills.[1] These kinds of instructional practices are assumed to be effective in improving students' academic achievement and to moderate the risks of school failure. This emphasis on instruction often overshadows policies that could minimize the social inequalities that contribute to unequal educational outcomes among children. The children that are targeted are not only in low performing schools, they are more likely to face adverse family and community disadvantages such as poverty, high unemployment among adult family members, inadequate nourishment, overcrowded and unsafe environments, and violence.[2] Research has shown that there are negative educational consequences if, for example, a parent is not employed, or if the child is growing up in poverty.[3]

Scholars, educators, and policymakers have long been interested in understanding how schools can be structured to minimize unequal educational outcomes for students of varying social backgrounds. Much attention is paid to how schools can minimize the achievement gaps for students from economically disadvantaged families, students with disabilities, students with limited English proficiencies, and minority groups. However, the national emphasis to change instructional practices, a decision which has traditionally been made by school districts and individual teachers, as the lever by which schools can be structured to minimize unequal educational outcomes is a relatively recent phenomenon in education policy discourse. Yet, the amount of research on whether instructional practices can moderate the economic inequalities that contribute to low academic achievement is relatively thin. Using data from the

Early Childhood Longitudinal Study (ECLS-K), a nationally representative sample of the 1998–1999 kindergarten class, this chapter examines whether instruction moderates the adverse effects of family poverty on mathematics achievement during kindergarten.

The present study advances our understanding of young children's mathematics achievement in important ways. First, previous research that examines the association between mathematics instruction and mathematics achievement has relied on small and targeted populations. Targeted and small samples do not provide a broad and sweeping view of heterogeneous classes of students. In contrast, analyses that use nationally representative samples are well suited to inform policies that are designed to move whole classes of students toward specified academic goals. Second, the concurrent effects of different kinds of instructional practices on mathematics achievement have not been analyzed. It is important to understand whether a single approach to mathematics instruction works best, or whether multiple approaches that are used in concert will work best in the classroom. The data that are used for the analysis in this chapter, the Early Childhood Longitudinal Study (ECLS-K), permit a full exploration of the independent effects of a range of mathematics instructional practices that could affect mathematics achievement.

BACKGROUND

Children in low-income families enter kindergarten below the level of academic achievement that children in high-income families exhibit, which suggests that family income, even prior to the start of school, may be positively associated with academic achievement.[4] As early as 36 months of age children below poverty whose families experienced an increase in their income of at least one standard deviation above the mean had similar cognitive outcomes as children in families who were not below poverty.[5] In contrast, similar increases in income had little effect for children in families who were not below poverty.[6] After children begin school their rate of academic progress continues to differ. For example, during kindergarten children in low-income families make greater strides in their basic mathematics skills such as being able to count beyond ten, whereas children in high-income families make greater stride in solving basic addition/subtraction problems.[7]

Policies that increase family income can improve students' academic achievement. In a random assignment to assess the impact of the New Hope Project, an antipoverty program in Wisconsin that offered wage supplements sufficient to raise income above the poverty threshold, children whose families received earnings supplement had higher academic achievement compared to a similar group of children whose families did not receive earnings supplement.[8] However, the effects of earnings supplement on academic achievement were significant for boys, but not for girls. Also, a comprehensive synthesis of several large-scale experimental programs that offered earnings supplement for families living in poverty found that programs which increased employment and income had positive effects on academic achievement.[9]

Even though these experimental studies show that family income is a powerful predictor of academic achievement and that income policies could improve academic achievement, other factors such as choice of child-care arrangements, participation in structured activities, parenting, social processes in the home, as well as the community's resources are major forces that could also affect students' academic achievement. For example, Richard Rothstein[10] conducted a comprehensive review of the social, economic, and education literature to understand how to close the black-white achievement gap. Rothstein's analysis illustrated a strong association between family background and academic achievement. He concluded that even with the existence of high-quality teaching, schools might not be equipped to simultaneously address long-term social differences such as access to books and other literacy experiences, parenting practices, child-care experiences as well as the lack of community resources which existed before as well as during the time that children are in school.

The effects of instruction on mathematics achievement have been primarily examined with small samples of elementary school students, and these studies have not examined whether instruction may be a moderator of the adverse effects associated with family poverty during childhood. The lessons from this literature are that emphasizing critical thinking, individualizing instruction, and using collaborative teaching techniques improves mathematics achievement.[11] In addition, if the instructional practice relies on children's own thinking rather than imposes knowledge, and if the instructional practice requires children to be actively engaged then there are positive effects on mathematics achievement.[12] The positive association between these kinds of instructional practices and mathematics achievement are illustrated in a collection of studies, which employed data from a random assignment of first grade teachers. This collection of studies showed children were more likely to recall number facts, and to exceed in problem solving abilities when their teachers emphasized application of concepts, provided examples of concepts, used collaborative techniques that promoted interaction in small group and de-emphasized strategies that evolved from the teacher.[13]

An experimental study of low-achieving and low-income elementary school students evaluated the effects of problem solving and peer collaboration practices on mathematics achievement. The students were assigned to a problem-solving instructional group, a peer collaboration instructional group, and a control group. This experimental study, which was conducted by Marika Ginsburg-Block and John Fantuzzo,[14] concluded that problem solving and collaborative teaching strategies resulted in higher mathematics achievement when compared to similar students who were not exposed to either of these strategies. However, since their analysis was based on a small cross-sectional sample, the results cannot be generalized to all low-income elementary school students.

An observational study of second grade classrooms found that collaborative instructional practices had positive effects on mathematics achievement. Specifically, classrooms in which there was an emphasis on practicing prescribed computation procedures from the textbook had lower scores than classrooms where students collaboratively engaged with each other to develop solution strategies.[15] However, an

observational study of similar classroom activities concluded that encouraging children to work collaboratively were not beneficial for girls' mathematics achievement.[16]

In contrast to the small experimental and observational studies just discussed, statistical analyses that relied on larger samples and on older cohorts of elementary school students have not produced a consistent set of findings of the effects of instruction on mathematics achievement. The first set of findings suggests instruction is not associated with mathematics achievement. For example, Stephen Klein and Brian Stecher[17] used a stratified random sample of elementary and middle-school students from 11 schools in six cities. After controlling for student characteristics, the authors found a positive but not a statistically significant association between instruction and mathematics achievement. In their analysis mathematics instruction was defined as the sum of 22 teacher-reported items covering questions about the teacher's use of cooperative learning groups, inquiry-based activities and open-ended assessment techniques. Klein and Stecher also found that lecture, practice, memorization, and short answer assessment techniques were unrelated to mathematics achievement. Another analysis of elementary school students in high-poverty school districts in San Antonio, Texas, reinforced the finding that collaborative learning strategies as well as lecture, use of worksheets, practice, or drill were not significantly related to mathematics achievement.[18] In another study with data on eighth graders from the National Assessment of Educational Progress (NAEP), Harold Wenglinsky[19] also found that drill and practice were not effective teaching strategies.

The second set of findings suggests mathematics instruction is significantly associated with mathematics achievement. Using a sample of elementary schools in California, David Cohen and Heather Hill[20] found that mathematics achievement improved when teachers emphasized different methods to solve a problem, had students work in small groups, work on individual projects and on mathematics questions with more than one solution. However, they measured student achievement at the school level whereby schools with higher achievement scores were interpreted as having a more proficient student body. Another study of students in high-poverty schools suggested that implementing instructional reforms which involved more student-initiated activities and collaborative activities among students had positive effects on mathematics achievement, whereas activities that were more teacher-initiated activities were negatively associated with mathematics achievement gains.[21] In analyses with data from the National Assessment Educational Progress, mathematics instruction involving higher-order thinking skills such as developing skills in problem solving and reasoning skills, and mathematics instruction which encouraged understanding of concepts rather than memorizing facts were positively associated with mathematics achievement.[22]

The literature suggests that mathematics instruction matters. Studies with larger samples of students show that instructional practices such as lecture, use of worksheets, practice, or drill are more likely to repress mathematics achievement. The literature also suggests that actively engaging children and incorporating their thinking into the instructional activities have positive effects on mathematics achievement. On the other hand, in some studies collaborative learning activities have been found to have

positive but not statistically significant effects on mathematics achievement. Although instruction matters, it is also the case that social class plays an important role in understanding differences in mathematics achievement. Children from middle-class families enter school with more basic knowledge of mathematics than children from lower-class families. The effects of social class and family poverty which are present even before school begins could be due to differences in access to quality child care and preschool, access to books and literacy activities, differences in parenting practices as well as other long-term social differences which schools might not be equipped to address.

PERSPECTIVES AND HYPOTHESES

An in-depth research synthesis by the National Research Council[23] concluded that the school environment should emphasize learning through understanding rather than the acquisition of disconnected sets of facts and skills. Instructional practices that de-emphasize lectures, encourage understanding of concepts, and develop skills in problem solving and reasoning skills are more likely to promote an effective learning environment than rote drill and practice of mathematical facts and skills.[24] If these kinds of instructional practices are adopted then the school will have instituted an effective learning environment, and student achievement will improve.[25]

The National Research Council's research synthesis, though it recognized the significance of quality classroom instruction, also emphasized that the family remained the child's primary source of support for learning. If the family's income is low, parental investments in educational resources might, often time, be inadequate to improve children's school readiness, or to help sustain the academic skills children acquire during school.

Given the importance of the family in understanding the differences in students' academic skills, it cannot be ignored that the effects of poverty and other family disadvantages will continue to affect children's educational potentials even after the school's influences begin to weigh in. Undoubtedly school influences do matter, but it is unclear whether school influences outweigh the disadvantages that are associated with family poverty. There is strong evidence that students have tremendous growth in their mathematics and reading skills, especially during kindergarten[26] as well as during elementary school.[27] Moreover, research has suggested that, at least in the early grades, schools are more effective at improving children's proficiencies in mathematics than they are at improving children's proficiencies in reading.[28] Given that schools contribute to young children's learning outcomes, it is important to understand how the classroom environment operates to enhance students' learning. If the classroom environment plays a significant role in improving mathematics achievement and in minimizing the achievement gaps for different groups of children, it seems worthwhile to identify and to expand our knowledge about the specific classroom practices which might improve mathematics achievement and could moderate the effects of social disadvantages such as family poverty.

Based on the literature, it is expected that engaging children in activities in problem solving and reasoning skills will have positive effects on mathematics achievement. It is also expected that children below poverty will benefit the most from these instructional practices in terms of higher mathematics scores.

THE DATA AND SAMPLE

The analysis draws data from the Early Childhood Longitudinal Study, Kindergarten cohort (ECLS-K), sponsored by the U.S. Department of Education, National Center for Education Statistics (NCES). The ECLS-K followed a nationally representative sample of the 1998–1999 kindergarten cohort who were in public and private kindergarten programs. Data were collected from the child, the parents or guardians, schools and teachers. Children used pointing devises or gave verbal responses while participating in various activities during an untimed one-on-one assessment. Each time the child was assessed their parents or guardians provided information about themselves and the child's family. Also, this is the first nationally representative sample where child, family, and classroom characteristics can be modeled simultaneously. Each sampled child is linked to his or her school as well as their teacher. Teachers provided information about their teaching practices, educational background, teaching experience and the classroom setting for the sampled children in their classroom.

The ECLS-K used a multistage probability sample design to select a nationally representative sample of kindergartners. The primary sampling units are geographic areas consisting of counties or groups of counties. In the second stage schools within the sampled primary geographic areas were selected. In the final stage students within each of the sampled schools were selected.

The analysis includes students who were assessed in fall and spring of the kindergarten year, and who attended a public or a private kindergarten program. The final sample includes 13,054 students who did not change teacher or school during the year. The sample is distributed among 1,558 teachers in 608 public kindergarten programs and 214 private kindergarten programs.[29]

Measuring Mathematics Achievement

The Early Childhood Longitudinal Study (ECLS-K) used a two-stage format for the mathematics assessment. The first stage is a routing performance that determined the second stage to be administered based on the child's level of ability. The mathematics domain includes recognizing numbers, counting, comparing and ordering numbers, solving word problems, recognizing and solving problems involving graphs and geometric relationships. The mathematics scores are calculated from an Item Response Theory (IRT) model, which are estimates of the number of items students would have answered correctly if they had taken all the questions in the mathematics assessment. The assessment also allows for estimates of the child's score within a narrow range of defined mathematics subskills taught in kindergarten. The five

mathematics subskills, which are derived from the K-4 curriculum standards of the National Council of Teachers of Mathematics, are:

(1) Counting, which is the ability to identify one-digit numbers, recognize geometric shapes, and one-to-one counting up to ten objects;
(2) Relative Size, which is the ability to read all one-digit numbers, count beyond ten, recognize a sequence of patterns, and use nonstandard units of length to compare objects;
(3) Skills in ordinality/sequence are the ability to read two-digit numbers, recognize the next number in a sequence, identify the ordinal position of an object, and solve a simple word problem;
(4) Addition/Subtraction is the ability to solve simple addition and subtraction problems; and
(5) Multiplication/Division is the ability to solve simple multiplication and division problems and to recognize more complex number patterns.

Each of the five specific mathematics subskills is measured as the probability of a correct response, which is also calculated from an IRT model. The score for each of these five specific mathematics subskills takes on values between zero and one. The IRT scoring makes longitudinal measurement of achievement gains possible because the common items in the routing test and in the overlapping second-stage forms allow the scores to be placed on the same scale. The IRT scores are already computed with the ECLS-K data.

Family Poverty and Classroom Instruction

Six dichotomous variables represent the child's poverty status.[30] The first variable represents children below 50 percent the poverty threshold. The second variable represents children between 50 and 100 percent the poverty threshold. The third and fourth variables capture children who are marginally above poverty, which include children between 100 and 150 percent the poverty threshold and children between 150 and 200 percent the poverty threshold. The last two variables capture children in more economically advantaged families; their family income is between 200 and 300 percent the poverty threshold, or above 300 percent the poverty threshold.

Seven percent of the children are below 50 percent poverty, and 11 percent are between 50 and 100 percent poverty. The majority of the children, 43 percent, are above 300 percent poverty. About 8 percent of the children are in families where English is not the primary language that is spoken at home, 7 percent of the children have parents who do not have a high school diploma, and 21 percent of the children live in a single-parent family. Forty-nine percent of the sample are girls, 15 percent are blacks, 14 percent are Latinos, and 65 percent are whites.

Teacher-reported answers are relied upon to derive quantitative indicators of mathematics instruction. In the ECLS-K teachers are asked two sets of questions about their teaching practices. One set of questions asked teachers to answer on a scale

from one (never) to six (daily) how often children in their class engaged in various mathematics activities. The available responses were: never, once a month or less, two or three times a month, once or two times a week, three or four times a week, and daily. The second set of questions asked teachers to answer on a scale from one (skill is not taught in kindergarten) to seven (daily) how often each of various mathematics skills is taught in their class. The available responses were: skill is not taught in kindergarten, should already know, once a month or less, two or three times a month, once or two times a week, three or four times a week, and daily. The items were combined into five classroom instruction scales. The scales were determined based on results from two factor analysis models. Each of the instruction scales is adjusted for the number of items with valid data. At least two-thirds of the items must have valid data, otherwise the composite scale is set to missing.

Four of the instruction scales are based on the first set of questions which asked about mathematics activities teachers engaged in. One scale is a sum composite score of the items that capture activities with "worksheets, textbooks, and chalkboard." These activities are usually thought of as rote drill and practice. The second scale, "manipulative, measurement and rulers," includes playing mathematics related games, working with manipulative (e.g., solid blocks), using rulers, using measuring cups, using spoons or other measuring instruments. The third scale, "collaborative learning activities," includes activities such as explaining how a mathematics problem is solved, solving problems in small groups or with a partner, working on problems that reflect real-life situations, working in mixed achievement groups and peer tutoring. The fourth scale, "aesthetic activities," includes activities with music, using creative movement or drama to understand mathematics concepts.

The fifth instruction scale, "data analysis, statistics and probabilities," is based on the second set of questions which asked about the mathematics skills that teachers used. This scale includes items such as reading simple graphs, performing simple data collection and graphing, fractions, using measuring instruments accurately, estimating probabilities, estimating quantities and writing mathematics equations to solve word problems. These skills are more likely to incorporate the child's own thinking, to engage the child to think critically about solving problems in mathematics, and to help the child build reasoning skills.

The data show that kindergarteners spend most of their instructional time in activities with geometric manipulatives to learn basic operations, work with rulers, use measuring cups, spoons or other measuring instruments, and play math related games. Kindergarteners also spend a substantial amount of time in collaborative learning activities, such as solving math problems in small groups or with a partner, and working in mixed achievement groups on math activities.

HOW KINDERGARTNERS FARE IN MATHEMATICS

Figure 3.1 shows mathematics score is negatively associated with family poverty. That is, the average mathematics score decreases as poverty increases. However, during kindergarten the average gain in mathematics score is similar irrespective of the family's

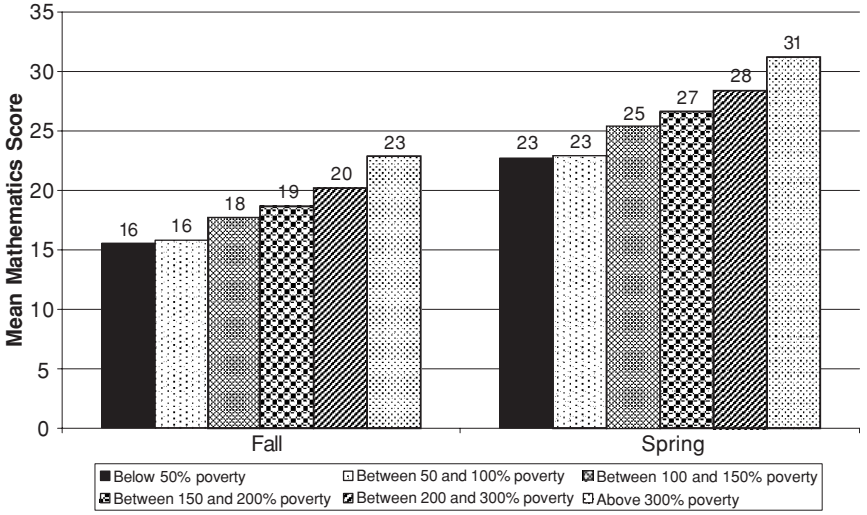

Figure 3.1
Mean Mathematics Scores by Family Poverty during Fall and Spring Kindergarten

poverty status. Children below poverty gain about 7 points, and children above poverty gain about 8 points (Figure 3.1). Since the average number of points children gain is similar whether they are below or above poverty, the poverty achievement gap, which is evident at the beginning of kindergarten, persists as children leave kindergarten.

Figure 3.2 shows the association between mathematics score and family socioeconomic status (SES), a composite score that includes parents' level of education, family income, and parental employment. Mathematics score is positively associated with family SES. That is, as family SES increases mathematics score increases. The average number of points gain is similar to the number of points gain when scores are examined by family poverty. For example, as shown in Figure 3.2, children in low- and middle-SES families gain about 8 points and children in high-SES families gain about 9 points.

Because education is one of the most important facets of income, poverty, and social class the differences in mathematics score and the number of points gained are also examined by parent education. Figure 3.3 shows children whose parents have at least a college degree enter kindergarten with more skills in mathematics than children whose parents have a high school diploma or whose parents have not graduated high school. However, once enrolled in school even children whose parents did not complete high school make large and significant gains in their mathematics skills. As shown in Figure 3.3, children whose parent did not complete high school gain about 8 points in their mathematics scores, which is similar to the number of points gained when the data are examined by family poverty and family SES.

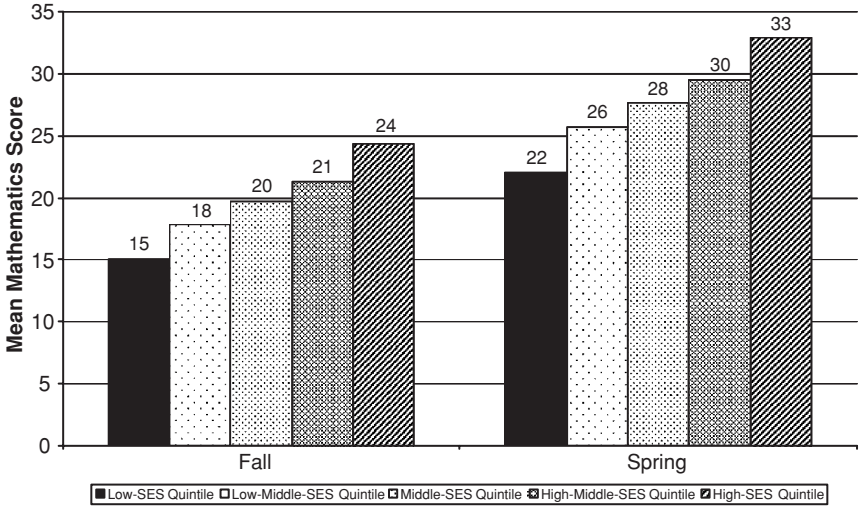

Figure 3.2
Mean Mathematics Scores by Family SES during Fall and Spring Kindergarten

A persistent achievement gap in mathematics is also evident by gender, race/ethnicity, living in a single-parent family, whether English is spoken in the home, and whether the child is in a public or a private school. For example, at the beginning of kindergarten, the average mathematics score is 18 points for children in single parent families, and 21 points for children in two-parent families. At the end of

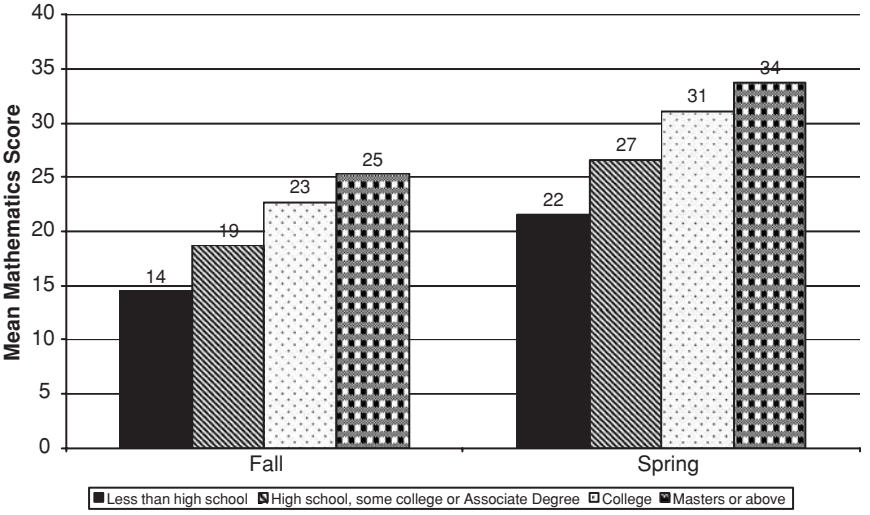

Figure 3.3
Mean Mathematics Scores by Parent Education during Fall and Spring Kindergarten

kindergarten, the average mathematics score is 25 points for children in single-parent families, an increase of 7 points; and the average score for children in two-parent families increases from 8 points to 29 points. The difference in score between the two groups remains since both groups improve on their mathematics skills. Similarly, children whose primary home language is not English have lower mathematics score than their counterparts. The average mathematics score for children whose primary home language is not English increases to 24 points from 17 points; and for children whose primary language is English the gain in their average mathematics score is 8 points, an increase to 28 points from 20 points.

Black and Latino children have lower mathematics score than white children. The average mathematics score for blacks and Latinos is 4 points lower than the average mathematics score for white children. The data also show that Asian children have higher mathematics score than white children. However, the higher mathematics score for Asian children are likely due to differences in social class. Asian children who could not pass the English assessment test were not given the mathematics assessment. Thus, the sample of Asian children who took the mathematics assessment and received a score is more likely to be fluent in English, and they are in more affluent families. In contrast, the sample of white children is more heterogeneous in terms of family characteristics such as parent education, income, and social class. The data also show that boys have higher mathematics score than girls; however, the difference is not statistically significant.

The average number of points gained in total mathematics score ranges from 7 to 9 points; however, the gains differ in specific mathematics subskills—counting up to ten, recognizing the sequence of basic patterns (relative size), comparing the relative size of objects (ordinality/sequence), solving basic problems in addition/subtraction, and multiplication/division. Specifically, children below poverty make gains in basic mathematics skills (counting up to ten, recognizing the sequence of basic patterns), whereas children above poverty make gains in more complex mathematics skills (solving problems in addition/subtraction and multiplication/division).

Figure 3.4 shows how students score in solving basic mathematics problems—counting up to ten, recognizing the sequence of basic patterns (relative size) and comparing the relative size of objects (ordinality/sequence)—and family poverty at the beginning of kindergarten.

Figure 3.5 shows the same information as Figure 3.4 at the end of kindergarten.

A comparison of Figures 3.4 and 3.5 reveals that, at the end of kindergarten, children below poverty have closed the gap in counting up to ten. However, as shown in Figure 3.5, at the end of kindergarten there still remain large differences in students' ability to recognize the sequence of patterns and comparing the relative size of objects. The average score in knowledge of recognizing the sequence of basic patterns (relative size) and in comparing the relative size of objects (ordinality/sequence) for children below poverty more than doubled. Since all children improved in recognizing the sequence of patterns (relative size) and in comparing the relative size of objects (ordinality/sequence), the average score for children below poverty did not increase by a large enough amount to eliminate the gap (Figures 3.4 and 3.5).

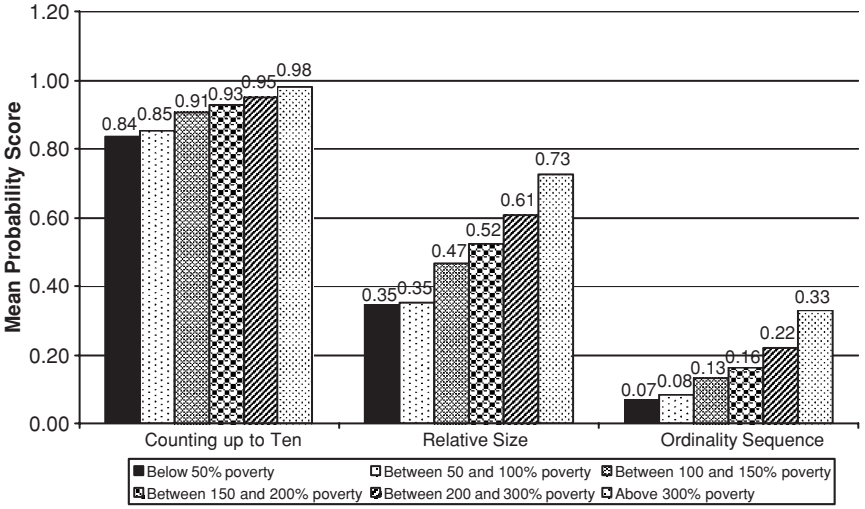

Figure 3.4
Mean Probability Score in Basic Mathematics Subskills during Fall Kindergarten

Figure 3.6 shows that, at the beginning of kindergarten, the mean score in solving addition/subtraction and multiplication/division problems was low. In particular, few children were able to correctly solve any basic problems in multiplication/division, irrespective of their poverty status. Over the course of the kindergarten year, children above poverty made significant stride in solving problems in addition/subtraction

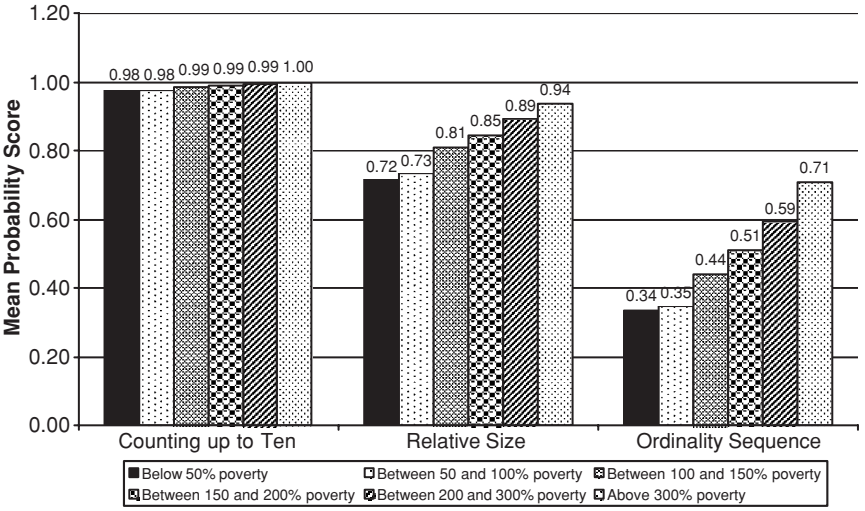

Figure 3.5
Mean Probability Score in Basic Mathematics Subskills during Spring Kindergarten

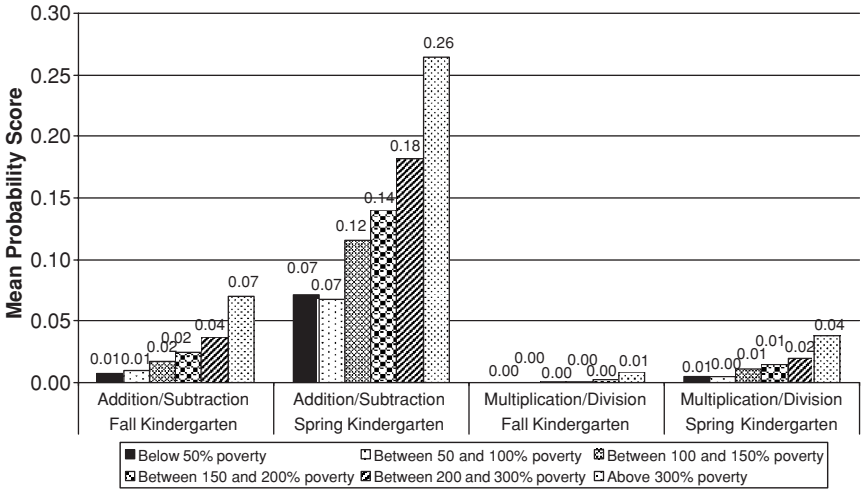

Figure 3.6
Mean Probability Score in Addition/Subtraction, Multiplication/Division during Fall and Spring Kindergarten

compared to children below poverty. Even though the average score in multiplication/division remained relatively low during kindergarten, Figure 3.6 shows that children above poverty did make substantially more progress than children below poverty in solving these kinds of mathematics problems. In fact, as shown in Figure 3.6, the poverty achievement gap in addition/subtraction and in multiplication/division actually grew during kindergarten. A widening achievement gap in children's ability to solve basic addition/subtraction and multiplication/division problems, also exists by family SES, parent education, and race/ethnicity.

The data were examined for differences in kindergartners' problem-solving ability in all five mathematics subskills by gender, parent education, and race/ethnicity. An examination of academic performance in each of the five mathematics subskills reveals mixed evidence that boys are ahead academically. Girls are slightly ahead in counting up to ten and in recognizing the sequence of basic patterns (relative size). However, by the end of kindergarten girls lost their slight advantage in being able to compare the relative size of objects (ordinality/sequence). Boys, on the other hand, started kindergarten with a slight advantage in being able to perform basic addition, subtraction, multiplication, and division problems, and they continue to build on those skills during kindergarten.

Children with a college-educated parent are more likely to accurately compare the relative size of objects; they are also more likely to correctly solve basic problems in addition/subtraction, and multiplication/division than children whose parents have a high school diploma.

Black and Latino children enter kindergarten with lower mathematics skills than white children. During the kindergarten year, black and Latino children make

substantial progress in basic mathematics skills (e.g., counting up to ten, recognizing the sequence of patterns). Black and Latino children make significantly less progress than white children in comparing the relative size of objects, solving problems in addition/subtraction, and in multiplication/division. Consequently, a race/ethnic achievement gap in solving problems in multiplication/division, which did not exist at the beginning of kindergarten, has grown significantly by the end of the kindergarten year.

Children who attend private schools are able to answer more questions correctly in all five mathematics subskills compared to children in public schools. This, however, probably reflects differences in family poverty, SES or parent education between children who attend private schools and those who attend public schools.

MATHEMATICS INSTRUCTION AND ACHIEVEMENT GAINS

To examine the effects of mathematics instruction and the extent to which instruction might account for the lower achievement gains for children in poverty, a classroom fixed model—a two-level hierarchical linear model where students are nested within classrooms—is estimated. The results, shown inTable 3.1, are consistent with the descriptive results presented above. Mathematics scores are negatively associated with family poverty. That is, children who are below poverty have the lowest achievement gains, and children who are marginally above poverty (between 100 and 150 percent of poverty) have slightly higher achievement gains than children below poverty. For example, the estimates presented in Model 1 in Table 3.1, show that the average gains in mathematics for children below poverty is 0.44 point lower than the average gains for children above 300 percent poverty, and the average gains for children who are marginally above poverty is 0.35 point lower than the average gains for children above 300 percent of poverty. There is no statistical difference among children above 150 percent poverty after controlling for initial mathematics score, demographic variables, and other confounding variables.

The effects of parent education on achievement gains are very robust. Children with a parent without a high school diploma have significantly lower gains than children with a parent with a high school diploma, as well as lower gains than children with a college-educated parent. The model was estimated to account for the interaction between poverty and having a parent with a college degree. The interaction term is positive, indicating that children below poverty with a parent with a college degree performed better than children below poverty with a parent without a college degree.

The effects of instruction are not as robust as the effects of family poverty or parent education. Certain kinds of instructional practices do have significant positive effects on achievement gains. Instructional activities with worksheets as well as instructional activities using graphs, estimating probabilities and quantities, and writing mathematics equations to solve word problems—activities which engage the child, and which employ the child's own thinking and reasoning skills—have positive and significant effects on achievement gains (Table 3.1). The average gain is 0.26 point as the amount of time devoted to activities with worksheets increases, while the average

Table 3.1
Estimates of Models to Explain the Effects of Mathematics Instruction and Poverty on Achievement Gains during Kindergarten

	Model 1		Model 2	
	Estimated Coefficients	**Significance Level**	**Estimated Coefficients**	**Significance Level**
Achievement at the beginning of kindergarten	0.90	***	0.90	***
Family Poverty				
Below 100% poverty	−0.44	**	−0.45	**
Between 100 and 150% poverty	−0.35	*	−0.36	*
Between 150 and 200% poverty	−0.14		−0.16	
Between 200 and 300% poverty	−0.08		−0.08	
Parent Education				
Less than high school	−0.42	*	−0.42	*
College	0.35	**	0.35	**
Masters or above	0.57	***	0.57	***
Gender and Ethnicity				
Child is female	−0.31	***	−0.30	***
Latino (a)	−0.52	**	−0.53	***
Black	−1.22	***	−1.21	***
Asian	0.31		0.32	
Other ethnicity	−0.32		−0.32	
Mathematics Instruction				
Worksheets, textbooks, chalkboard	0.26	***	–	
Collaborative activities	0.10		–	
Aesthetic activities	−0.05		–	
Geometry manipulative, measurements, rulers	−0.29	**	–	
Data analysis, statistics, probabilities (Reasoning Skills)	0.21	***	–	
Variance between classrooms	2.62		2.80	
Variance among students within classrooms	21.28		21.29	
Percent of total variance between classrooms	11%		12%	

See note 33.

gain is 0.21 point as the amount of time devoted to activities with graphs, estimating quantities, and writing math equations to solve word problems increases. The results confirm the effectiveness of critical thinking and actively engaging students in problem solving skills. On the other hand, the finding of a significant positive effect from using activities with worksheets is unexpected. Other studies have shown either no effect or a negative effect on mathematics score from using rote drill and practice. However, since the present analysis uses a much younger cohort of students than the samples from prior studies, the results suggest that it is effective to frequently allow kindergarteners to practice basic computational skills.

As family income increases, the amount of time spent on activities with worksheets, using collaborative groups as well as activities with music or creative movement or drama (e.g., aesthetic activities) decreases significantly. This indicates that children below poverty spend significantly more time exposed to these instructional practices than other children. As previously discussed children below poverty lag behind in basic mathematics skills at the beginning of kindergarten, and they do have higher rate of gains in basic mathematics skills such as counting up to ten and recognizing the sequence of basic patterns (relative size). The positive coefficient for instructional activities with worksheets most likely suggests that such activities are beneficial in helping young children practice basic computational skills.

The amount of time spent on activities with graphs, estimating quantities, and writing math equations to solve word problems—those activities which incorporate children's own thinking, engage children to think about mathematics and help them build reasoning skills—increases with family income. In essence children below poverty have the least exposure to these kinds of practices, which is contrary to the desire to increase low-income children's exposure to the practices that will help them develop skills in problem solving and reasoning skills.

Working with manipulatives such as using solid blocks, rulers, and other instruments like cups and spoons for measuring is the most frequently used practices during mathematics lessons in kindergarten. Yet, as the results in Table 3.1 show, achievement gains are lower by about 0.29 point as the amount of time in those activities increases. Using collaborative learning activities such as solving problems in small groups or with a partner, working in mixed achievement groups and peer tutoring, are not significantly associated with achievement gains. These findings of negative effect from using manipulatives, and of no significant effect from using collaborative learning activities could indicate ineffective use of the time spent in those activities. Although the model controls for the amount of time spent in mathematics lessons on a typical school day, the data cannot differentiate the quality of time that is devoted to any particular instructional practice. Since teachers rely on a multitude of practices during their mathematics lessons, any advantages associated with the most effective instructional practices—using worksheets, and using skills to engage the child to think critically about solving problems in mathematics, and to help the child build reasoning skills—are trumped by the negative effects associated with activities with manipulative, and the use of drama and music to teach mathematics.

The results indicate that 12 percent of the variance in mathematics achievement gains occurs between classrooms, and 89 percent of the variance occurs among students within classrooms. Adding the mathematics instruction variables to the model accounts for 6 percent of the variance between classrooms, but does not account for any of the variance among students within classrooms.

An assessment of the extent to which mathematics instruction might explain the poverty achievement gap is made by comparing the change in the coefficients for family poverty before and after the instruction variables are introduced in the model. Model 1 in Table 3.1 shows the results with mathematics instruction, and Model 2 shows the results without mathematics instruction. The magnitude of the coefficients for family poverty decreases by negligible amounts after controlling for the fact that children of different social backgrounds might have less exposure to the instruction practices. Similarly, the coefficients for parent education, and race/ethnicity decrease by negligible amounts after mathematics instruction is added to the model. Thus, mathematics instruction, though significantly associated with achievement gains, does not explain much of the poverty achievement gap, or the gap associated with parent education and race/ethnicity. In fact, the poverty achievement gap is reduced substantially only after initial achievement in mathematics is taken into account. After controlling for achievement at the beginning of kindergarten, the reduction in the coefficient is 74 percent for children below 100 percent poverty, and 66 percent for children between 100 and 150 percent poverty. This suggests that children in the poorest families are less well positioned in their knowledge of mathematics when they begin kindergarten than other children, and it could very well be the most important contributor in perpetuating unequal educational outcomes.

SUMMARY AND IMPLICATIONS

Current education policies view quality instruction, student testing and holding schools and students accountable as the levers for improving student learning of mathematics, reading, and increasingly science. The emphasis on instruction often overshadows policies that could minimize the social inequalities contributing to unequal educational outcomes among children. Research consistently shows that growing up in poverty has long-term effects on students' academic achievement. Emerging research reveals that there are negative effects associated with family poverty even before school begins. Consequently, children in poverty begin school less prepared academically. Family circumstances that undercut cognitive skills such as poverty, high unemployment among adult family members, inadequate nourishment, overcrowded and unsafe environments, and violence continue to be present throughout school. These family circumstances are important contributors to the persistent achievement gaps. The disparity in the basic mathematics skills students possess even before they begin kindergarten contributes to the achievement gap that persists in later grades. The results presented in this chapter suggest policies should seek to minimize the disadvantages that undermine the academic potentials of children in poverty before they begin school.

During the kindergarten year, children below poverty make gains in different set of mathematics skills than children above poverty. For example, by the end of kindergarten children below poverty do catch up and do close the achievement gap in basic mathematics such as counting up to ten, and recognizing the sequence of patterns (relative size). On the other hand, children above poverty have already begun to make significant gains in solving problems in addition/subtraction and multiplication/division. The fact that children above poverty are able to make these kinds of gains during their first year of school is likely due to their advantages in basic mathematics skills at the start of kindergarten.

The effects of instruction on mathematic scores are not as large as anticipated, and the effects of instruction are not always consistent with the assumptions behind educational policies. Children below poverty benefit more from formal classroom instruction than children who are not in poverty. It was expected that activities with worksheets, often viewed as a mode of rote drill and practice, would have negative effects or at least would have no effects on mathematics score. The analysis showed this was not the case. It is possible that practicing with worksheets is beneficial when children are learning the most basic computational skills that are taught in kindergarten. It is also possible that the reliance on this kind of instruction could lose its potency in later grades when the mathematics curriculum requires greater student engagement to reason and solve problems rather than simple computational skills.

The findings presented in this chapter suggest that exposing students to instructional practices that emphasize learning through understanding, and minimizing emphasis on the acquisition of disconnected set of facts and skills is a sound approach to improve mathematics skills. The analysis also shows, however, that the benefits associated with increasing the amount of time engaging the child to think critically are potentially muted because children below poverty formally begin school with fewer mathematics skills than children above poverty. The social disadvantages, including the effects of family poverty, which restrict the most disadvantaged groups of children from attaining their full cognitive potentials before they enter school should also be addressed.

A possible explanation why the direct effects of instruction are not larger than the effects of family poverty is that kindergarten teachers may lack the specialized knowledge to effectively employ the kinds of instructional practices that promote learning of mathematical skills in the way intended by the policies. The policies governing the training and content knowledge that kindergarten and elementary school teachers are required to possess are modest.[31] For example, states rarely require the educational training of elementary teachers to include mathematics courses or mathematics teaching methods courses. Moreover, teacher licensure tests do not include substantive questions to test teachers' content knowledge in mathematics.[32] This suggests that elementary school teachers might be inadequately equipped from their teacher preparation program to effectively employ the practices that will have much larger effects on young children's mathematics knowledge and skills. Yet, another possibility is that there is insufficient amount of time devoted to mathematics instruction. In kindergarten, literacy activities tend to absorb much of the total instructional time. Given

that some instructional effects exist, school districts and schools should seek to find ways to set in place the policies and practices that will prepare elementary teachers to deliver more quality mathematics instruction that is consistent with the goals of engaging all children and allow them to acquire higher mathematical thinking skills early and consistently throughout school.

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29. The sample excludes children who changed school or teacher because retaining students who moved to another school or changed teacher makes it difficult to disentangle the separate effects of family and school factors that contribute to learning since those students are members of multiple schools and classrooms during the year. Retaining only the students that progress normally without interruptions yields estimates that can be said to generalize to those students only. During the kindergarten year 1,255 students changed school, and an additional 628 students had a different teacher in the same school in the spring of the kindergarten year. It could not be ascertained whether 1,497 students had a different teacher during the school year because teachers for 225 students were interviewed in fall only, and teachers for 1,272 students were interviewed in the spring only. Those cases are excluded because of the ambiguity whether it is the same teacher in both fall and spring.

An additional 695 children were excluded because they did not have a baseline mathematics score. Some of the reasons that children are not assessed are: absenteeism on the days the assessment was scheduled for their school, or children whose home language is not English and who did not pass the English assessment test. Children whose home language is Spanish are given a Spanish version of the mathematics assessment. The children who are not assessed are disproportionately from low-income families; they are more likely to be Asian, Latino, and Black.

30. The poverty thresholds are the total money income, which the federal government estimates, a family should have to meet its basic needs. The poverty thresholds take into account the number of individuals in the family and children under the age of 18. The thresholds are adjusted annually for cost of living using the consumer price index. In 2004 the poverty threshold for a family of four persons was $19,223. Families whose income is below their thresholds are considered poor; and families whose income is above their thresholds are considered not poor.

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33. *** significant at 0.001 level; ** significant at 0.01 level; * significant at 0.05 level;— indicates the variable is not included in the models in Table 3.1. The following variables are not shown: whether parent is employed full time, whether parent is not employed, age of child at the start of kindergarten, number of months that elapsed between fall and spring child assessment, child's weight at birth, whether the child is enrolled in a part-time kindergarten program; the child's primary mode of care arrangements prior to kindergarten: care by relative, care by a nonrelative, Head Start Program, center care, parental care, all other care arrangement including multiple arrangements; the child's participation in structured activities: parent play activities with child (sum composite of the following items: tell stories, sing songs, help child with arts and crafts, involve child with household chores, play games or do puzzles, talk about nature or do science projects, build or play construction toys with child, play a sport or exercise together), child reading activities (dichotomous variable: if the child reads at least three to six times per week: parents read books to child, child looks at picture books outside of school, child reads or pretends to read), performance and creative activities (dichotomous variable: if the child engages in at least one of those activities: dance lessons, organized clubs, organized performing arts), music, drama and language activities (dichotomous variable: if the child engages in at least one of those activities: music lessons, drama classes, non-English instruction), sports and athletic activities (dichotomous variable: if the child engages in both of these activities: organized athletic activities, athletic or sporting events), arts and craft activities (dichotomous variable: if the child engages in at least one of those activities: art classes, craft classes), educational trips (dichotomous variable: if the child engages in at least two of those activities: visited library, gone to play, concert or other live shows, gallery, museum or historical site, zoo, aquarium or petting farm), number of children's books and media (sum composite: how many children books in the home, how many children's records); whether it is a single parent family, number of siblings in the household, whether English is the language spoken at home, number of places the child lived since birth; how class time is structured: teacher-directed whole class activities, teacher-directed small group activities, child selected activities; how much class time is used for math lessons; whether it is a private kindergarten program; whether the school is located in central city or a small town and rural; proportion of students in the school who are minority; average SES in the classroom.

CHAPTER 4

ARE CHILDREN IN POVERTY CLOSING THE LEARNING GAP? EDUCATION REFORM AND ELEMENTARY SCHOOL PERFORMANCE IN KENTUCKY

Edward B. Reeves

The effects of family socioeconomic status on student achievement have been reported in thousands of studies over the past 40 years: The higher the socioeconomic status of the family, the higher the achievement of students will be. This finding has been substantiated for a wide variety of measures of socioeconomic status (SES), including family income, parents' educational level, and parents' occupation. Student SES is related to grades, achievement test scores, curriculum placement, dropout, college plans, years of schooling completed, high school graduation, and postsecondary enrollment and degree completion. Student's family background has also been shown to correlate with occupational success. Furthermore, these patterns are not restricted to the United States, but are found in virtually every industrialized society.[1]

Recently, this "iron law" linking student SES and education outcomes has been questioned by education reform in the United States. The issue hangs on evidence that has been compiled only in the last decade by a few researchers. These sparse studies suggest that student SES has a negligible effect on *change* in academic achievement compared with the large effect it has on academic achievement measured at *a single point in time*.[2] This new perspective has come about with the sea change in education policy that has washed across the country during the past two decades. Since the mid-1980s, various state governments have been making schools accountable for what students learn and insisting that steady improvements in learning must be demonstrated by achievement test results that are given on a recurring basis.[3] Kentucky was in the vanguard of states that undertook sweeping educational reform.

With the passing into law of the Kentucky Educational Reform Act of 1990, the Kentucky Department of Education began requiring that public schools make annual assessments of academic progress at various grade levels. Originally, Kentucky lawmakers gave little thought to how student poverty could influence the state-mandated

assessment results,[4] but this has changed. In 2002, the federal No Child Left Behind Act mandated the closing of the learning gap between low-income children and more advantaged children. Now, all states are expected to conduct annual testing in their public schools to assess the learning gap, although each state is permitted to devise its own system for accomplishing this objective.[5]

It still remains to be discovered if the states are going to be successful in closing the learning gap for children in poverty, and if so how quickly can this be done. The mandate is to achieve the goal of general educational proficiency by the year 2014. No one knows if this goal is attainable, although as annual data on school performance continues to be collected reasonable projections can be made.[6] The present study documents the effects of low-income children on public elementary school performance and improvement in Kentucky during a 7-year period, from 1999 to 2005. It will be shown that poverty causes some schools to lag well behind other schools that serve advantaged student populations. Furthermore, the evidence that the gap in learning could be shrinking is not supported when the achievement data are correctly analyzed and interpreted. Kentucky elementary schools—even when they have a preponderance of poor students—are making progress if the state assessment tests are to be believed, but the learning gap between affluent and poor remains as wide currently as in previous years. One feature of Kentucky public schools that provides some basis for optimism, however, is the state's high proportion of rural schools. These schools, which also serve lower-income students, are showing a rate of improvement that exceeds nonrural schools.

EDUCATION AND CHILDREN IN POVERTY

The United States is a society where individual achievement through dedication and effort has long been celebrated. Americans embrace rags-to-riches stories and the life histories of persons who overcome adversity to rise to pinnacles of success. American society and culture offer numerous avenues for the expression of individual achievement. These deeply held values extolling individual freedom and success, born no doubt in the history of immigration and pioneer settlement of the nation, make it difficult for many Americans to understand how debilitating poverty can be for children. Oddly enough, in education where the welfare of children is taken very seriously, poverty is too often ignored—as if this were a form of adversity that ought to be overcome—or is recognized but then dealt with ineffectively. A recent speech at a major conference attended by educational researchers made these points in dramatic fashion.

At the 2005 annual meeting of the American Educational Research Association, the featured speaker was the well-known educational psychologist David Berliner. Professor Berliner's topic was education and children in poverty.[7] He captured the attention of his large audience with two striking images. First, he called poverty the "600-pound gorilla in the school house" that Americans don't want to confront or talk about. The second image that Berliner presented concerned the story of a drunken man who was searching for his lost keys under a street lamp. When asked by a passerby

what he was looking for, the drunk replied that he had dropped his keys in the dark across the street and was now looking for them. The passerby asked why he was looking for his keys under the lamp if he dropped them elsewhere. To this the drunk replied, "The light is better over here." Berliner noted that No Child Left Behind policy is like the drunk, looking for solutions to low achievement in the most convenient spot (in schools) and failing to look where the fundamental causes of low achievement are to be discovered (in impoverished homes and economically disadvantaged neighborhoods). "I believe we need to worry whether the more important keys to school reform are up the block, in the shadows, where the light is not bright," is how Berliner put it.[8]

The research linking low educational achievement and poverty is voluminous, as I have stated. But, despite the myriad studies, we are only beginning to grasp the huge scope of this problem. A review of the research literature will suggest what I mean.

A good place to start is the *Equality of Educational Opportunity* report that was published in 1966 following a 2-year study of more than 650,000 students in 4,000 schools nationwide.[9] Often referred to by the name of the study's lead author, James Coleman, the "Coleman Report" was intended to make a comprehensive study of the equality of educational opportunity in American public schools. The education policymakers who commissioned the study as well as Coleman himself were fairly sure of what the study would find. Vast differences between schools in the academic achievement of their respective students would be found and these differences would be directly related to gross inequalities in the distribution of resources among the nation's schools. In other words, Coleman and others expected that differences between schools with regard to their financial capacity, physical plant and facilities, the quality of their teaching staff and so on would go a long way toward explaining the great differences in achievement. What they found was something very different.

The core finding of the Coleman Report was this: there is much greater variation in achievement test scores within schools than between schools. This finding carried a momentous implication. Whatever characteristics cause schools to be different in their resources and quality, they account for only 10 to 20 percent of the variation in student achievement. Schools do not have a large influence on student achievement. But if schools play such a small role in determining student achievement, what determines the rest of the variation? The answer proposed by the Coleman Report was that the characteristics of students' families and neighborhoods were responsible for the largest share of the variation in student achievement. This finding was met with shock and consternation—not the least from educators who saw that their importance to the education process might be far less than anyone had suspected. Since the publication of *Equality of Educational Opportunity*, numerous efforts have been made to refute its conclusions, but the evidence supporting it has been overwhelming.

Christopher Jencks and colleagues at Harvard University reinforced the Coleman Report's finding by demonstrating that family background characteristics explained 50 percent of the individual differences in educational achievement.[10] These background characteristics constitute advantages or disadvantages that children bring with them to school, and schools are not successful in altering their influence. Another

study, by Coleman and Hoffer, compared student achievement in public and private high schools.[11] This study was a milestone because it began to systematically define the multidimensional resources that families possess in large or small measure which foster their children's success in school.

The material resources of the family constituted one dimension influencing student achievement, according to Coleman and Hoffer. Material resources include family income as well as household amenities, such as separate bedrooms for children, a place to study where the child will not be interrupted, reading material kept in the home, and so forth. Another dimension of family resources consists of the parent's own educational level and experiences. Well-educated parents are role models for their children's success. A third dimension of family resources consists of parents' relations with their children: whether they discuss their children's experiences at school, supervise their homework, and similar supportive activities at home. Parents' effort to foster their children's success at school was discovered to be further improved if the family structure was characterized by the presence in the home of the biological mother and father and a limited number of siblings. Single-parent families, blended families, and families with large numbers of children were noted to have difficulty providing needed supervision and support for children. Coleman and Hoffer also concluded that religiously oriented private high schools were more successful educating minority and low-income students because the "functional community" of these schools overcame many of the deficiencies at home.

Later research, extending the earlier work of Coleman and Hoffer, showed that many types of family resources are correlated with income.[12] And more evidence of family resources was uncovered. Parental involvement in the school—such as PTO participation and volunteering to help at the school—had a positive influence on achievement test scores and grade point average; and parent involvement in the school was related to the family's socioeconomic status.[13] Other research showed that the nature of the community or neighborhood in which families lived could significantly affect children's learning. Strong communities and neighborhoods where parents know one another and can compare notes on how their children are progressing in school are localities where achievement is nourished.[14] Some research pointed out that rural communities were more likely to have these qualities than metropolitan areas.[15]

Other studies have shown that upper-middle-class parents are more effective negotiating with school officials to obtain desired benefits for their children than are working-class or unemployed parents.[16] Middle- and upper-income parents see to it that their children take advantage of enriching out-of-school activities, such as private music lessons, visits to museums, attendance at concerts, and similar cultural activities.[17] When school is not in session, families with greater incomes can assure rewarding experiences for their children that translate into greater academic achievement. Especially during the summer break, children of middle- and upper-income parents may take vacations to interesting locations and the children may benefit from well-supervised camp experiences and summer courses that enhance the child's educational skills in foreign languages, computers, art, and so forth.[18] Extracurricular

activities provided by the school are another area where greater participation by middle class and affluent students is associated with academic success.[19]

A recent study found that social class background is associated with significant differences in vocabulary knowledge as early as 36 months of age. The vocabulary gap does not narrow as a result of schooling.[20] In addition, David Berliner has catalogued a variety of illnesses and health conditions that often go untreated for children in poverty and that have clear implications for poor performance in school. Among the health conditions that he discusses are ear infections, vision problems, asthma, nutritional deficiencies, lead and mercury poisoning, and complications from low birth weight. Moreover, he catalogues childhood traumas that are social in their origin. These traumas can also afflict the children of more affluent families, but they are more likely to escape detection and assistance when they occur within poor families because of the social disorganization within impoverished neighborhoods. These are the traumas that result from alcoholism, drug addiction, abusive treatment in the home, violence at school, violence going from school to home, and criminal activity generally.[21] Thus, it appears that the evidence for an association between child poverty and low performance in school is strong, multistranded, and one of the best-documented relationships in all of social science.

KENTUCKY: A CASE STUDY

An Impoverished State with Disadvantaged Children

In 1990, Kentucky ranked 46th among the States with a poverty rate of 19.0 percent. The national average in that year was 13.1 percent of the population in poverty. A decade later, Kentucky was tied with Arkansas in the 44th position with a poverty rate of 15.8, a reduction of 3.2 percentage points from the previous decade. Meanwhile, the national average had declined at a much slower rate (–0.7) to 12.4 percent in poverty. These trends suggest that poverty, overall, declined in Kentucky during the 1990s. Nevertheless, Kentucky remains one of the most impoverished states. Only Alabama, Louisiana, Mississippi, New Mexico, and West Virginia have greater proportions of their residents below the poverty level.[22]

The picture doesn't improve when we turn to the indicators of child welfare in Kentucky. For 2005, The Annie Casey Foundation gave Kentucky an overall rank of 42nd among the 50 states for the welfare of its children.[23] Table 4.1 details the information on which this low ranking is based. The median income of Kentucky families with children is well below the national average. Moreover, Kentucky has larger percentages of children in low-income families, of children in poverty, and of children in extreme poverty than does the nation at large. The percentage of Kentucky children in households where the household head has a work disability is greater than twice the national percentage, while the percentage of Kentucky children in low-income households where no adult has worked in the past 12 months exceeds the national average by 3 percentage points. Even more sobering is the evidence of the poor health status and higher mortality of children in Kentucky. The percentage of

Table 4.1
Kentucky and National Indicators of Child Welfare

	Kentucky	National
Median income of families with children	$40,000	$50,000
Children in low-income families (income below 200% of poverty level)	46%	39%
Children in poverty (income below 100% of poverty level)	24%	18%
Children in extreme poverty (income below 50% of poverty level)	11%	8%
Children in households where the household head has a work disability	9%	5%
Children in low-income households where no adult has worked in the past 12 months	8%	5%
Low-birth-weight babies	8.6%	7.8%
Infant mortality rate (deaths per 1000 live births)	7.2	7.0
Child death rate (deaths per 100,000 children ages 1–14)	25	21

Note: All data are 2002–2003 estimates.
Source: The Annie Casey Foundation, KIDS COUNT State Level Data Online; retrieved on February 11, 2006 from www.kidscount.org.

low-birth-weight babies, the infant mortality rate, and the child death rate are higher in Kentucky than across the nation.

Not all comparisons between Kentucky and the nation are this invidious. For example, Kentucky approximates the national average in the percentages of children who have health insurance, 2-year-olds who are immunized, and children in single-parent households.[24] But these few areas in which Kentucky is on par with the rest of the country do not erase the hard evidence of child welfare deficiency.

It is surprising, therefore, to turn to the evidence for the educational performance of Kentucky's children. When compared with the national averages Kentucky's performance gets a mixed review, but it is better than one could have expected. Recent results from the National Assessment of Educational Progress (NAEP) show that Kentucky fourth and eighth graders exceed the national averages in the percentages scoring at or above proficient in reading and science. However, Kentucky lags well behind the national average in mathematics proficiency at both the fourth and eighth grade levels.[25] According to a recent report by SchoolMatters,[26] Kentucky is one of a handful of states where fourth- and eighth-grade reading performance exceeds expectations after controlling for the percentage of economically disadvantaged students. And what is perhaps even more impressive, the report noted that Kentucky's fourth-grade proficiency in mathematics is within the performing-as-expected zone when student poverty is controlled. However, Kentucky eighth graders still perform at less than the expected level, even after the adjustment for poverty has been made. With some reservations, then, this report provides evidence that Kentucky does well by its children educationally, despite the many handicaps that the state's children face.

Kentucky Education Reform

Kentucky public schools have elevated educational achievement across the state since the passage of the Kentucky Educational Reform Act of 1990. This progress has been measured by the state's own testing system as well as by the National Assessment of Educational Progress (NAEP) testing program. Below, we will be concerned with determining if the learning gap seen in elementary schools serving economically disadvantaged students is closing. To lay the groundwork for this, it will be useful to briefly describe education reform in the state and the testing system that has been implemented to assess progress in the schools.

Kentucky was among the first states to implement a comprehensive educational reform in 1990.[27] The reform legislation mandated annual testing of selected grade levels in all Kentucky public schools. From the beginning, the testing protocol was innovative, calling for open-ended (essay) questions and writing portfolios. Student achievement was assessed in a variety of academic subject areas, most importantly in the areas of reading, mathematics, and science. More recently, norm-referenced (NAEP-like) questions have been added. A major revision of the test protocol occurred in the late 1990s. One cannot easily examine testing trends across this change in testing methods. Nevertheless, there is currently 7 years of test data available using the revised protocol, encompassing the years 1999 through 1995. These are the data that will be used in the analysis presented in the next section.

It is probably not inappropriate to credit Kentucky's positive educational performance relative to the national average to the success of the state's educational reform initiative. The NAEP achievement *gains* in reading and mathematics of Kentucky schools have outstripped the national gains, and Kentucky's gains are comparable to those achieved by Texas and Minnesota, where educational reform was implemented a few years earlier, in the 1980s.[28] But what are the implications of these gains for poor students closing the learning gap in Kentucky schools? The gains in test scores do not automatically signal that economically disadvantaged students are posting higher gains than more advantaged students. Conceivably, Kentucky's gains could be achieved by strong growth in economically advantaged schools and lesser or equal performance gains in disadvantaged schools. Or it could be achieved with exceptional gains in schools with disadvantaged students. To find out which scenario is correct, we need to examine the evidence. Moreover, as we will see below, performance gains have occurred in rural schools where many of the most economically disadvantaged students in the state are served. Kentucky has a large number of rural schools and relatively few schools that exclusively serve inner-city disadvantaged students. Thus, there may be evidence for a closing of the learning gap specifically in rural schools.

Are Poor Students Closing the Learning Gap?

Before we turn to the question of poor students closing the learning gap, it will be helpful to visualize how Kentucky elementary schools have been performing on the state-mandated tests. Figure 4.1 plots the mean of each year's test scores for

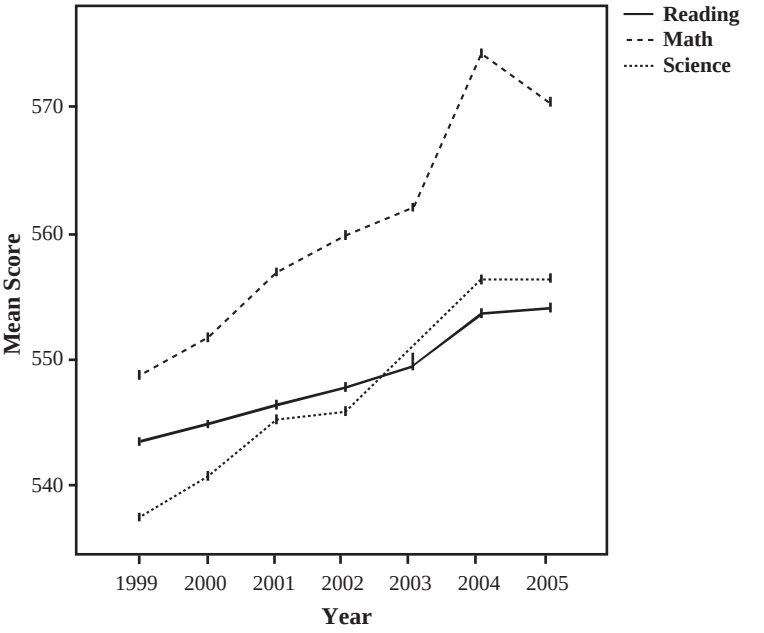

Figure 4.1
Trends in Reading, Mathematics, and Science Scores for Kentucky Elementary Schools, 1999–2005

the subject areas of reading, mathematics, and science. As the graph shows, the test scores usually moved upward between 1999 and 2005. The slope of the gain may be slightly steeper for mathematics and science than for reading. Another conclusion that can be drawn from these plotted trends is that they are not smooth and linear, but exhibit kinks and plateaus. The statewide mathematics score even moved downward in 2005! Such anomalies are not uncommon with school performance scores, and they are related to the problem of measurement error that I will discuss below. One conclusion that should not be drawn from the trends shown in Figure 4.1 is that students are performing better in mathematics than in either reading or science. The scale scores that measure school performance are designed for consistency across years and within subject area; they are not designed for making comparisons between two or more subject areas.

We can gain an understanding of whether poor students are closing the learning gap in Kentucky by correlating elementary school test scores with the percent of economically disadvantaged students[29] in the school. Thus, in this section, we will correlate low-income students with test results in reading, mathematics, and science. Table 4.2 shows the coefficients[30] when percent student poverty is correlated with test scores in reading, mathematics, and science across the 7-year period for which there is data. The coefficients shown in the table represent the average correlations

Table 4.2
Correlations of Elementary School Test Scores with Percent Student Poverty, 1999–2005

Academic Area Tested	*N*	Correlation Coefficient	Sig.
Reading	5,350	–0.47	0.00
Math	5,289	–0.46	0.00
Science	5,350	–0.36	0.00

Note: The correlation coefficients are averaged across 7 years.

across the 7 years. The three correlation coefficients indicate substantial negative associations between student poverty and test scores. All of the coefficients are statistically significant. This is certainly the result we should expect given the vast literature linking poverty with lower educational achievement. In Kentucky, as in the nation at large and in many international contexts, the presence of economically disadvantaged students means lowered test scores.

The analysis in Table 4.2 is static, however. It only compares academic achievement with student poverty in a year-by-year fashion. This approach indicates that, from year to year, academic achievement and student poverty are negatively correlated. It does not tell us if the learning gap between poor and advantaged students is closing. To determine that, the *change in test scores* (from 1999 to 2005) must be correlated with percent student poverty. It turns out that this seemingly simple operation is fraught with difficulties! The measurement of change is always problematic. The reasons for this are not hard to understand, and their ramifications are serious. Failure to consider these issues can lead to erroneous conclusions about what is happening to the learning gap.

First of all, it is important to recognize that measurement is never free of error. Whenever we take measurements of members of a population, or of a sample drawn from the population, there will be error in our measurements. For example, I note this every time I step on the scales to determine my weight. My bathroom scales are digital and measure weight in 0.5 pound units. When I step on the scale more than once I usually get slightly different results. Therefore, if I want a more accurate estimate of my weight, I sometimes step on the scales three times in quick succession and take an average of the three measurements. An analogous method of dealing with measurement error can be adopted to estimate test scores and changes in scores.

Generally speaking, we attempt to minimize the error inherent in any act of measurement by taking greater care with our measurements, by using more discriminating instruments for measuring, or by averaging repeated measurements. With respect to measuring educational performance, the first two approaches concern improvements to test administration and design. The third approach—which involves averaging repeated test results—is particularly useful for suppressing the error that results from measuring school performance with tests that have been administered

annually. Single-year test results are notoriously subject to cohort error. Cohort error means that test scores are sensitive to the unique qualities of the cohort of students who took the tests that particular year—qualities that may be quite different for the cohort taking the tests in another year. Because of the error that can be attributed to cohort differences, a plot of school performance across a period of years often moves erratically. Averaging scores across adjacent years is a widely used technique for dampening this source of error.

Second, if we take two measurements at different points in time, both sets of measurements will contain error. Now, if we try to relate the two sets of measurements, subtracting the measurement taken earlier in time from the later measurement in order to estimate the change that has occurred, we will find that this measure of change contains even greater error than either of the measurements that were used for its calculation. It is important to realize that this will always be true: the measurement of change will always have greater error than the measurements that were used to calculate change. So now we have a serious problem. How do we deal with it?

Again, averaging provides the solution. We make the original measurements on which our calculation of change is to be based more accurate—that is, less prone to error. Repeated measurements are averaged to obtain a more accurate estimate of the baseline, or initial score. Likewise, an average is taken of the repeated measurements of the final score. Now, when the average initial score is subtracted from the average final score, the resulting measure of change will contain less error. Averaging scores in this manner is a common way to reduce (but not eliminate) the error that is intrinsic to the measurement of change.

Unfortunately, our problems are not yet behind us. There is another potential source of error when analyzing change. It is referred to by various terms, such as: "regression to the mean," "reversion to the mean," or, more simply, "mean reversion." For convenience, I will employ the latter term. "Mean reversion" refers to the curious fact that the measure of change—call it the "gain score"—and the initial score, which was also used to calculate the gain score, will be negatively correlated.[31] Figure 4.2 shows an example of this. The graph plots the association of the reading gain score from 1999 to 2005[32] in Kentucky elementary schools with the initial reading score in 1999. Notice that the plot shows a remarkable tendency: the lower the 1999 reading score, the greater the gain score, and the opposite is also true. Note that when the 1999 reading score is high, the gain score may well be less than zero. In other words a high initial score may be associated with a negative gain. In contrast, schools that initially score the lowest usually achieve not just a positive gain; their gain scores are the largest of all! The diagonal line running through the scatter plot shows the negative association between the reading score in 1999 and the gain score. This downward sloping line illustrates the effect of mean reversion.[33]

Mean reversion is not something that we can wish away or ignore, any more than we can wish away or ignore measurement error, but it does not always pose a serious problem for the study of change. Mainly, it is a problem when we confuse the effect of mean reversion with the effect on the gain score of some other variable—percent student poverty, for example. Let me be clear about this. Mean reversion is a negative

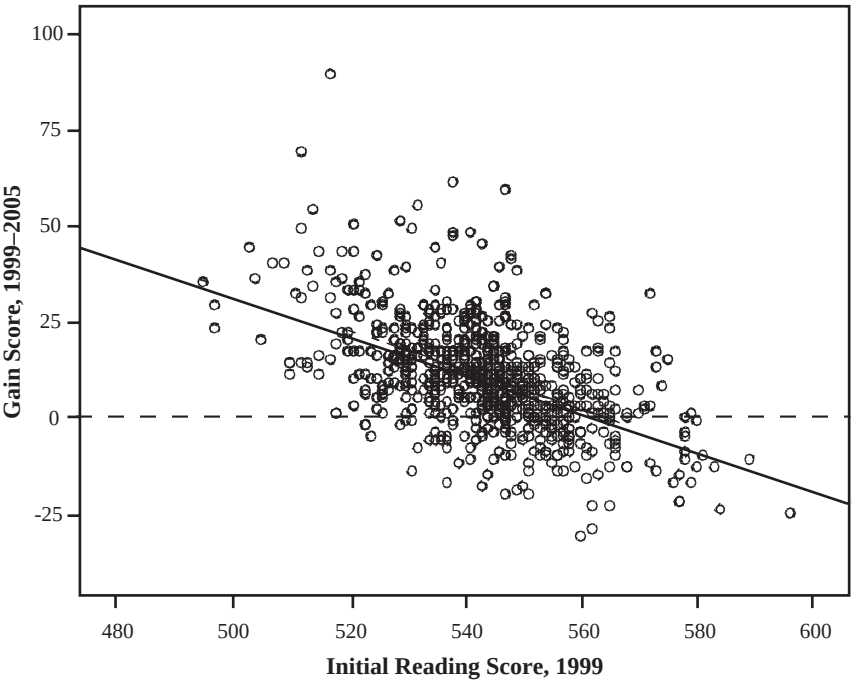

Figure 4.2
The Gain Score is Negatively Correlated with the Initial Score: An Illustration of Mean Reversion
Note: **Each dot is an elementary school; $N = 726$ schools.**

relationship between the initial score and the gain score. If another variable, such as student poverty, is associated with the gain score and also negatively associated with the initial score, then the possibility exists that the apparent association between student poverty and achievement gain is spurious. That is to say, the apparent association is confounded by mean reversion, and may not be real at all! In the present example, student poverty is negatively correlated with the 1999 reading, mathematics, and science scores, and the correlation coefficients are rather large: -0.6, -0.6, and -0.5, respectively. If the correlations between the gain scores in these subject areas and student poverty turn out to be significantly positive, there is ample reason to suspect that the relationships are confounded by mean reversion.

Table 4.3 shows the results of correlation analyses in which we obtain the results, first, by not suppressing measurement error with averaging and, second, by using averaged measurements. Secondly, the table compares the results from simple correlations with the results from partial correlations that adjust for mean reversion. These various methods of achieving correlation are not academic exercises; they are of utmost importance if we are to obtain an accurate assessment of whether or not poor students are closing the learning gap.

Table 4.3
Correlations of Elementary School Gain Scores with Percent Student Poverty

		Simple Correlation		Adjusted for Mean Reversion	
Academic Area Tested	***N***	**Correlation Coefficient**	**Sig.**	**Correlation Coefficient**	**Sig.**
		A. 7-Year Gain Score			
Reading	726	0.24	0.00	–0.11	0.00
Math	699	0.25	0.00	–0.14	0.00
Science	726	0.26	0.00	–0.06	0.12
		B. 5-Year Gain Score (averaged for measurement error)			
Reading	721	0.24	0.00	–0.03	0.40
Math	695	0.25	0.00	0.01	0.88
Science	721	0.25	0.00	0.02	0.52

Table 4.3A presents results based upon the gain score from 1999 to 2005 without averaging for greater measurement accuracy. This table presents two sets of results for comparison, simple correlation and partial correlation adjusted for mean reversion. The simple correlations between the gain scores in reading, mathematics, and science and the 7-year average of percent student poverty[34] range from 0.24 to 0.26. These moderate positive correlations also have high statistical significance. The effects on the correlation coefficients of adjusting for mean reversion are dramatic. The correlation of reading and mathematics gain scores, after the adjustment, are −0.11 and −0.14 respectively, with strong statistical significance for both of these coefficients. By adjusting for mean reversion, we have achieved an "about face" in the results. Instead of the moderate positive correlations obtained without adjusting for mean reversion, we now find the correlations to be negative. And although these negative correlations are not strong, their statistical significance is great. The correlation of the science gain score with student poverty is also negative but roughly half as strong as the other two, and it is, not surprisingly, insignificant. That is, we might as well say that the correlation between the science gain score and student poverty is equal to zero.

The results displayed in Table 4.3A tell a clear story. We would be incorrect to rely upon the simple correlations that show positive relationships between student poverty and the elementary school gain scores in any of the three subject areas. Any policymaker, educator, or citizen who saw these results and took comfort from them would be seriously mistaken. The real relationships between the 7-year gain scores and student poverty are either weakly negative, as in the case of reading and mathematics, or near zero, as in the case of science. However, we do not want to conclude our analysis here. We want to know what the results are when we use the more conservative 3-year averaging method of measuring the initial score and the final score.

By using the 3-year averaging method, we gain greater accuracy in our estimate of the gain score but at the cost of constricting the range of the scores from 7 to 5 years. The simple correlations shown in Table 4.3B are of moderate size and their statistical significance is strong. To this point, averaging the measurements produces correlations little different from what was found in Table 4.3A. The difference comes when we examine the results of adjusting for mean reversion. In Table 4.3B, adjusting for mean reversion renders correlation coefficients that are not significantly different from zero for any of the academic areas tested. Thus, these calculations suggest that schools with greater percentages of economically disadvantaged students are not closing the learning gap in reading, mathematics, and science, but neither are they falling behind. It appears from these findings that Kentucky elementary schools are reproducing about the same learning gap in each new cohort of students. Meanwhile, all schools are improving regardless of the prevalence of poverty among their students.

Rural Elementary Schools Are Closing the Gap

There is more to this story, and it concerns the progress being made in Kentucky's rural schools. This is relevant to the topic because the student populations of rural elementary schools have lower family incomes than their peers in nonrural elementary schools. In Kentucky, 45 percent of the elementary schools are rural. Rural elementary schools are located in nonmetropolitan counties and are associated with communities where the population is less than 2,500 inhabitants. The percentage of low-income students in rural and nonrural elementary schools is significantly different. In rural elementary schools, the mean percent student poverty is 61.0, whereas in nonrural elementary schools it is 48.5—a 12.5 percentage-point difference. These statistics are important because rural elementary schools are closing the learning gap despite their greater numbers of low-income students.

This can be demonstrated using the same methods employed previously. Table 4.4 presents the results of correlating elementary school gain scores with rural location of the school. The simple correlations in Table 4.4A show positive, relatively weak, yet very significant associations between the gain scores and rural school. After adjusting for mean reversion, the correlations for reading and mathematics gain scores are substantially reduced, while the adjusted correlation for science is little affected. These adjusted correlation coefficients remain positive and significant for reading and science, but the adjusted correlation for mathematics has been reduced nearly to zero.

Table 4.4B uses the more conservative, 3-year averaging method. In this table we find that the simple correlations are also weak, positive, and statistically significant. After adjusting the correlations for mean reversion in Table 4.4B, the results are similar to what was presented in Table 4.4A: Rural schools are gaining on their nonrural counterparts in the academic areas of reading and science (but not mathematics), despite their greater percentages of economically disadvantaged students.[35] Both methods of calculating the adjusted correlations support this conclusion. The effects of rural location on elementary school gains in reading and science are very small, as indicated by the fact that the adjusted correlation coefficients do not exceed 0.10.

Table 4.4
Correlations of Elementary School Gain Scores with Rural School

		Simple Correlation		Adjusted for Mean Reversion	
Academic Area Tested	***N***	**Coefficient Coefficient**	**Sig.**	**Coefficient Coefficient**	**Sig.**
		A. 7-Year Gain Score			
Reading	724	0.16	0.00	0.09	0.01
Math	708	0.12	0.00	0.02	0.70
Science	724	0.11	0.00	0.10	0.01
		B. 5-Year Gain Score (averaged for measurement error)			
Reading	718	0.13	0.00	0.08	0.03
Math	704	0.11	0.00	0.05	0.20
Science	721	0.09	0.02	0.08	0.03

Still, slow progress closing the learning gap is being made in rural schools in reading and science.

What accounts for the success of rural schools? In a more comprehensive analysis than I have presented here, Reeves and Bylund[36] concluded that in Kentucky,

> . . . rural schools may be advantaged by a readiness for improvement under the stimulus of educational reform. What we mean by "readiness for improvement" is this: prior to educational reform, rural schools languished in a climate of low expectations; after reform raised expectations, rural schools have responded dramatically.[37]

But whatever the reason for the progress of rural schools in Kentucky, low-income students in these schools are the beneficiaries. Of course, a corollary of this is that in metropolitan areas low-income students are not benefiting.[38]

CONCLUSIONS

After taking proper precautions for analyzing the effects of poverty on change scores, we have discovered that public elementary schools with economically disadvantaged student bodies are not closing the learning gap in reading, mathematics, or science, but neither are they falling farther behind. For each new cohort of students, schools reproduce the same inequality of learning as for previous cohorts. Kentucky has, at this point, not addressed closing the learning gap in a comprehensive or effective manner. Indeed, until recently, state educational officials were content to note that some schools with high percentages of economically disadvantaged students are listed each year among the top gainers. This is taken to be evidence that disadvantaged schools are capable of substantial progress. No attention was given to mean reversion as an explanation for such anomalies.

Slow progress is being made in rural elementary schools, however, in the areas of reading and science, although not in mathematics. This is significant because the student populations of rural schools are at a greater economic disadvantage than their nonrural counterparts. Although the reasons for this pattern are not completely clear, it appears likely that rural communities and rural schools are more closely interrelated than occurs in metropolitan areas. This creates a form of "social capital"[39] that sustains the improvement of student performance in rural schools. By changing the expectations of teachers as well as parents in rural areas, Kentucky education reform may have provided the catalyst that activated rural social capital and resulted in the slight but statistically significant gains in achievement that were identified.

Issues of poverty and educational improvement are extremely complex. We know this from a voluminous record of research, some of which was reviewed above. "One size fits all" solutions are unlikely to achieve uniform results. Kentucky, a state characterized by a large percentage of rural schools with economically disadvantaged students, does not fit the same profile as a state like Illinois, which has a huge multiethnic, economically deprived urban school population in Chicago.[40] In Kentucky, the best hope for closing the learning gap lies in building on the strength of rural communities. In Chicago, this task is made far more difficult, but not impossible, by the socioeconomic disparities and ethnic diversity that characterize urban schools and neighborhoods. If "trust in schools" is a core resource for school improvement, as Anthony Bryk and Barbara Schneider[41] suggest, then perhaps Kentucky's poor children are in a somewhat better position to close the learning gap than are poor children in America's large cities.

NOTES

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29. I use the common measure of economic disadvantage: the percentage of students in the school eligible for participation in the free or reduced-price lunch program. Participation in this program is restricted to children in low-income and poverty-level families.

30. The correlation coefficient is an estimate of the association between two variables. A correlation coefficient that is near the maximum value of −1.0 indicates a strong positive association. When the coefficient is near the minimum value of –1.0, this indicates a strong negative association. A correlation of 0.0 (or thereabouts) means that no association between the two variables exists. Correlation coefficients can also be subjected to significance testing.

31. The phenomenon of mean reversion was first noted in the 19th century. Measurements to compare the height of parents and their adult children showed that, when other influences on height were controlled, parents of less than average height tended to have children taller than themselves while parents of greater than average height tended to have shorter children.

32. The gain score was calculated by subtracting the 1999 reading score from the 2005 reading score.

33. Donald T. Campbell and David A. Kenney, *A Primer on Regression Artifacts* (New York: Guilford Press, 1999) is a basic reference on mean reversion. For a more technical presentation, see Kenneth Y. Chay, Patrick J. McEwan, and Miguel Urquiola, "The Central Role of Noise in Evaluating Interventions That Use Test Scores to Rank Schools," *The American Economic Review* 95 (2005): 1237–1258.

34. This extremely conservative, and accurate, measurement of percent student poverty is also used for the results shown in panel B of Table 4.3.

35. Here is an instance where mean reversion does not have a profound influence on the results.

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CHAPTER 5

The Accumulation of Disadvantage: The Role of Educational Testing in the School Career of Minority Children*

Sandra Mathison

This chapter discusses the ways standardized testing puts children of color and children living in poverty at a disadvantage. This disadvantage begins early in the school career of a child and repeats itself again and again. Education, when driven by standardized testing, is not the great equalizer it is so often portrayed to be in the mythical world where merit counts most.

TESTING IN K-12

Testing starts early and it occurs often in the life of an average student, even more often if a student is at either end of the achievement spectrum, that is, gifted or learning disabled. In a recent analysis of the U.S. Department of Education's Early Childhood Longitudinal Study, Kindergarten Cohort (ECLS-K), Lee and Burkam conclude: "There are substantial differences by race and ethnicity in children's test scores as they begin kindergarten. Before even entering kindergarten, the average cognitive score of children in the highest SES group are 60 percent above the scores of the lowest SES group. Moreover, average math achievement is 21 percent lower for blacks than for whites, and 19 percent lower for Hispanics."[1] Setting aside the unjustified confidence in the meaningfulness of standardized test scores for young children,[2] this report illustrates just the beginning of a lifetime of characterizations and decisions that will be made and indeed institutionalized for children of color and those living in poverty.

Beginning in kindergarten, test results are used to sort, track, and monitor the abilities, achievements, and potentials of students. The danger is that standardized test results will be weighed more heavily than they ought to be, that decisions once

made cannot or will not be reversed, and that other compelling information may be ignored.

The uses of standardized testing are more far ranging than most people realize. While there is considerable variation from one district to the next, children will be administered at least one but typically many more standardized tests within a single year. Except for Iowa and Nebraska, every other state administers English and mathematics state-mandated tests from grades 3 to 8, and of those 48 states, 31 administer state-mandated tests in at least two of grades 9–12.[3]

Table 5.1 illustrates the testing experience of a child from kindergarten through high school in an upstate New York school district.

The Case of High Stakes Tests

What are high stakes tests? They are tests that have serious consequences attached to the results—these consequences may be for students, teachers, principals, schools, and even states. For students, these consequences include whether they will graduate from high school, whether they will be promoted to the next grade or retained, whether they will spend their summer in school, or whether they will be required to participate in tutoring that extends their time in school substantially. Although high stakes tests can confer rewards as well as sanctions, more often there are punishments. These punishments can be direct (such as taking over or closing school, replacing administrators or teachers, or withdrawing accreditation) or indirect (such as publishing test scores in the local newspaper, shaming, or job reassignment).

High stakes testing is disproportionately found in states with higher percentages of people of color and living in poverty. A recent analysis of the National Educational Longitudinal Survey (NELS) shows that 35 percent of African American and 27 percent of Hispanic eighth graders will take a high stakes test, compared to 16 percent of whites.[4] Looked at along class lines, 25 percent of low-SES eighth graders will take a high stakes test compared to 14 percent of high-SES eighth graders.

The *Quality Counts* report indicates that of the 23 states that require passing a standardized test to graduate, about half are in the south, that is, states with substantial minority populations.[5] Another two states (Maryland and Washington) and the District of Columbia are either piloting a graduation test or phasing one in the next couple of years. States that do NOT have a graduation test include West Virginia, Oklahoma, Kentucky, Illinois, Hawaii, Delaware, Colorado, Michigan, Vermont, Wisconsin, Pennsylvania, S. Dakota, N. Dakota, Connecticut, Arkansas, Oregon, Rhode Island, Maine, Kansas, New Hampshire, Missouri, Nebraska, Wyoming, Montana, and Iowa.

Students of color are more likely to take high stakes tests and they also score lower than white students. From the Web sites of a sample of any state department of education (for illustrative purposes Massachusetts, New York, and Kentucky are described here) one can demonstrate this conclusion. In 2003 in Boston, 43 percent of white students and 85 percent of Hispanic students failed the tenth grade math

Table 5.1
An Illustration of the Testing in the Life of a Student

Grade	Test
Kindergarten	Boehm Test of Basic Concepts
1st	Gates MacGinitie Reading Test[a]
2nd	Gates MacGinitie Reading Test[a]
	Stanford Diagnostic Math Test[a]
	Terra Nova (reading and math)
3rd	Gates-MacGinitie Reading Testing[a]
	Stanford Diagnostic Math Test[a]
	Terra Nova (reading and math)
	School and College Ability Test (SCAT)[b]
	Cognitive Abilities Test (CogAT)
4th	Gates MacGinitie Reading Test[a]
	Stanford Diagnostic Math Test[a]
	School and College Ability Test (SCAT)[b]
	NYS English Language Arts Test
	NYS Math Test
	NYS Science Test
5th	Gates MacGinitie Reading Test[a]
	Stanford Diagnostic Math Test[a]
	Terra Nova (reading and math)
	School and College Ability Test (SCAT)[b]
	NYS Social Studies Test
6th	Terra Nova (reading and math)
	School and College Ability Test (SCAT)[b]
7th	Terra Nova (reading and math)
	Cognitive Abilities Test (CogAT)
8th	NYS English Language Arts Test
	NYS Math Test
	NYS Science Test
	NYS Social Studies Test
	NYS Foreign Language Test
	NYS Technology Test
9th	Regents Exams:
10th	English Language Arts
11th	Mathematics
12th	Global History and Geography
	U.S. History and Government
	Science
	Language other than English
	PSAT
	SAT

[a]For remedial students only.
[b]Johns Hopkins Talent Search test for gifted program.

test. In Schenectady, New York, 62 percent of children of color and 41 percent of white students failed the fourth grade ELA. In a neighboring Albany school district, 68 percent of children of color failed this test, compared to 33 percent of whites. In Kentucky's Jefferson County Public Schools, scores on reading tests demonstrate the same relationship: 63 percent of white fourth graders were proficient, compared to 34 percent of African American children; 54 percent of white seventh grade students were proficient, compared to 27 percent of African Americans; and in eleventh grade 37 percent of whites were proficient compared to 13 percent of African American students.

The remainder of this discussion will focus on three outcomes of high stakes testing, and the ways in which minority children are particularly disadvantaged:

- The disproportionate impact of state testing on drop out rates for minorities.
- The bizarre effect of monetary rewards for students.
- The diminishment in the quality of education as a consequence of testing, for all, but especially for minority students when differential performance on tests is translated into the "achievement gap."

The Impact of Testing on Drop Out Rates for Minorities

Both graduation tests and tests given earlier in a students' career are having a substantial impact on the numbers of students who drop out of school. The increased drop out rates are based on two factors, the graduation tests themselves and the impact of increased rates of retention in grade, especially in eighth and ninth grades.

Graduation Tests

The number of states requiring graduation tests is on the rise and by 2008 more than half of the states plan to have such a test in place. (See Figure 5.1.) This represents a dramatic increase in a less than 30-year period. In 1983 when *A Nation at Risk*, the flash point for the standards-based and test-driven educational reform movement, was published, three states had minimum competency testing in place (Florida, North Carolina, and Nevada) that amounted to a graduation or exit test. *A Nation at Risk* called for rigorous tests to assess exiting high school students. Dorn points out that concerns about a decrease in high school graduation rates is particularly pointed given that most teenagers graduate.[6] The proportion of all students who obtain a high school diploma has steadily increased in the last 50 years with more dramatic increases for minorities. It is this context that suggests backsliding in national educational aspirations with the advent of high stakes graduation tests.

Amrein and Berliner report actual or estimated percentages of students who take and fail high school graduation tests in 18 high stakes testing states (Figure 5.2).[7] They find a considerable variability across states: a low of 0.5 percent in Virginia where the basic skills graduation test is administered in sixth grade to a high of 10 percent in New York and 12 percent in Georgia. Looking at pass rates on graduation

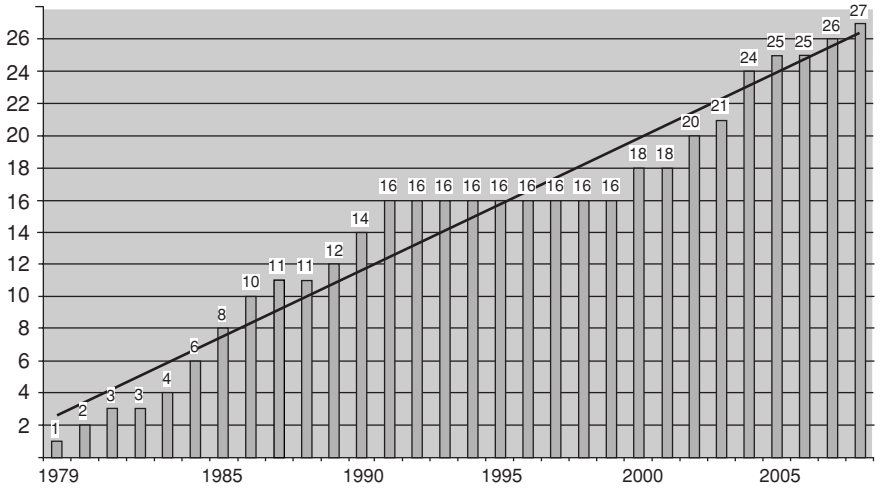

Figure 5.1
Number of States with High School Graduation Tests 1979–2008
Source: **Amrein & Berliner (2001)**

tests for subgroups of students, in 10 states the percentage of black and Hispanic students passing the test on the first try is consistently lower than the percentage of white students.[8] Usually the difference is quite dramatic (for example, in Florida 32 percent of black, 45 percent of Hispanic, and 73 percent of white students pass the reading exit examination on the first try) and even when it is not, the pass rates for all students in the state are high (for example, in Georgia, New Mexico, and South

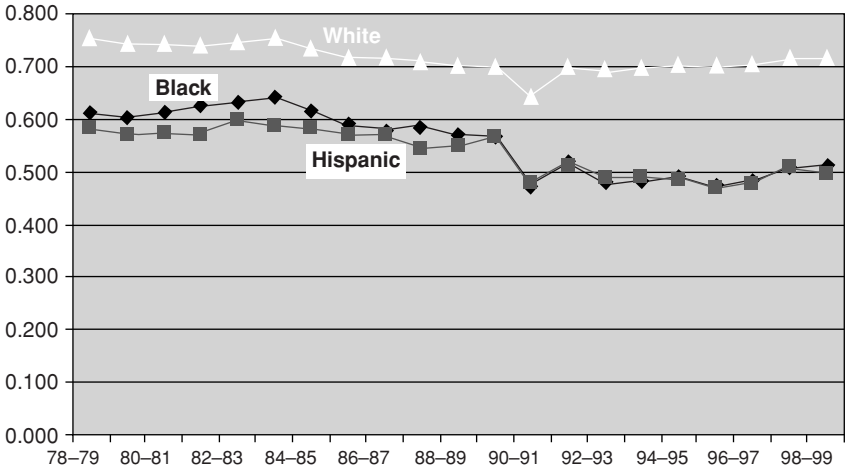

Figure 5.2
Illustration of Differential School Graduation
Source: **Haney (2000)**

Carolina.) "These gaps are worrisome because if a failure to pass an exit exam on the first try does encourage students to drop out of school, then minority students and other subgroups with lower initial pass rates will be much more negatively affected by exit exams."[9]

Although the relationship is a complex one, the presence of an exit exam is related to students either dropping out or taking the GED. An examination of data from the National Center for Education Statistics illustrates that since 1985 there has been a more than 20 percent increase in the number of GED test takers nationwide, mostly for people 19 years of age or younger.

In addition, "states requiring graduation exams had lower graduation rates and lower SAT scores. Individually, students from states requiring a graduation exam performed more poorly on the SAT than did students from states not requiring an exam."[10] So, while failing the graduation tests may keep a substantial number of students from receiving a high school diploma, these tests also reverberate through schools in many other ways. It is likely that graduation tests affect what is taught and that this may create a mismatch with college entrance exams and thus work against even those students who succeed on the state-mandated tests.

Retention in Grade

There are two grade levels at which retention is most common: first grade when under-age boys are retained to permit them time to "mature," and again in eighth and ninth grade when students are on the cusp of entering high school. Currently, Louisiana, Florida, Georgia, Delaware, North Carolina, Wisconsin, Texas, and Missouri have state policies that permit the retention of students based on state-mandated tests.[11] The extent to which state test scores may be used informally or at the local district level for retention decisions is not known.

Students of color are retained at high rates and there is an unhealthy interaction between grade retention and the presence of high stakes testing. Analyses of the NELS data indicate the mere presence of a high stakes test is a strong predictor of higher drop out rates.[12] Thirty years ago only about 4 percent of students were expected to repeat grade nine but that percentage has grown to about 12 percent, and as high as 20 percent in states with high stakes tests such as Florida, South Carolina, and New York.

Haney found, "Only 50 percent of minority students in Texas have been progressing from grade nine to high school graduation since the initiation of the TAAS testing program. Since about 1982, the rates at which black and Hispanic students are required to repeat grade nine have climbed steadily, such that by the late 1990s, nearly 30 percent of black and Hispanic students were "failing" grade nine (Figure 5.3). Cumulative rates of grade retention in Texas are almost twice as high for black and Hispanic students as for white students."[13] One conclusion from this study is that retaining students in ninth grade boosts the tenth grade TAAS scores (because the potential low scorers are excluded) *and in effect* keeps many of these students from ever taking the test as the likelihood they will drop out of school increases dramatically. New York City's retention of third grades is another example of testing in a grade

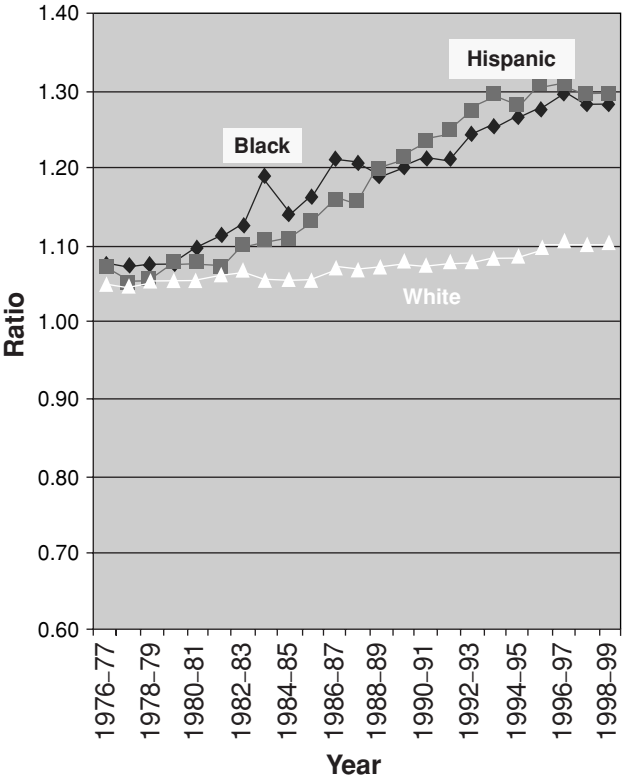

Figure 5.3
Illustration of Differential Retention in Grade Effects
Source: **Haney (2000)**

prior to the state-mandated tests—this strategy potentially culls out students who would do less well on the test and who, if promoted to fourth grade with their age cohort, might potentially lower the overall school and district scores.

In Massachusetts, with the implementation of a tenth grade high stakes test the overall retention rates for ninth graders jumped from 6.3 percent in 1995 to 8.4 percent in 2001. In 2001, 12 districts held back 20 percent of ninth graders. The districts with the highest ninth grade retention rates, between 27 and 38 percent, enroll a majority of nonwhite students.

In parallel to these changes in retention rates, we see increases in the number of students dropping out of school. Being retained in grade, especially in middle and high school, at least triples a student's likelihood of dropping out of school.

If students persist and take a high school graduation test, those who do poorly on the test are more likely to drop out of school *and* this poor test performance disproportionately affects students with high grades. In other words, students who have by other indicators done reasonably well in school are disproportionately influenced

by poor test scores to drop out of school. It appears that high stakes testing contributes substantially to grade retention in middle and high school and to the failure of students to graduate from high school.

The Bizarre Effect of Monetary Rewards for Students

Six states give scholarships to students for high performance on state-mandated tests—California, Delaware, Massachusetts, Michigan, Missouri, Nevada, and Ohio.[14] These scholarships provide neither incentives nor opportunities for minority students to go to college, in spite of the rhetoric to that effect. Scholarship money goes to students who would have attended college anyway—they maintain the status quo with regard to access to a college education.

Michigan's Merit Scholarship Program, administered by the Treasury Department, is a good example of this scenario. Using money from a settlement with cigarette companies, Michigan awards scholarships based on performance on the Michigan Education Accountability Program, or MEAP. In Michigan, one in three white, one in five Native American, one in five Hispanic, and one in fourteen African American test takers receive scholarships. In the Detroit area, 80 percent of students in affluent suburban districts, which are white, compared to 6 percent of students in the Detroit city schools received scholarships. Not only does the Michigan scholarship program reward those already college bound, but does so by diverting money that should have gone to Michigan's poor and indigent who are suffering from tobacco-related diseases. Michigan is currently being sued by the ACLU, MALDEF, and the NAACP for these and other corrupting effects of high stakes testing in that state.

The Diminishing Quality of Education for All Children, and Especially for Minority Students As Manifest in the "Achievement Gap" Rhetoric

Many researchers are concluding that high stakes testing not only does not improve education, but indeed diminishes its quality. High stakes testing is contributing to the,

- deprofessionalization of teachers,
- narrowing of the curriculum,
- adoption of curriculum driven by tests that under-represent the purposes of schooling,
- only teaching what is tested,
- elimination of project-based student work, field trips, recess,
- creation of unproductive stress.[15]

High stakes testing has these negative consequences for all children, but it is especially so for children of color, because they are disproportionately exposed to and punished by the effects of high stakes tests. In addition, because the use and impact of tests is ubiquitous we are diverted from thinking about causes, from thinking about the basic technical shortcomings of the tests as well as the scoring, standard setting,

and interpretation, and from the interests served by these test-based accountability schemes. An obvious manifestation of this diversion is the rhetoric of the "achievement gap."

Is there really an achievement gap? The rhetoric of the achievement gap adopts a deficit model of those scoring lower on tests, often seeking explanations based on differences in natural abilities, a harkening back to early eugenics of standardized testing. Or at least to the identification of cultural deficiencies among those doing less well on the tests. This rhetoric leads to a search for solutions in those children and families deemed deficient. Solutions advocated tend to be more of the same strategies that aren't working now—tutoring, grade retention, extended school days/years, and the adoption of pedagogies that deskill both teachers and students, like direct instruction techniques and phonics-only curriculum. These strategies might lead to short-term gains in test scores, but do not result in meaningful learning.

The rhetoric of the achievement gap looks for solutions that alter children and families of color and those living poverty, but not for solutions that alter teachers competencies, curriculum, pedagogy, school organization or school finance. Alternatives to the search for how to remedy poor and minority children and families might be,

- fundamental restructuring of schools (e.g. alternatives to top down management);
- improvement of school climate (e.g., sufficient paper, books kids can take home and even keep, toilet paper in the bathrooms, air conditioning, adequate space, classrooms instead of trailers, quiet places for one-on-one interactions with students— "Books, supplies, and lower class size!");
- curricular alternatives (e.g., Afro-centric or Latino-centric curriculum, bilingual education);
- efforts to decrease class size or create small schools;
- reform of school financing (e.g., elimination of local property taxation for school financing);
- the racial profiling inherent in discipline policies and practices;
- the Courts' role in resegregating schools, creating what the Harvard Civil Rights Project calls apartheid schools;
- much greater caution about using hastily developed, unvalidated tests that are used by policymakers in ways that violate professional standards and are frequently inaccurately scored

The "achievement gap" is more accurately a *test score gap*. It's also an *opportunity gap*. And, a visit to an affluent white suburban school and one to an urban primarily minority school will illustrate there is a *resources gap*, and that same visit will also reveal an *income gap*. Focusing on the test score gap without attention to these other gaps will do little to alleviate the inherent racism in educational opportunity and achievement.

COLLEGE ENTRANCE TESTS

In the face of great odds, children of color and living in poverty do complete high school and aspire to attend postsecondary education where they encounter another

Table 5.2
2002 College Bound Seniors SAT Scores

	Verbal	Math	Total	
Ethnic Group				
African American or Black	430	427	857	
Mexican or Mexican American	446	457	903	
Puerto Rican	455	451	906	
Other Hispanic or Latino	458	464	922	
American Indian or Alaskan Native	479	483	962	
White	527	533	1060	
Asian, Asian American, Pacific Islander	501	569	1070	
Other	502	514	1016	
Family Income				
Less than $10,000/year	417	442	859	
$10,000–$20,000/year	435	453	888	+29
$20,000–$30,000/year	461	470	931	+43
$30,000–$40,000/year	480	485	965	+34
$40,000–$50,000/year	496	501	997	+32
$50,000–$60,000/year	505	509	1014	+17
$60,000–$70,000/year	511	516	1027	+13
$70,000–$80,000/year	517	524	1041	+14
$80,000–$100,000/year	530	538	1068	+27
More than $100,000/year	555	568	1123	+55
All Test-Takers (Approximately 1.3 million)	504	516	1020	

Source: College Board, *College-Board Seniors National Report*, 2002.

potential setback in the form of college entrance tests. Based on a lack of validity and the differential performance of minority and poor children (see Table 5.2 and Table 5.3) there has been increasing criticism and rejection of both SAT and ACT scores for college admissions.[16] Still, many colleges expect students to take these admissions tests, and Tables 5.2 and 5.3 illustrate the disadvantage for minority students and the impact of income on test scores. Sacks concludes, "there is little doubt that the prevailing paradigm about merit has consistently reproduced social and economic advantages for the "dukes of the system," the relatively few who conform to widely held views of merit."[17]

College admissions scores are used for more than admissions, however. Scholarship awards are also based on SAT or ACT scores. In a letter to Florida's Governor Jeb Bush, Fairtest, MALDEF, and others outline the problems:

> While African Americans comprised 14.4 percent of all SAT and ACT takers, they received only 3 percent of all Academic Scholars Awards (100% funding) and only 8.3 percent of Merit Scholarship Awards (75% funding). Latinos, who made up 13.7 percent of all test takers, earned only 8.7 percent of the Academic Scholars Awards

Table 5.3
2002 College Bound Seniors ACT Scores

Ethnicity		
African American/Black	16.8	
American Indian/Alaskan Native	18.6	
Mexican American/Chicano	18.2	
Puerto Rican/Hispanic	18.8	
Other	19.2	
Multiracial	20.9	
Asian American/Pacific Islander	21.6	
Caucasian American/White	21.7	
Household Income		
Less than $18,000/year	17.8	
$18,000–$24,000/year	18.6	+0.8
$24,000–$30,000/year	19.4	+0.8
$30,000–$36,000/year	19.9	+0.5
$36,000–$42,000/year	20.4	+0.5
$42,000–$50,000/year	20.8	+0.4
$50,000–$60,000/year	21.3	+0.5
$60,000–$80,000/year	21.8	+0.5
$80,000–$100,000/year	22.4	+0.6
More than $100,000/year	23.3	+0.9
All Test-Takers (1.1 million test-takers)	20.8	

Source: ACT High School Profile Report: H.S. Graduating Class of 2002 National Report.

and 12.3 percent of Merit Scholarships. White students, by contrast, comprised 53.4 percent of test takers, yet received 76.3 percent of the Academic Scholars Awards and 71.5 percent of Merit Scholarships.

The use of SAT and ACT score cut-offs to determine eligibility is a major reason why proportionately few African American and Latino students received these lucrative scholarships. Students must score 1270 or higher on the SAT, or 28 or higher on the ACT, in order to qualify for Academic Scholars; the Merit Scholarship Award eligibility is set at a SAT of 920 or an ACT of 20. Yet in Florida, the average SAT score was 857 for African Americans and 952 for Latinos, both of which are more than 300 points below the cut-off for the Academic Scholars Award. For whites in Florida, the average score was 1044. Other measures of academic preparation, such as grades, do not demonstrate such a great racial disparity. It is the high test score minimums, particularly for the Academic Scholars program, that put receipt of these awards far out of the reach of many students of color.[18]

The move away from needs-based and toward merit-based scholarships, such as in the Florida example, is happening in all parts of the country with similar results. In

the Introduction to their edited collection, Heller and Marin parody the deleterious effects of such scholarships:

> Imagine someone reacting to higher education's current situation by saying that what we needed were large new programs to subsidize white and middle- to upper-income students to attend college, and that it was not necessary to raise need-based aid even enough to cover new tuition increases. We would give some minority students entering awards because of their relatively high grade point averages from inferior segregated schools. However, we will take their aid away when they cannot get a "B" average in a vastly more competitive college setting and blame them for not being up to the task. A huge amount of money would go into this new program, far more than was spent for the need-based scholarships in some states. We would get the money from an extremely regressive tax-a-state lottery that drew money disproportionately from poor and minority players. In other words, poor blacks and Latinos would end up paying a substantial part of the cost of educating more affluent white students, who would have gone to college even if they had not had the additional financial incentive. And to add insult to injury, colleges would cut their own financial aid funds, or shift these resources to give more money to high scoring students. In cases where the financial aid made more students eager to go to a particular institution in the state, rather than an out-of-state school where they would have to pay tuition, the in-state institution could raise its selectivity ratings by excluding students with lower scores, students who would usually be minority and from less affluent families.[19]

CONCLUSION

There is every reason to believe that access and quality of schooling is differentiated in this country and that differentiation is along race and class lines. Standardized testing plays a substantial role in maintaining this differentiation beginning in kindergarten on through school and into access to professions and jobs. This issue is one that must be addressed as a K-16 issue, not one isolated in either public schools or higher education. This K-16 alliance also includes parents, and the rise of grassroots organizations that combine the knowledge and resources of educators, researchers, and parents are on the rise.[20] Researchers are now beginning to see the common threads that can support a critique of testing as it is employed across the K-16 educational spectrum. Elsewhere I have described the hegemony of accountability that is test-driven and illustrated how this is manifest in both K-12 and postsecondary contexts.[21]

There is little reason to believe that current test based reforms in precollegiate, collegiate, and professional education will redress the inequities between white and minority students and between those living in poverty and those not. Indeed this testing has the potential to further deepen and divide Americans along race and class lines.

NOTES

[*] This chapter is a slightly revised version of an article of the same name previously published in *Workplace: A Journal for Academic Labor*, July 2003. Available at http://www.cust.educ.ubc.ca/workplace/issue5p2/mathison.html.

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4. S. F. Reardon and C. Galindo (2002). Do high stakes tests affect students' decision to drop out of school? Evidence from NELS. Paper presented at the annual meeting of the American Educational Research Association, New Orleans, April 2002.

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12. Reardon and Galindo, Do high stakes tests affect students' decision to drop out of school?

13. W. Haney (2000). The myth of the Texas miracle in education. *Education Analysis Policy Archives*, 8 (41) [Online]. Available at http://epaa.asu.edu/epaa/v8n41/.

14. These data are based on the *Quality Counts* 2001 report, as *Quality Counts* 2006 does not provide similar data.

15. See the following references for more detailed discussions of the impact of high stakes testing on teaching, teachers, and learning.

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20. See http://www.eval.org/hstlinks.htm for a list of grassroots organizations, many of which are regional or state based, but some are national in scope, such as the Rouge Forum or the fledgling ACT NOW, Advocates for Children and Teachers National Organizing Workshop.

21. S. Mathison, and E. W. Ross (2002) The hegemony of accountability in schools and universities. *Workplace: A Journal of Academic Labor* [Online]. Available at http://www.louisville.edu/journal/workplace/issue5p1/mathison.html

CHAPTER 6

Family and Other Baseline Correlates of GED versus Other Academic Attainment Statuses among Adolescents

Richard K. Caputo

Over the past 30 years in the United States, the earning capacity of those both with and without benefit of a high school degree has deteriorated, particularly more so for the latter, such that the progress made against poverty in the post–World War II period ceased.[1] In 2004, 12.7 percent of all people (except unrelated individuals under age 15) of all educational levels fell below the U.S. official poverty thresholds (37.0 million persons) compared to 21.8 percent (or 10.2 million persons) of those without a high school diploma based on highest grade completed.[2] For those under 25 years of age compared to those 25 years of age or older, 17.9 percent and 10.0 percent respectively of all educational levels were poor compared to 18.7 percent and 23.9 percent respectively of those without a high school diploma. In 1992 among those 25 years of age or older, 11.0 percent of all educational levels fell below the U.S. official poverty thresholds compared to 25.8 percent of those without a high school diploma.[3] Throughout the 1970s and 1980s, increasing percentages of the high school dropouts among noninstitutionalized males 20–29 years of age reported no earnings, from 6.5 percent in 1973 to 13.0 percent in 1987, while the real annual earnings of black male dropouts and graduates respectively fell 44 percent and 36 percent.[4] Increases in unemployed young black males, that is, with no annual earnings, were reported to have occurred more recently as well.[5]

In light of socioeconomic disadvantages associated with dropping out of high school and in an effort to increase the efficacy of early intervention efforts, the present study examines distal family processes, parental styles, peer activities, and other background measures as predictors of obtaining General Equivalency Degree (also known as General Educational Development or GED) certificates versus other academic achievements among adolescents. This study focuses on GED recipients because they are more likely than conventional high school graduates to be poor

and they have been found to have less favorable outcomes over the life course in such areas as cognition, depression, physical illnesses, and household income.[6] Given that economic status has been found to be strongly correlated across generations,[7] obtaining a traditional high school diploma rather than an alternative such as the GED takes on added importance. In addition, GED recipients are often classified with conventional high school graduates,[8] perhaps to their detriment.[9] This lumping continues to occur even though nonequivalency of the GED certificate and traditional high school diploma has been observed and noted since the 1980s,[10] albeit with some exceptions.[11] To the extent that many studies, reports, and government statistics lump high school graduates and GED recipients together, they may be remiss. In Philip Gleason and Mark Dynarski's and Gary D. Sandefur, Sara McLanahan, and Roger A. Wojtkiewicz's studies of dropout risks, for example, it would have been helpful to know if the lack of predictive validity of most risk factors was similar for conventional high school completers and for GED recipients.[12]

There has also been some concern about educational policies enacted by the Federal Government resulting in higher dropout rates and less investment in human capital by dropouts. The Goals 2000: Educate America Act passed in 1994[13] and The No Child Left Behind Act of 2001[14] are cited as examples.[15] Both acts stress the importance of test-taking, which may encourage educators to jettison marginal students from their ranks, while enabling states to count GED recipients as graduates.[16]

Russell W. Rumberger long ago called for a comprehensive model of factors associated with dropping out of high school, one that incorporates distal and proximate measures.[17] The author contends that intervention efforts relying primarily or exclusively on proximate factors and processes associated with adolescents' academic achievement may be less successful because such efforts would begin too late and have insufficient time to take effect. There is some empirical support for reliance on distal factors associated with academic achievement, including the classic study by James Samuel Coleman et al., which highlighted the importance of socioeconomic background.[18]

The focus on GED is also important in light of ongoing questions regarding the merits of the GED,[19] the increased proportion of contemporary high school students, especially among males and racial/ethnic minorities, who leave prior to completing all their courses successfully,[20] and the decreased labor force participation rates of high school dropouts 16–24 years old since 1990.[21] Given their higher rates of poverty and increased social marginalization, high school dropouts present a formidable challenge to educators, social workers, and others concerned about the well-being of these individuals as well as on their ability to meet the country's workforce needs of the twenty-first century.[22] This is the case especially in the United States where cash assistance for low-income single parents, many of whom participate in the welfare-to-work program known as Temporary Assistance for Needy Families (TANF) and have adolescent children with serious emotional and behavioral problems,[23] is increasingly dependent on labor force participation and where an aging population will in all likelihood become increasingly dependent on the Social Security contributions of younger workers.[24]

This chapter proceeds with a brief description of today's GED. Historical treatment can be found elsewhere.[25] The related literature regarding adolescents' academic achievements primarily through high school is then reviewed. The major research issue and hypotheses are then presented. Study methods, results, and a discussion of practice and policy implications in light of findings follow accordingly.

TODAY'S GED

Over one million adults worldwide took one or more of the five GED tests in 2001, a record number, with nearly 70 percent receiving the credential; the number of test takers, however, dropped to 603,019 in 2002 but rose to 703,512 in 2003.[26] In 2003, the U.S. total was 552,396, with 387,470, slightly more than 70 percent, passing the battery of tests; it should be noted, however, that in 2003 only 2 percent of the U.S. population of adults without a high school degree were tested, 1.7 percent of those adults completed the battery of tests, and 1.2 percent passed.[27]

Approximately 95 percent of U.S. colleges and universities admit students with GED certificates on the same basis as traditional high school graduates.[28] The scope of the GED can also be assessed in dollars. In fiscal year 1999–2000, federal funds targeted for adult education programs authorized by the Adult Education and Family Literacy Act of 1998 totaled $365 million.[29] They increased to $587 million in 2003, with projected expenditures of $2.5 billion for 2004–2008,[30] although they declined to $569.7 million in fiscal year 2005.[31] The main beneficiaries of these funds were GED preparation programs offered by public high schools, community colleges, community-based organizations, and prisons. No formal training, however, was required to take the test. Hence, there was little if any socialization component to the GED. By design, the GED was meant to distinguish dropouts with high-level cognitive skills, rather than institutionalize workplace norms.

LITERATURE REVIEW

The empirical literature in regard to academic achievement, especially of high school dropouts, is extensive, spanning several decades, and it is not easily summarized. What follows is a review of recent studies (within the past 10 years) whose findings about correlates of academic achievement in general and GED attainment in particular were used as guides to variable selection and for the theoretical organization of salient family background, baseline, and other measures used in the present study. In general among those 16–24 years of age, men have been more likely to drop out of high school than women since the mid-1980s and more recently those of Hispanic origin about twice as likely as those of non-Hispanic black origin who in turn are twice as likely to drop out as those of non-Hispanic white origin.[32] In addition, the lower income "event" drop out rate has stabilized since 1990 and remains about 10–13 percent compared to 4–6 percent for middle-income youth and 1–3 percent for upper-income youth.[33]

Robert Haveman and Barbara Wolfe have summarized much of the earlier studies regarding determinants of children's educational choices.[34] Their review of seven high school graduation and eight educational attainment studies[35] published between 1982 and 1994 showed that the human capital of parents, typically measured by the number of years of schooling attained, was statistically significant and quantitatively important to children's educational attainment no matter how it was defined. Family structure was also found to influence high school completion and educational attainment. Growing up in a one-parent family was inversely related to educational attainment and being raised in an intact family increased the odds of graduating from high school. Theoretically, the presence of both parents increased the human capital available to children, especially as mothers' educational levels increased, in addition to devoting more time and other resources to children than would be the case in single-parent families. Other factors found to influence either high school graduation or educational attainment included the number of siblings, religiousness, school-related parenting practices, and the presence of reading materials in the home.

Most of the studies Haveman and Wolfe examined, also found that race was not associated significantly with educational attainment when accounting for family income and other background measures. Social investment measures such as unemployment rates, quality of the neighborhood, region of country, suburban vs. urban residence, and the like were also reported to be correlated with children's educational attainment, but of marginal statistical significance when controlling for other factors. Among the high school graduation studies only one[36] made explicit reference to the GED as educational attainment, but GED certificate holders were lumped with high school graduates.

Several recent studies focused only on high school dropout rates. Karen A. Randolph, Roderick A. Rose, Mark W. Fraser, and Dennis K. Orthner, for example, focused on children in single female-headed families receiving cash income from the Aid to Families with Dependent Children (AFDC) program in 1993 and 1994.[37] They reported that unstable labor force participation of mothers increased the hazard rate at which the children dropped out of high school. With the exceptions of first-grade retention, race and sex, all measures of this study were proximate, for example, suspension, truancy, participation in extracurricular activities and the like while in high school. Given the restricted sample of the Randolph et al. study, generalizations across schools, school districts, urban areas, or states were limited. Rumberger had noted similar limitations in an earlier review of high school dropout studies.[38]

Beth Spenciter Rosenthal studied nonschool correlates of high school dropouts.[39] Taking an ecological approach that organized such measures along macro, mezzo, and micro dimensions, Rosenthal reported that SES was the best documented, with students from lower socioeconomic status much more likely to drop out of school. Minority group status disappeared when controlling for family background characteristics such as SES. Men were more likely to drop out than women. Community characteristics associated with dropouts included urban residency, living in the South and West, living in poor areas (indexed by per capita income, percentage of school families receiving public assistance, and average wage levels), living in areas with

higher percentages of female-headed, non-white, and foreign-born communities. Social support for remaining in school, measured by parents' level of education, amount of reading materials in the home, and percent of friends who remain in school, were also associated with likelihood of dropping out. Family processes also influenced likelihood of dropping out of high school. Students whose parents were more involved in and monitored their everyday activities were less likely to drop out. Dropouts had poorer relationships with their parents compared to completers and they saw their parents as more punitive. Parents of dropouts were found, however, to use a more permissive parenting style but were also more likely to use extrinsic punishments.

In their study of the effects of family type on high school graduation, Sandefur, McLanahan, and Wojtkiewicz showed that living, at age 14, with someone other than both parents had negative consequences for children's high school graduation (regardless of whom they lived with) and that such effects persisted when controlling for income and for some psychological attributes of the adolescents.[40] Similar intergenerational religious affiliation, which provides a greater sense of shared experiences, though not directly linked to educational attainment, has been shown to affect adolescents' delinquent behavior, which in turn may influence children's educational attainment.[41]

Haveman and Wolfe's[42] and Rosenthal's[43] theoretical frameworks, which incorporate children's, parental, and social investments in education, guide the present study. Economic and social psychological bodies of theory and research underlie their framework. Economic theory treats children's educational attainment or human capital as a function of household production and parental investment in time and money.[44] Haveman and Wolfe also note the importance of social investments such as school-related government expenditures, residential tax bases, neighborhood quality, and the like to the development of human capital. Social psychological theory views children's educational attainment in part as a consequence of parents' ability to instill the requisite motivation and skills in their children and in part as a function of peer influence. Rosenthal stressed the importance of separating social supports affecting students' social-psychological makeup into two clusters of measures: family support and peer support. In addition to identifying the major categories of measures used in this study (personal characteristics, responding parent characteristics, family structure, and community environment), economic and social psychological theories also provide the selection criteria of main-interest vis-à-vis control measures within each category.

At issue for purposes of this study is the extent to which family structure and parental involvement in children's elementary school years are better predictors of adolescents' obtaining GED certificates than community environment when controlling for a variety of parental background, personal, and other baseline measures. Specifically, this study addresses the following questions:

1. To what extent are family structures and parental involvement while their children are in elementary school robust predictors of GED receipt?

2. How does community environment during a child's elementary school years affect the likelihood of obtaining a GED certificate independently of the aforementioned family structure and parental involvement?
3. How do age, gender, race/ethnicity, SES, and other family background measures affect the likelihood of GED receipt among adolescents?

Answers to these questions are important in part because findings can suggest viable avenues of early, preventive interventions by human service providers and by policymakers. For example, educators, school social workers, and others who work with elementary school children can benefit from knowing how a child's family structure and parental involvement are likely to affect that child's likelihood of obtaining GED certificates vis-à-vis dropping out of high school, completing high school, or going beyond high school by the time they get to high school. To the extent such distal factors such as family structure and parental involvement during children's elementary school years matter, early school-based intervention strategies can be designed accordingly. In addition, to the extent that distal community factors such as peer-group activities and presence of gangs matter more or less than family structure and parental involvement during children's elementary school years, policymakers may want to direct more resources to equalize opportunities for children who might be adversely affected by these factors over which school-based initiatives have little or no influence. Further, to the extent that dropping out of high school and GED receipt have stigmatizing effects and other adverse outcomes that last well into adulthood,[45] identification of distal predictors for purposes of prevention and early intervention to ensure better academic achievement becomes that much more important.

This study goes beyond previous studies in several significant ways. First, it relies on a nationally representative sample of youth obtained from a recent cohort. Second, it distinguishes GED recipients from those who completed high school with or without the GED, as well as from those whose highest level of academic achievement was the high school degree and from those who obtained neither the GED nor a high school degree. Third, it incorporates measures of activities in which adolescents report their peers partake, thereby making possible separate treatment of family versus peer support as Rosenthal had recommended.[46]

METHODS

Data and Subjects

Data were obtained from the 1997 National Longitudinal Survey of Youth (NLSY97) the purpose of which was to collect information on youth labor force experiences and investments in education. The NLSY97 is a nationally representative sample of 8,984 people living in the United States in 1997 who were born during the years 1980–1984. Two subsamples comprised the NLSY97. The first was a

cross-sectional sample (6,748) designed to be representative of people living in the United States during the initial survey round and born between January 1, 1980 and December 31, 1984. The second probability sample comprised a set of supplemental samples (2,236) designed to over-sample Hispanic and black people living in the United States during the initial survey round and born during the same period as the cross-sectional sample. Data are particularly suited for this study because participants were asked specifically about enrollment in or completion of GED certificate programs. Additional information about sampling design and fielding procedures can be found in the *NLSY97 User's Guide*.[47]

The study sample ($n = 2{,}433$) was restricted to those enrolled in elementary schools in survey year 1997. It comprised only those respondents whose enrollment status was obtained in survey year 2003, the most recent year of available data, and about whom information on all study measures was reported, and for whom mutually exclusive categories of race/ethnicity (white, black, or Hispanic) could be determined. Questions about family processes in the initial 1997 round were asked only of respondents 12–14 years of age.

Measures

Academic achievement status, the study's outcome measure, was obtained from a survey question regarding a respondent's enrollment status at the time of interview in survey year 2003. Four mutually exclusive categories were created: (1) high school dropouts with no GED or other terminal degree; (2) GED recipients whose certificate was their terminal degree; (3) traditional high school graduates for whom this degree was the terminal degree and who did not have GED certificates; and (4) traditional high school graduates who pursued additional years of schooling and who did or did not have GED certificates.

Correlates or predictors of academic achievement status were grouped into two main categories, namely main-interest measures and control measures. Main-interest correlates were classified into five domains: (1) personal characteristics of respondents; (2) responding parents' background characteristics; (3) family structural characteristics; (4) family involvement characteristics; and (5) community environment characteristics. Personal characteristics of respondents while in elementary school included ability, behavioral problems, delinquency, ever repeated a grade, participated in Head Start, number of schools attended, and use of abusive substances. The Peabody Individual Achievement Test (PIAT) Math Assessment, administered to all respondents who had completed less than 9 years of schooling in 1997, was used to measure elementary school ability. PIAT is among one of the most widely used brief assessments of academic achievement, with demonstrably high test-retest reliability and concurrent validity. The version used in this study is PIAT-Revised (PIAT-R).[48] A behavior and emotional problem scale was created by Child Trends, Inc., an organization involved in the NLSY97 questionnaire design process. Documentation of detailed descriptions, which includes results of reliability and validity tests conducted

by Child Trends, Inc., of this and other scales and indices used in this study as noted below were found in Appendix 9 of the *NLSY97*.

Codebook Supplement Main File Round 1[49]

The behavior and emotional problem scale was constructed from four 3-point (0–2, not true to often true) items asked of responding parents about the youths. Scores of the behavior and emotional problem scale ranged from 0 to 8, with higher scores signifying more behavioral problems (alpha = .65 for boys and .57 for girls). Whether youths participated in a Head Start program when they were children was obtained from a question to that effect asked of responding parents. This measure was included in light of on-going policy as well as scholarly concerns regarding the well-being of Head Start participants vis-à-vis other children as they go through elementary and high school.[50]

The substance abuse index was constructed from three yes-no items asked of youth in regard to whether they ever smoked cigarettes, had a drink of an alcoholic beverage, or used marijuana. Scores ranged from 0 to 3, with higher scores signifying more instances of substance abuse.

Personal characteristic control measures included age, ethnicity/race, health, and sex. Health was obtained from a question asked of parents about the youth and when unavailable from the parents from the youths' reports. The reported item asked to rate the youth's health on a five-point scale, which was recoded such that 1 = poor health and 5 = excellent health. Higher scores signified better health.

Main-interest responding parents' background characteristics included measures of whether they had completed high school, lived with both their parents at age 14, and type of residence where they grew up (center city, suburban, or other). These measures were included to capture parents' socioeconomic backgrounds. Completion of high school and growing up in the suburbs vis-à-vis elsewhere was meant to signify the potential human capital parents had to offer their children. Living with both parents was meant to capture the benefits of purportedly transmitted social capital from the parents to their children. Such social capital has often been attributed to intact family structures vis-à-vis growing up in single-parent households.[51]

Responding parents' background control measures included whether responding parents were born in the United States, ever had health problems since the birth of respondents, and ever received public cash assistance. Whether households were three-generational was used as a control measure for family structural characteristics. Parent-youth religious agreement was used as a control measure for family involvement characteristics. Community environment control measures included the area of residence unemployment rate and the region of country of residence.

Main-interest family structural characteristics of the youth in 1997 included measures of number of adults aged 18 and over in the household, presence of mother and father in the household, and socioeconomic status (SES). The first two measures were meant to capture potential social support. SES signifies parents' potential human

capital. It was constructed by Center for Human Resource staff from all sources of income, accounted for family size, and relied on U.S. poverty threshold indices to determine whether youth lived in poor families.

Whether youths lived in three-generation households and enriched home environment were used as controls for family structural characteristics. Child Trends, Inc. developed the enriching environment index from three items (each coded 1 for enriching and 0 for not enriching) asking youths whether their home had a computer or a dictionary and whether they spent any time within the week prior to survey taking extra classes or lessons such as music, dance, or foreign language lessons. Scores ranged from 0 to 3, with higher scores signifying a more enriching environment.

Main-interest family involvement characteristics included measures of responding parent's involvement in youth's school, parental style, and quality time. Parents' involvement in youth's schools index was created from two items asking responding parents if they attended PTA meetings or volunteered to help out in classrooms. Responses to each of the two (yes = 1, no = 0) responses were summed and averaged, yielding scores with a range of 0–1. Child Trend, Inc. created a measure of parenting styles from several items asked of youth in regard to how they perceived their parents treating them throughout childhood. Questions were asked about each parent in the family. For purposes of this study, responses reflect those about mothers in all families where they were present and about fathers in those families where mothers were not present. This measure comprised four mutually exclusive categories: (1) Uninvolved (permissive and not very or somewhat supportive); (2) Authoritarian (strict and not very or somewhat supportive); (3) Permissive (permissive and very supportive); and (4) Authoritative (strict and very supportive). The Quality Time scale was created from three items asking youth about the number of days per week they ate, had fun, or did something religious with the family (alpha = .51). Responses to each item were summed then averaged, with higher scores signifying more quality time. Parent-youth agreement of religious affiliation was used as a control measure for family involvement.

Main-interest community environment characteristics included measures of positive and negative activities of youths' peers, student–teacher ratio in schools, urban area, and whether gangs were in the school of the neighborhood. Two measures of peer activities were created from ten items asking youth about the percentage of their peers who engaged in activities such as going to church regularly, getting drunk, belonging to gangs, using illegal substances, planning to go to college, and the like. The ten items were subjected to factor analysis (Principal Component Analysis and Varimax rotating procedures) and then loaded into two groupings, one suggesting positive activities (going to church regularly, participating in school activities, planning to go to college, doing voluntary work; eigen value = 1.53, with factor loading ranging from .570 to .833) and the other suggesting negative activities (smoking, getting drunk more than once per month, belonging to gangs, using illegal substances, and cutting classes; eigen value = 3.31, with factor loadings ranging from .523 to .630). Region of residence was used as a control measure for community environment characteristics.

Procedures

Chi-square and, due to an unbalanced design, General Linear Model (GLM) procedures were used on unweighted data to determine statistically significant bivariate relationships between academic achievement status and nominal and continuous level measures accordingly. For purposes of parsimony, only those bivariate measures found to be statistically significant were used in the multivariate analysis. Multinomial regression analysis was used to determine which measures had greater predictive capacity for each academic achievement status outcome vis-à-vis obtaining the GED as the terminal degree. Measures were entered in a forward direction, with main-interest measures entered first followed, accordingly, by control measures in the following order: personal, responding parent, family structure, family involvement, and community involvement.

RESULTS

Of the 2,433 youth in the study, 107 or 4.4 percent (weighted) had obtained the GED as the terminal degree as of survey year 2003; 406 or 14.4 percent were high school dropouts; 586 or 23.2 percent had obtained a traditional high school degree as the terminal degree, but no GED; and 1,334 or 58.2 percent had gone beyond high school, with or without a GED. The youth ranged from 18 to 20 years old. Males and females were equally represented in the study sample and they averaged 19 years of age in survey year 2003. The majority of adolescents were non-Hispanic white (74%). Most responding parents (85%) had completed high school, while 16 percent of the adolescents lived in poor families in 1997.

As can be seen in Table 6.1, most nominal level measures had a statistically significant relationship with academic achievement status. Of particular note for purposes of this chapter were the poverty-related measures and their relationship to academic achievement. Higher percentages of the youth who were Head Start participants were dropouts or GED recipients than were those who were not Head Start participants (28.3% vs. 13.7% and 6.2% vs. 3.9% respectively), as were youth who lived in poor families in 1997 vs. those who did not (33.8% vs. 11.7% and 7.1% vs. 3.6% respectively), and who reported the presence of gangs in their schools or neighborhood (19.5% vs. 14.4% and 4.7% vs. 4.2% respectively). Youths whose parents had completed high school were less likely to drop out of high school or obtain GED certificates than those whose parents had not completed high school (11.8% vs. 35.0% and 3.9% vs. 6.2% respectively), as were youths whose parents had lived with both their parents at age 14 (14.5% vs. 22.6% and 4.3% vs. 4.7% respectively), who were residing with their mothers and fathers in 1997 (13.0% vs. 26.3% and 3.4% vs. 7.1% respectively).

As can be seen in Table 6.2, most ordinal and interval level measures also had a statistically significant relationship with academic achievement status. Keeping to our focus on poverty-related measures, delinquency, use of abusive substances, and negative peer influences distinguished GED recipients and high school dropouts from

Table 6.1
Bivariate Chi-Square Results (Row percents)

Variable	Value Label	Academic Achievement Status				χ^2 Value
		Dropouts	GED	High School	>High School	
Personal characteristics						
Main interest						
Ever repeat a grade	Yes	40.5	9.4	30.1	20.1	223.153***
	No	13.2	3.7	23.2	59.9	
Head Start participant	Yes	28.3	6.2	25.0	40.5	79.724***
	No	13.7	3.9	23.9	58.5	
Control						
Ethnicity/race	Hispanic	21.3	2.9	28.2	47.6	66.323***
	Non-Hispanic Black	22.0	5.5	27.0	45.4	
	Non-Hispanic White	12.8	4.4	21.4	61.3	
Sex	Female	14.2	3.5	20.7	61.6	44.311***
	Male	19.2	5.2	27.4	48.2	
Responding parent						
Main interest						
Completed high school	Yes	11.8	3.9	22.7	61.6	219.046***
	No	35.0	6.2	29.2	29.6	
Lived with both parents at age 14	Yes	14.5	4.3	22.1	59.1	51.660***
	No	22.6	4.7	29.4	43.4	
Type of residence raised	Center City	20.4	5.0	21.8	52.7	24.430***
	Suburb	11.3	3.8	21.1	63.8	
	Other	17.0	4.4	5.7	53.0	
Control						
Born in United States	Yes	16.3	4.8	24.2	54.7	7.701
	No	19.2	1.6	23.1	56.0	
Health problems since birth of respondent	Yes	17.6	6.9	28.2	47.2	7.813
	No	16.6	4.1	23.7	55.6	
Public assistance recipient (ever)	Yes	24.6	6.3	27.7	41.3	221.545***
	No	8.2	2.3	20.2	69.3	

Family structure						
Main interest						
Presence of mother & father in HH	Yes	13.0	3.4	23.8	59.9	96.562***
	No	26.3	7.1	24.8	41.8	
Socioeconomic status	Poor	33.8	7.1	27.8	31.3	211.615***
	Not Poor	11.7	3.6	23.0	61.7	
Control						
Three-generation HH	Yes	19.8	5.9	25.1	49.1	11.626**
	No	15.8	4.0	23.8	56.4	
Family involvement						
Main interest						
Parenting style	Uninvolved	22.3	4.9	28.3	44.6	35.167***
	Authoritarian	18.9	5.8	24.7	50.6	
	Permissive	16.8	3.6	23.8	55.8	
	Authoritative	13.4	4.0	22.4	60.2	
Control						
Parent–youth religious agreement	Agree	15.8	4.3	23.9	56.0	5.603
	Not Agree	19.3	4.7	24.8	51.3	
Community environment						
Main interest						
Urban residence	Yes	17.0	4.4	23.4	55.3	1.607
	No	16.0	4.5	25.6	53.9	
Whether gangs in school or neighborhood	Yes	19.5	4.7	24.0	51.7	13.426**
	No	14.4	4.2	24.1	57.3	
Region of residence	Northeast	15.1	4.6	20.3	60.0	23.582**
	North Central	16.4	3.4	23.2	57.0	
	South	18.6	6.0	23.9	51.5	
	West	16.7	2.7	27.7	54.9	

***$p < .001$, **$p < .01$.

Table 6.2
Bivariate ANOVA Results

Variable	Academic Achievement Status				*F*-value	Post-Hoc Tests[a]
	Dropouts(DO)	GED	High School(HS)	Beyond HS(BHS)		
Personal characteristics						
Main interest						
Ability (PIAT Math scores)	87.50	92.16	91.88	100.18	129.69***	DO < HS < BHS; DO < GED < BHS; HS, DO
Behavioral problems	2.62	2.18	2.02	1.47	64.16***	DO, GED, HS > BHS; DO > HS
Delinquency	1.83	1.89	1.30	0.91	39.77***	GED, DO > HS > BHS
Schools attended (#)	0.96	1.15	1.10	1.19	12.41***	DO < HS, GED, BHS; HS < BHS
Use of abusive substances	1.07	1.12	0.81	0.65	23.40***	GED, DO > HS > BHS
Control						
Age	18.93	19.09	19.00	19.03	2.00	
Health	4.03	4.10	4.20	4.42	29.35***	DO, GED, HS < BHS; DO < HS
Family structure						
Main interest						
Adults 18+ yrs. old in HH (#)	1.80	1.74	1.92	1.98	8.80***	GED, DO, HS, BHS; GED < BHS; DO < BHS
Control						
Enriched environment	1.30	1.49	1.58	2.00	120.65***	DO, GED, HS < BHS; DO < HS
Family involvement						
Main interest						
Parent involved in school	1.66	1.70	1.73	1.91	26.30***	DO, GED, HS < BHS
Quality time	3.14	3.04	3.13	3.17	0.33	
Community environment						
Main interest						
Negative peer activities	8.85	8.91	7.99	7.64	13.77***	GED, DO > HS, BHS
Positive peer activities	10.28	10.35	10.44	11.15	23.61***	DO, GED, HS < BHS
Student–teacher ratio	2.32	2.13	2.33	2.33	1.24	
Unemployment rate	2.34	2.15	2.34	2.33	1.19	

[a]For post hoc tests, the statistical significance of between group comparisons was determined at the .05 level.
***$p < .001$.

those who completed high school as the terminal degree and from those who went beyond high school. GED recipients and high school dropouts, for example, reported the highest percentage of peers engaged in negative activities, 8.91 percent and 8.85 percent respectively, which significantly differed from those with terminal high school degrees (7.99%) and those who went beyond high school (7.64%). Dropouts, GED recipients, and terminal degree high school graduates had comparably greater levels of behavioral/emotional problems and lower levels of parental involvement in schools and positive peer influences than did those who went beyond high school. Although GED recipients had about the same ability as traditional high school graduates, signified by their respective PIAT scores (92.16 vs. 91.88), their mathematical ability was below that of youth whose education went beyond high school (100.18), while above that of dropouts (87.5). No relationship was found between academic achievement status and the unemployment rate of their residence in 1997.

As Table 6.3 shows, three measures of interest distinguished GED recipients from dropouts and all three had to do with characteristics of the adolescents: ability, behavioral/emotional problems, and schools attended. Decreased ability increased the likelihood of adolescents dropping out vis-à-vis obtaining the GED certificate (3% for each point lower on PIAT, OR = .097, $p < .01$), as did attending *fewer* elementary schools (37% for each school, OR = .063, $p < .01$), while more behavioral/emotional problems increased the likelihood of their dropping out (OR = 1.21, $p < .01$). One control measure, region of residence, was also found to distinguish GED recipients from dropouts. Living in the North Central part of the United States increased the odds of dropping out of high school by nearly two times that of obtaining a GED certificate (OR = 1.94, $p < .05$). No differences were found between dropouts or GED recipients in regard to race/ethnicity, sex, or SES.

Only one measure of interest distinguished GED recipients from adolescents who completed high school as the terminal degree. Repeating a grade in elementary school decreased the odds of completing high school by 46 percent (OR = .054, $p < .05$). Three control measures were also found to distinguish GED recipients from adolescents who completed high school as the terminal degree: two ethnicity/race measures and region of residence. Being black non-Hispanic or being Hispanic vis-à-vis being white non-Hispanic increased the odds of completing high school (OR = 2.21 and 2.77, $p < .01$ respectively). Living in the North Central part of the United States increased the odds of completing high school by twice that of obtaining a GED certificate (OR = 2.10, $p < .05$).

As Table 6.3 also shows, four measures of interest distinguished GED recipients from adolescents who had gone beyond high school: two personal characteristics of adolescents (ability and repeating a grade), one parental characteristic (having a responding parent who completed high school), and one family structure characteristic (presence of both parents in the household). Ability was positively related to going beyond high school vis-à-vis obtaining a GED certificate (OR = 1.03, $p < .01$), as was having respondent parents who completed high school (OR = 2.04, $p < .01$) and having both parents in the household (OR = 1.83, $p < .05$), while repeating

Table 6.3
Multinomial Regression: Odds Ratios (OR)

	Academic Achievement Status[a]		
Variable	**Dropouts**	**High School**	**Beyond High School**
Personal characteristics			
Main interest			
Ability	0.972**	0.992	1.030**
Behavioral problems	1.207**	1.062	0.918
Ever repeat a grade	0.834	0.536*	0.267***
Schools attended	0.632**	0.944	1.286
Control			
Ethnicity/race			
Black Non-Hispanic	1.317	2.212**	2.379**
Hispanic	1.887	2.771**	3.129**
White Non-Hispanic (reference)			
Sex (1 = female)	1.095	1.187	2.070**
Responding parent			
Main interest			
Completed high school	0.738	1.333	2.036**
Control			
Public assistance recipient (ever)	0.837	0.599	0.397***
Family structure			
Main interest			
Presence of mother & father in HH	1.025	1.673	1.831*
Control			
Enriched environment	0.791	1.117	1.734**
Community environment			
Control			
Region of residence			
North Central	1.936*	2.096*	2.014*
South (reference)			
West	1.749	2.533**	2.558**
−2 Log Likelihood	4283.85 ($\chi^2 = 1110.33$, df = 93, $p < .001$)		

Note: Only statistically significant measures are shown.
[a]Reference category is GED.
***$p < .001$, **$p < .01$, *$p < .05$.

a grade in elementary school decreased the odds of going beyond high school by 73 percent (OR = 0.27, $p < .001$). Six control measures were also found to distinguish GED recipients from adolescents who went beyond high school: two ethnicity/race measures (black non-Hispanic and Hispanic), sex, one parental characteristic measure (receipt of public assistance), one family structure measure (enriched

environment), and one region of residence measure (North Central). Being black non-Hispanic or being Hispanic vis-à-vis being white non-Hispanic increased the odds of going beyond high school vis-à-vis obtaining a GED certificate (OR = 2.38 and 3.13, $p < .01$ respectively), as did being female (OR = 2.07, $p < .01$), living in an enriched family environment (OR = 1.73, $p < .01$), and residing in the North Central part of the United States (OR = 2.01, $p < .01$). Having a responding parent who had been a recipient of public assistance decreased the odds of going beyond high school vis-à-vis obtaining a GED certificate by 60 percent (OR = 0.40, $p < .001$).

DISCUSSION

Findings of the study indicate that only a few of the bivariate correlates of academic achievement status found to be statistically significant are robust when distinguishing adolescents who obtain GED certificates from dropouts, high school completers, and those going beyond high school. This does not extinguish the substantive significance of those measures that still serve as useful markers to identify a pool of adolescents at risk. Socioeconomic status, for example, is one of the substantively significant measures whose statistical significance disappears when controlling for a variety of other personal and environmental measures. Nonetheless, it is important for policymakers and professionals who work with adolescents to know that a far higher percentage of youth residing in poor families drop out of high school than those from middle- and upper-income families and among those who do get the GED or graduate certificates from high school, they are also far less likely to pursue additional education. The multivariate findings suggest that poverty may not per se be the cause of such disparities in academic achievement among adolescents, but the bivariate correlation between SES and academic achievement nonetheless points in the direction of where to locate those less likely to reap the benefits that accrue to those who either complete their high school education at the least or go beyond it.

Race/ethnicity and gender are robust measures of academic attainment. Findings indicate, for example, that although non-Hispanic black and Hispanic youth have higher percentages of dropouts than non-Hispanic white youth, they are more likely to complete high school than to obtain a GED. These findings suggest that if ways can be found to reduce the likelihood of dropping out, non-Hispanic black and Hispanic adolescents have a greater likelihood of completing high school rather than obtaining a GED. Given prior evidence that GED recipients have many longer-term adverse outcomes which are similar to high school dropouts vis-à-vis high school completers, as Richard K. Caputo has shown,[52] such findings suggest that drop-out prevention intervention efforts targeting non-Hispanic black and Hispanic adolescents are warranted.

Findings also suggest that ever repeating a grade in elementary school distinguishes adolescents who obtain GED certificates from high school completers, when controlling for other measures. This finding suggests that social workers, high school counselors, and others interested in adolescents' academic achievements can increase the likelihood of adolescents' completing high school as the terminal degree vis-à-vis

obtaining GED certificates by focusing primarily on those who had ever repeated a grade in elementary school. Such efforts would be particularly beneficial to non-Hispanic black and Hispanic youth since they are disproportionately more likely to drop out of high school than are white youth.

Findings also suggest that interventions focusing on adolescents' ability, behavioral/emotional problems, and number of elementary schools attended would also increase the likelihood of obtaining GED certificates. As noted above, however, GED recipients have many longer-term adverse outcomes similar to high school dropouts. Findings of this study suggest that educational resources might be better used by focusing on the identification of factors associated with the likelihood of repeating a grade in elementary school and of remaining in the same schools, and then designing program and policy responses accordingly.

Findings of this study also suggest that resources devoted to improving elementary school children's ability and reducing their behavioral/emotional problems if successful would nonetheless be insufficient in regard to increasing the likelihood of completing high school rather than obtaining GED certificates. This is not to say that ability and behavioral/emotional problems in elementary school are not related to the likelihood of repeating a grade. Rather, findings suggest that other factors, not accounted for in this study, that contribute to repeating a grade in elementary school need to be identified and addressed in order to increase the likelihood that adolescents will complete high school. To ensure that elementary school children obtain the requisite developmental, educational, and social skills to complete all grades without repeating any, findings of this study suggest that resources should be devoted to the identification of such factors and to the design and implementation of program and policy responses accordingly.

To the extent social workers, high school counselors, and others interested in adolescents' academic achievements, however, want to increase the likelihood of adolescents' going beyond high school vis-à-vis obtaining GED certificates, findings of this study point to two other main factors of interest (whether adolescents' parents have high school degrees and whether mothers and fathers are present in the household) and one control factor (sex—that is, women are more likely to go beyond high school than to obtain a GED).

Parental completion of high school is a form of human capital that is positively related to children's academic achievement and findings of this study support those of Haveman and Wolfe.[53] Having two parents in the household signifies greater availability of time and attention of children's developmental and educational needs while in elementary school and findings of this study corroborate those of Sandefur, McLanahan, and Wojtkiewicz.[54] Taken together, these two study findings raise family-related policy issues. Clearly, two-parent households are more likely to provide greater levels of human capital to their children than single-parent households. Policymakers may be more inclined to exhort the virtues of two-parent families and devote resources to such unions rather than to place those resources at the disposal of single-parent families with children of high school age. Such policymakers would be remiss, however, if single parents and their children were left adrift. Findings of this

study suggest that resources would be wisely spent when devoted to identification of factors associated with and implementing programs designed to reduce the likelihood of poor performance and repeated grades in elementary school regardless of family structure. Elementary school children from single-parent families, many of whom are likely to be poor, might have greater need with more dire long-term consequences in light of more limited human capital than is the case for children of two-parent families. Attention to non-Hispanic black and Hispanic youth and to a lesser extent to men who currently make up less than half of entering college students and graduates is warranted.

In conclusion, this study examined five major categories of characteristics thought to influence children's academic achievement through high school and beyond with a particular focus on the GED. Socioeconomic status was deemed a suitable marker for locating adolescents most likely to drop out of high school or obtain a GED rather than graduate from or go beyond high school. Ability, behavioral/emotional problems, and number of elementary schools attended were found to be robust predictors of adolescent attainment, distinguishing adolescents who obtain GED certificates from high school dropouts. In the multivariate analyses, no differences were found between dropouts or GED recipients in regard to race/ethnicity, sex, or SES. Being black non-Hispanic or being Hispanic vis-à-vis being white non-Hispanic, however, increased the odds of completing high school and women were more likely to go beyond high school than to obtain a GED. Other findings highlighted the importance of focusing on factors that influence the likelihood of repeating grades in elementary school and remedying these in order to increase the likelihood of completing high school. Corroborating other research, family structure was found to be important in this regard, with single-parent families presenting a formidable obstacle to high school completion vis-à-vis two-parent families. Practice and policy implications were discussed.

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53. See note 43.

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CHAPTER 7

Between the Lines, on the Stage, and in the Club: Additional Ways Students Find to Overcome Disadvantage through School

Jason M. Smith

The title of this volume, *The Promise of Education*, conjures particular images—students taking notes in class, studying hard, taking exams, "doing well in school" and thereby improving their social status by graduating, going to college, and so forth. Attention to success through education ordinarily focuses on these academic and cognitive pathways, and well they should. Achievement in grade school and high school is well linked to "success" in life, in terms of further educational attainment, as well as occupational attainment, income, and so forth.

But, as Samuel Bowles and Herbert Gintis note, "[S]chooling does more than enhance cognitive skills."[1] Many scholars have investigated the ways in which schools affect the habits and styles students adopt,[2] and the social networks in which students are embedded.[3] From the work of these authors and others, it can be seen that schools provide sites for the development of knowledge beyond the academic: social skills and relationships, work habits, and hopes for the future. Schools are places where young people come into contact with people who can guide them into successful adult lives by setting positive examples for them to follow; by helping them to develop attitudes and behaviors directed towards achievement and contributing to society in positive ways; and by providing information about opportunities that may be open.

School is also where students are involved with other students, learning from the activities, relationships, attitudes, and knowledge of these peers. The importance of school in the social world of the adolescent has been well established, going back at least to James S. Coleman's work on *The Adolescent Society*.[4] One of the most important lessons from that work is that, in the lives of adolescents, many school-related things are of great importance, but not all of them are academic or classroom-related. Prime among these is the extracurriculum. Students were asked, "If you could be remembered here at school for one of the three things below, which one

would you want it to be: brilliant student, athletic star [for boys]/leader in activities [for girls], or most popular?" The most common response for boys was athletic star (44.4%), and for girls it was leader in activities (37.0%).

Like the classroom regimen, participating in extracurricular activities may provide students with advantages noted above and prior scholarship has borne this out. James Shulman and William Bowen's 2001 book, *The Game of Life*,[5] demonstrated how high school athletes receive an admission advantage at some of America's most elite universities, an advantage greater than that of legacies or racial minorities. With the ever-increasing numbers of applicants, and the ever-increasing demands for a college degree to gain entry into the job market, gaining admission to college is becoming more and more competitive. Students from disadvantaged backgrounds face more obstacles than most, from higher rates of dropping out and lower standardized test scores, to less encouragement to attend and poorer preparation for higher education, and a lack of information on or contact with colleges and financial aid.[6]

While prior studies have shown evidence of positive effects of participation, no studies have focused exclusively on students from "high poverty schools."[7] It is possible that the dynamics and benefits of participating in school-sponsored activities may function differently for these students when compared with others. This chapter will pursue this line of inquiry by investigating the effects of extracurricular participation on a student's odds of dropping out of high school, of graduating from high school, and of attending some form of postsecondary education (PSE), focusing exclusively on students from high-poverty schools.

RECENT SCHOLARSHIP ON THE EXTRACURRICULUM

The extracurriculum has garnered renewed interest of late in the sociological literature. As noted, the activities that schools provide students beyond the classroom have long been of interest to social scientists, but recently sociological inquiry into the effects of extracurricular participation has been renewed and expanded. Past studies have shown that participation in the extracurriculum has positive effects on educational aspirations and attainment,[8] occupational aspirations and attainment,[9] and earnings.[10] More recently, the resurgence of interest in the extracurriculum has replicated these findings.[11] Joseph Mahoney[12] and Ralph McNeal[13] separately showed that participation increases the odds of completing (i.e., not dropping out of) high school, while J. Eccles and B. Barber[14] found that participation in extracurricular activities decreased risk-taking behavior.

What is there about participation in extracurricular activities that explains these findings? Extracurricular participation can be a place for learning skills (e.g., teamwork, goal formation), and for forming relationships that surround a student with peers and adults that foster mobility. Michael Hanks and Bruce Eckland[15] found that participation placed students in a peer group that was more college- and achievement-oriented. Andrew Guest and Barbara Schneider[16] employed both community and school contexts, as well as individual identity, to explain the beneficial outcomes of participation in sports and nonsports on both achievement and ambition. They

found that a student in a lower- or middle-class school who thinks of him/herself as an athlete is seen by others as a better student, and is more likely to get higher grades and go on to college. They also found that, in schools with higher academic expectations and higher socioeconomic makeup, taking part in nonsport activities leads a participant to be seen as a better student.

Beckett Broh[17] showed strong evidence that social capital may be the mechanism for the positive outcomes of extracurricular participation. Broh notes that social capital is both a mechanism for social control, as well as information and resource dissemination, provided that the people involved have some resource(s) they are willing and able to share. In the case of extracurriculars and educational outcomes, these resources could include information on colleges, advice on application procedures, tips regarding applying for financial aid or taking college entrance exams, or even connections with admissions officers. Participation in school activities generally increases student–parent contact, student–teacher interaction, and parent–school connections, and that this explains much of the positive effect of participation on math and English grades in twelfth grade. Curtis, McTeer, and White[18] also acknowledged the importance of the concept of capital, using ideas of cultural, physical, and social capital in their "General Theoretical Interpretations" section, though they did not include them empirically in their analyses.

In addition to the more developed theoretical and empirical incorporation of social capital, Broh's study also goes beyond the usual sports/nonsports dichotomy to decompose participation into various categories, including interscholastic sports vs. intramural, music groups, drama, student council, journalism, and vocational clubs. This sort of breakdown of activities was first employed (in similar, but slightly different form) in McNeal's analysis of the effects of participation on dropout rates noted above. Activities have different demographics and prestige within the school, and, therefore, put participants into contact with diverse groups of peers and provide differing levels of status within the school. This differential context will cause various activities to have variable effects on participants and their outcomes.

As evidenced by the more theoretically developed approaches of McNeal; Broh; Curtis, McTeer, and White; and Guest and Schneider, the approach social scientists are taking in order to understand the effects of extracurricular participation is improving. However, other shortcomings exist in most of the literature that have not been addressed fully. Most of the previous studies produced results that were not generalizable to the entire high school population, since the data were often regional, and are now quite dated. Furthermore, many of the above studies only included males.

There are numerous problems with the extant literature because of these factors. Getting some form of postsecondary education has come to be a much more necessary part of occupational attainment in the last 35 years, given the restructuring of the U.S. economy. More people are able to attend higher education thanks to Affirmative Action and other legislation. In addition, the athletic enterprise has become much more important and influential in college admissions, thus having been a high school athlete in the last 15 to 20 years is more important than in the early samples studied by

previous literature (see Shulman and Bowen's work for an extensive and enlightening discussion of this phenomenon). Furthermore, females have seen greatly increased opportunities to pursue sports. Female athletic opportunities were rather limited until the 1970s with the advent of Title IX in 1972, and even for years after that as institutions failed to implement changes required by that law. Not until the late 1970s to early '80s did the government even begin to pursue seriously enforcement of the statute. Rates of participation, and the lower level of intensity of what participation there was, made it unlikely that any effects for females would exist or be significant (statistically or substantively.) This is likely no longer the case, but the outcomes for girls are not as well documented as for boys in this area of extracurriculars.

Additionally, with the exception of the study by Broh and that by McNeal, most previous studies only consider extracurriculars in terms of sports, equating the effects of playing football and being on the swim team, or only compare sports with nonsports, ignoring the differences between vocational clubs and school music groups. Few of these studies explicitly include other activities like drama, journalism, or music, and when they do these activities usually are considered as an aggregate—extracurriculars in general, or only differentiating between "sport" and "nonsport" activities. As already noted, different types of activities have different demographics and, therefore, differential social influences on participants. Therefore, they may have different effects, and aggregating them all simply as "extracurriculars" can mask the effects of certain endeavors or make others look more (or less) facilitating than they are.

Clearly, research with more recent data from nationally representative samples that analyzes the effects of different types of activities is needed. Furthermore, with the advances of women in the realm of sport, as well as higher education and the labor force, incorporation of females is requisite when attempting to quantify the effects of participation for student outcomes. Such research will be more convincing for policy concerns, giving decision makers direct evidence of programs and activities that improve the life chances of high schoolers. To begin to fill these gaps in the literature, this study employs a nationally representative dataset collected between 1988 and 2000, that includes both males and females, and subdivides participation into more specific categories than "sport vs. nonsport".

The rest of this chapter will focus only on students from schools with at least half of their student bodies eligible for free- or reduced-price lunch. The analyses will investigate whether participants in extracurriculars have different rates of graduating from high school and of attending some form of postsecondary education (PSE). Based on prior research, these analyses can be expected to show that participation is associated with higher rates of graduation, as well as increased rates of postsecondary attendance.

DATA AND MEASURES

The data for these analyses comes from the National Education Longitudinal Study (NELS), with data most recently from 2000. This nationally representative sample

Table 7.1
Descriptive Statistics

Measure	Description	Mean (SD)
Female	Indicator for female students (1 = Yes)	0.498
Hispanic	Indicator for Hispanic students (1 = Yes)	0.31
Black	Indicator for black students (1 = Yes)	0.255
General participation	Participant in any extracurricular activity (1 = Yes)	0.794
Total participation	Total # of categories of activities in which student participated	1.656 (1.34)
High Profile sport	Participant in football, basketball, baseball, softball (1 = Yes)	0.274
Low Profile sport	Participant in soccer, swimming, other team sport, or other individual sport (1 = Yes)	0.215
Cheerleading	Participant in cheerleading, drill, or pompom team (1 = Yes)	0.075
Fine arts	Participant in band, choir, or drama (1 = Yes)	0.26
Academic clubs	Participant In science fair, academic honor society or academic clubs (1 = Yes)	0.272
Student government	Participant in student government (1 = Yes)	0.057
Social clubs	Participant in yearbook/newspaper, service, hobby, or vocational ed clubs (1 = Yes)	0.414
Drop out	Indicates if student dropped out between 10th and 12th grade (1 = Yes)	0.145
HS grade	Indicates if student received high school diploma (1 = Yes)	0.81
Any PSE	Indicates if student attended any postsecondary education (1 = Yes)	0.551
	Total *N*	1,445

of over 12,000 students follows students from the eighth grade until eight years after high school graduation (or what should have been their year of graduation, in the case of those who did not finish on time or at all.) Data on student background and extracurricular participation in a range of activities are available, as well as school characteristics. The dataset also includes whether or not the student graduated from high school, and what (if any) postsecondary institution they attended.

The full NELS 2000 sample ($n = 12{,}144$) was reduced to include only those students who had not dropped out before tenth grade, and then subsequently to include only those students who attended a high school where at least 50 percent of the student body was eligible for free or reduced-price lunches (a "high-poverty" school). This left a sample of $n = 1445$ for the analyses. Descriptive statistics of student demographics are in Table 7.1.

The measures for student participation were derived from a number of items in the NELS survey. Students were asked to self-report participation in a variety of school-based activities, ranging from various team and individual sports (e.g., football,

swimming) to other activities like drama club or science fair. For the current research, participation was categorized into seven areas:

1) High Profile Sports—including interscholastic baseball (softball for females), basketball, and/or football
2) Low Profile Sports—including any other sport, either team or individual; e.g., soccer, swimming, etc.
3) Cheerleading/Drill Team/PomPom Squad
4) Fine Arts—any sort of band, choir, or drama group
5) Academic Activities—academic clubs, honor societies, science fair, etc.
6) Student Government
7) Social and Occupational Activities—journalism/yearbook club, vocational education clubs like Future Teachers of America, plus service clubs and hobby groups

If a student participated in any one (or more) of the activities listed under the category, that student was coded as "1" for that variable. Variables for General ("Did the student participate in *any* activity?" Yes = 1) and Total participation (the number of the above categories in which a student participated) were also included. For example, a female student who played basketball, softball, and golf, as well as being in the drama club and serving as vice-president of her class would be a "Yes" for the general extracurricular participation variable (she was involved in the extracurriculum), a "4" on the total extracurricular participation variable (she was involved in High Profile Sports, Low Profile Sports, Fine Arts activities, and Student Government), and a "Yes" for each of those individual categories as well.

The outcome measures are dichotomous variables (1 = Yes) for Graduating from High School, and for attending some form of Postsecondary Education (PSE). Graduating from high school does *not* include obtaining a GED, since labor market studies have shown that the outcomes for GED holders are more akin to dropouts than holders of the diploma.[19] As they note in their abstract, "Exam-certified high school equivalents are statistically indistinguishable from high school dropouts." For this study, PSE includes *any* form of formal education completed after high school (except military training), from short courses at a local vocational/technical college to attendance at a 4-year university. The underlying idea is that participation in extracurriculars helps bond students to the educational system, encouraging and enabling them to persist within it to higher levels of attainment.

RESULTS

The results show a remarkable level of consistency. Across the board, graduation rates and rates of attendance in Postsecondary education are nearly always higher for those who participated in the extracurriculum than for those who do not participate at all. Whether these rates are analyzed by gender, race, or both simultaneously, being involved in school-related activities has positive effects on the percentages of

Table 7.2
Graduation and PSE Attendance Rates by Gender and Extracurriculars

	Boys	Girls
A. Graduation Rates		
No participation	72.3	69.2
Some participation		
1+ activities	82.1	85.3
1 category	79.5	81.5
2–3 categories	83.3	88.0
4+ categories	85.7	87.1
Categories		
High profile sport	82.4	80.4
Low profile sport	88.0	87.4
Cheerleading	77.3	81.4
Fine arts	87.2	88.1
Academic clubs	84.1	88.4
Student government	74.4	93.0
Social activities	78.4	84.9
n	725	720
B. PSE Attendance Rates		
No participation	43.2	44.1
Some participation		
1+ Activities	53.5	62.6
1 Category	42.3	55.0
2–3 Categories	58.2	68.6
4+ Categories	68.6	64.3
Categories		
High oprofile sport	56.7	52.3
Low profile sport	67.8	63.8
Cheerleading	63.6	67.4
Fine arts	59.1	68.1
Academic clubs	56.9	65.8
Student government	64.1	76.7
Social activities	50.5	60.3
n	725	720

students who graduate from high school and continue their educations after high school.

Tables 7.2A and 7.2B show the rates of high school graduation and postsecondary attendance separately for male and female students, based on their participation in the extracurriculum. For graduation rates, approximately 70 percent of both male and female nonparticipants graduated from high school, 69.2 percent for girls and 72.3 percent for boys. These rates increase to 85.3 percent and 82.1 percent,

respectively, for students who took part in at least one extracurricular activity. Being involved in multiple categories of extracurriculars further increases the rates of graduation, to a high of 88.0 percent for girls in 2 or 3 categories, and to 85.7 percent for boys in 4 or more categories. Each category of activities also graduates a higher proportion of its participants than the rate for those who do not participate in extracurriculars. For girls, these rates range from a low of 80.4 percent of High Profile Sport athletes, to a high of 93 percent for those in Student Government; for boys, the range is from 74.4 percent for Student Government to 88.0 percent for Low Profile Sports.

For Postsecondary Attendance, 44.1 percent of nonparticipant girls and 43.2 percent of nonparticipant boys go on to some form of formal educational training after high school. These rates are also increased appreciably for those who take part in the extracurriculum. Of the girls who were involved in any activity, 62.6 percent graduated; for boys the corresponding figure is 53.5 percent. Again, breadth of participation further enhances the rates of attendance, to a high of 68.6 percent for girls in 2–3 categories, and to 68.6 percent for boys in 4+ categories. As with graduation, PSE attendance is greater for those in each of the extracurricular categories than for nonparticipants. The lowest rate of PSE attendance for girls is in High Profile Sport (52.3%), and the highest is for Fine Arts (68.1%). For boys, 50.5 percent of those in Social Activities attend some form of PSE, while 67.8 percent of those in Low Profile Sports continued their educations after high school.

Tables 7.3A and 7.3B present the same set of outcomes, this time broken down by student race. White students not involved in the extracurriculum graduate 70.1 percent of the time, while the general participant graduation rate for whites is 87.3 percent. For blacks, 67.2 percent of nonparticipants and 78.9 percent of general participants graduate, while 74.7 percent of Hispanic nonparticipants and 81.7 percent of participants graduate. As with the gender-based analyses, being involved in a broader set of activities (i.e., multiple categories of extracurriculars) is positively associated with graduation rates. White and black students involved in 4 or more categories have the highest rates of graduation, 92.2 percent and 85.0 percent, respectively. For Hispanics, the highest rate is for those in 2–3 categories, 88.0 percent. For the various categories of activities, the graduation rates of participants are all measurably higher than the rate for nonparticipants (with one exception). White students range from 87.0 percent graduates (in Social Activities) to 92.0 percent (Student Government). Black students involved in the extracurriculum vary between 75.5 percent graduates (Social Activities) and 82.5 percent (Fine Arts), while Hispanic students fall between 71.4 percent for cheerleaders (the exception to the pattern), and 89.1 percent for Fine Arts.

In terms of attendance in PSE, 42.1 percent of white non-participants attend, compared to 59.7 percent of those involved in at least one activity. Non-participating black students attend PSE 37.5 percent of the time, while more than half—51.3 percent—of those black students active in the extracurriculum further their education after high school. Hispanic students who do not take part in any school-related activities attend PSE 46.5 percent of the time, outpaced by participants who go on in school 59.0 percent of the time. As before, those involved in more categories of activities have higher rates of PSE attendance, paralleling the results for graduation

Table 7.3
Graduation and PSE Attendance Rates by Race and Extracurriculars

	Whites	Blacks	Hispanics
	A. Graduation Rates		
No participation	70.1	67.2	74.7
Some participation			
1+ Activities	87.3	78.9	81.7
1 Category	83.7	76.4	76.0
2–3 Categories	88.8	79.6	88.0
4+ Categories	92.2	85.0	74.1
Categories			
High profile sport	88.1	77.1	79.3
Low profile sport	89.5	82.2	88.8
Cheerleading	88.6	77.1	71.4
Fine arts	90.8	82.5	89.1
Academic clubs	88.6	82.4	86.0
Student government	92.0	76.0	80.0
Social activities	87.0	75.5	77.0
n	484	368	448
	B. PSE Attendance Rates		
No participation	42.1	37.5	46.5
Some participation			
1+ Activities	59.7	51.3	59.0
1 Category	45.2	40.6	51.3
2–3 Categories	67.6	56.7	65.9
4+ Categories	70.6	60.0	59.3
Categories			
High profile sport	60.3	47.5	57.8
Low profile sport	73.3	50.7	68.4
Cheerleading	74.3	60.0	71.4
Fine arts	66.7	63.5	62.0
Academic clubs	63.8	55.1	62.4
Student government	76.0	60.0	70.0
Social activities	57.9	51.6	51.3
n	484	368	448

with white and black students in 4+ categories having the highest rates, and 2–3 categories showing the highest rates for Hispanics. Also reflecting the overall pattern of results discussed so far, the rates of PSE attendance vary between the different kinds of activities, but all exceed the rates for nonparticipants. Among white students, those in Student Government attend PSE most often, 76.0 percent, while the lowest rate is for those in Social Activities, 57.9 percent—still well above the 42 percent of nonparticipants. The highest rate among black students is for those in Fine Arts

Table 7.4
Graduation and PSE Rates by Race & Extracurriculars—Boys Only

	Whites	Blacks	Hispanics
A. Graduation Rates			
No participation	70.5	70.6	77.3
Some participation			
1+ Activities	85.1	77.7	80.4
1 Category	81.4	76.4	74.3
2–3 Categories	84.8	79.5	86.4
4+ Categories	96.0	78.3	72.7
Categories			
High profile sport	86.8	78.9	80.0
Low profile sport	88.1	85.4	88.5
Cheerleading	50.0	81.8	83.3
Fine arts	88.9	81.0	93.5
Academic clubs	88.4	78.5	84.3
Student government	92.3	60.0	71.4
Social activities	85.1	67.2	71.7
n	256	191	207
B. PSE Rates			
No participation	41.0	35.3	45.5
Some participation			
1+ Activities	58.5	43.3	55.2
1 Category	37.1	32.7	45.7
2–3 Categories	69.7	46.2	60.5
4+ Categories	72.0	60.9	72.7
Categories			
High profile sport	63.7	48.9	57.6
Low profile sport	77.6	52.1	69.2
Cheerleading	50.0	54.5	100.0
Fine arts	66.7	56.9	54.8
Academic clubs	62.8	44.6	61.4
Student government	69.2	53.3	85.7
Social activities	57.9	38.8	45.0
n	256	191	207

(63.5%), and the lowest is 47.5 percent for High Profile Sport athletes—a full 10 percent above the nonparticipant rate. Hispanic students show similar differences in PSE attendance rates, ranging from a high of 71.4 percent (for Cheerleaders) to a low of 51.3 percent (for those in Social Activities).

Tables 7.4 and 7.5 (each with parts A and B) disaggregate participants by both race and gender. As before, with only minor exceptions, participants in the extracurriculum

Table 7.5
Graduation and PSE Rates by Race & Extracurriculars—Girls Only

	Whites	Blacks	Hispanics
A. Graduation Rates			
No participation	69.6	63.3	72.7
Some participation			
1+ Activities	89.6	80.3	82.8
1 Category	86.2	76.5	77.4
2–3 Categories	93.3	79.7	89.5
4+ Categories	88.5	94.1	75.0
Categories			
High profile sport	91.4	71.4	77.4
Low profile sport	92.1	76.0	89.1
Cheerleading	93.5	75.0	68.2
Fine arts	92.0	83.8	86.9
Academic clubs	88.9	85.9	87.4
Student government	91.7	100.0	84.6
Social activities	89.2	81.5	80.4
n	228	177	241
B. PSE Rates			
No participation	43.5	40.0	47.3
Some participation			
1+ Activities	61.0	59.9	62.4
1 Category	53.8	49.0	56.0
2–3 Categories	65.2	67.1	70.9
4+ Categories	69.2	58.8	50.0
Categories			
High profile sport	51.4	42.9	58.1
Low profile sport	65.8	48.0	67.4
Cheerleading	77.4	62.5	63.6
Fine arts	66.7	69.1	65.6
Academic clubs	64.6	64.8	63.2
Student government	83.3	70.0	61.5
Social activities	57.8	60.9	55.4
n	228	177	241

graduate and attend PSE at higher rates than nonparticipants, regardless of race or gender, whether we consider extracurricular participation in general, by total number of categories, or by individual categories. For both boys and girls, of any race, being involved in the extracurriculum, especially in a variety of different types of activities, increases the odds of both graduating from high school and of continuing one's education at the postsecondary level.

DISCUSSION AND CONCLUSIONS

Students from high-poverty schools face challenges above and beyond those of average adolescents. Outcomes associated with going to such disadvantaged schools include poorer graduation rates and a lower likelihood of continuing education beyond the secondary level. Low high-school completion rates are a persistent and pernicious problem in high-poverty areas, which, when coupled with the ever-increasing need for further education to garner success in the labor force, only serves to further the disadvantage suffered by those in areas serviced by these schools. Many programs and public policies aim to trump these obstacles and improve the educational attainment of students from these types of schools, and the findings from this analysis contribute to that effort. Each of the above analyses has indicated the value of extracurricular participation for students of either gender, and of various racial backgrounds. Those who participate in extracurricular activities have higher graduation rates and higher rates of attendance in postsecondary education programs than those students who do not take part in school-based activities. Each category of extracurriculars also showed these patterns.

Why this occurs has been explored, if indirectly, in previous research. Hanks and Eckland note that students who plan to go to college, who routinely associated with college-oriented peers, and who discussed their plans with teachers were more likely to take part in the extracurriculum. This suggests a possible explanation for the pattern of results found here. Being involved in extracurriculars puts one in contact with a more academically oriented peer group, which in turn "rubs off" and serves to focus a person more on their studies as well. This perspective is supported by Otto and Alwin's study, where the positive effects of athletic participation on educational aspirations and attainment primarily operated through the influence of significant others. Broh's work demonstrated the positive impact of participation on social capital between students, parents, and teachers, which helped explain the positive effects on grades, which are also correlated with attainment. Furthermore, the desire to play a sport, or be involved in the school play, or participate in a particular school club with one's friends may motivate a student to stay in school to continue those activities. Past scholarship is supported by the findings here, replicating the positive effects of participation on graduation and postsecondary attendance, and extending that work, showing that these patterns exist even in the more challenging context of schools with impoverished student bodies.

This chapter demonstrates that, for students in high-poverty schools, there are positive effects to participation in extracurricular activities on educational outcomes, specifically earning a high school diploma, as well as attaining postsecondary education. Combining these results with those of other educational research makes the findings clear: the extracurriculum plays an important role in integrating students into their school, keeping them enrolled as opposed to dropping out, surrounding them with more academically oriented peers, getting them to earn their diploma, and fostering the continued attainment of education beyond the high school setting. With the obstacles faced by this student population, any programs and policies that can be

adopted to encourage such attainment are vital to the quest for upward mobility out of the ghettoes and disadvantaged neighborhoods for which so many public policies and politicians aim.

The policy implications are also clear. With yearly budget battles and funding shortfalls in these schools, cutting extracurricular activities clearly further disadvantages the students in these schools in terms of the outcomes of this analysis, not to mention the health (both physical and mental) and social benefits that one derives from participation in such activities. With so many obstacles already in these students' paths, public policy must seek to maintain the programs that help them clear these hurdles (pun intended) and aid them in attaining the education and human and social capital they need to find their way out of disadvantage. Priority must be placed on preserving the few assets students in these schools do have that can assist them in achieving their future goals and realizing their potential. Without such prioritizing, the already widening gap between the haves and have-nots will only grow more quickly. Extracurricular programs clearly have benefits for students in high-poverty schools; policymakers must endeavor to preserve these benefits.

DEDICATION

Dedicated to my mother, Becky A. Gonzalez, who passed away during the writing of this chapter.

NOTES

1. Samuel Bowles and Herbert Gintis. 2002. "Schooling in capitalist America revisited." *Sociology of Education* 75: 1–18.

2. See Paul Dimaggio. 1982. "Cultural capital and school success: The impact of status culture participation on the grades of U.S. high school students." *American Sociological Review* 47: 189–201; George Farkas. 1996. *Human capital or cultural capital? Ethnicity and poverty groups in an urban school district.* New York: Walter de Gruter. 2003. "Cognitive skills and noncognitive traits and behaviors in stratification processes." *Annual Review of Sociology* 29: 541–562; and Anne Swidler. 1986. "Culture in action: Symbols and strategies." *American Sociological Review* 51: 273–286.

3. See Andrew A. Beveridge and Sophia Catsambis. 2002. "Vital connections for students at risk: Family, neighborhood and school influences on early dropouts." In *American Educational Research Association Annual Meeting*. New Orleans, LA; Pierre Bourdieu. 1986. "Forms of capital." In *Handbook of theory and research for the sociology of education*, edited by J. Richardson. New York: Greenwood Press; Beckett A. Broh. 2002. "Linking extracurricular programming to academic achievement: Who benefits and why?" *Sociology of Education* 75: 69–95; Frank F. Furstenberg Jr. and Mary Elizabeth Hughes. 1995. "Social capital and successful development among at-risk youth." *Journal of Marriage and the Family* 57: 580–592; and E. M. Horvat, E. B. Weininger, and A. Lareau. 2003. "From social ties to social capital: Class differences in the relations between schools and parent networks." *American Educational Research Journal* 40: 319–351.

4. James S. Coleman. 1961. *The adolescent society: The social life of the teenager and its impact on education.* New York: Free Press.

5. James Shulman and William Bowen. 2001. *The game of life: College sports and educational values*. Princeton, NJ: Princeton Press.

6. Paul H. Carmichael. 1997. "Who receives federal title I assistance? examination of program funding by school poverty rate in New York state." *Educational Evaluation and Policy Analysis* 19: 354–359; Martin E. Orland. 1990. "Demographics of disadvantage: Intensity of childhood poverty and its relationship to educational achievement." In *Access to knowledge: An agenda for our nation's schools*, edited by J. I. Goodlad and P. Keating. New York: College Entrance Examination Board; Kevin J. Payne and Bruce J. Biddle. 1999. "Poor school funding, child poverty, and mathematics achievement." *Educational Researcher* 28: 4–13.

7. "High poverty schools" are usually defined as those schools where more than 50% of the student body is eligible for free- or reduced-price lunch. See James S. Kim and Gail L. Sunderman. 2005. "Measuring Academic Proficiency Under the No Child Left Behind Act: Implications for Educational Equity." *Educational Researcher* 34: 3–13; G. Orfield and C. Lee. 2005. *Why segregation matters: Poverty and educational inequality*. Cambridge, MA: The Civil Rights Project, Harvard University; and Steven W. Raudenbush. 2004. *Schooling, statistics, and poverty: Can we measure school improvement?* Princeton, NJ: Educational Testing Service.

8. M.P. Hanks and B.K. Eckland. 1976. "Athletics and social participation in the educational attainment process." *Sociology of Education* 49: 271–294; F. Howell, A. Miracle, and C.R. Rees. 1984. "Do high school athletics pay? The effects of varsity participation on socioeconomic attainment." *Sociology of Sport Journal* 1: 15–25; H. Marsh. 1993. "The effects of participating in sport during the last two years of high school." *Sociology of Sport Journal* 10: 18–43; L.B. Otto. 1976. "Social integration and the status attainment process." *American Journal of Sociology* 81: 1360–1383; L.B. Otto and D.F. Alwin. 1977. "Athletics, aspirations, and attainments." *Sociology of Education* 50: 102–113.

9. Marsh, "The effects of participating in sport during the last two years of high school."; Otto, "Social integration and the status attainment process."; Otto and Alwin, "Athletics, aspirations, and attainments."

10. F. Howell, A. Miracle, and C.R. Rees. 1984. "Do high school athletics pay? The effects of varsity participation on socioeconomic attainment." *Sociology of Sport Journal* 1: 15–25; Otto, "Social integration and the status attainment process"; J.S. Picou, V. McCarter, and F. Howell. 1985. "Do high school athletics pay? Some further evidence." *Sociology of Sport Journal* 2: 72–76.

11. John M. Barron, Bradley T. Ewing, and Glen R. Waddell. 2000. "The effects of high school athletic participation on education and labor market outcomes." *Review of Economic Statistics* 82: 409–421, J. Curtis, W. McTeer, and P. White. 2003. "Do high school athletes earn more pay? Youth sport participation and earnings as an adult." *Sociology of Sport Journal* 20: 60–76; R. Eide and N. Ronan. 2001. "Is participation in high school athletics an investment or a consumption good?" *Economics of Education Review* 20: 431–442; Shulman and Bowen, *The game of life*.

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13. Ralph B. McNeal. 1995. "Extracurricular activities and high school dropouts." *Sociology of Education* 68: 62–81.

14. J.S. Eccles and B.L. Barber. 1999. "Student council, volunteering, basketball, or marching band: What kind of extracurricular involvement matters?" *Journal of Adolescent Research* 14: 10–43.

15. Hanks and Eckland, "Athletics and social participation in the educational attainment process."

16. Andrew Guest and Barbara Schneider. "The Adolescents' extracurricular participation in context: The mediating effects of schools, communities, and identity." *Sociology of Education* (April 2003) 76 No. 2 89–109.

17. Broh, "Linking extracurricular programming to academic achievement: Who benefits and why?"

18. Curtis, McTeer, and White, "Do high school athletes earn more pay?"

19. S.V. Cameron and J.J. Heckman. 1993. "The nonequivalence of high school equivalents." *Journal of Labor Economics* 11: 1–47.

CHAPTER 8

To Work or Not to Work? The Role of Poverty, Race/Ethnicity, and Regional Location in Youth Employment

Constance T. Gager, Jacqueline C. Pflieger, and Jennifer Hickes Lundquist

Paid work has become a common and expected part of the lives of many youth in the United States. Recent data show that 2.9 million youth aged 15 to 17 were employed during the school year, and 4 million were employed during the summer months. The likelihood of employment for youth increases markedly through the progression of adolescence. For example, according to the U.S. Department of Labor, 9 percent of 15-year-olds reported working for pay, whereas 39 percent of 17-year-olds were working for pay in 2000.[1] Youth employment also varies by other individual as well as family characteristics, including race/ethnicity, gender, family income/poverty level, family structure, and regional location.[2,3] Yet a lack of recent research has focused on how youths' participation in paid labor may vary by the needs of their families. For example, youth in single-parent families may share a larger burden of housework or of caring for siblings than youth from two-parent families, which may constrain their available time for paid employment. In contrast, youth in single-parent families are more likely to live in poverty; thus, we might expect to see earlier entry into employment given family financial need. In this chapter, we describe how youth participation in paid work varies by these key youth and family characteristics, focusing especially on important contextual measures, including family income/poverty level, family structure, and regional location, while controlling for individual youth characteristics including gender, race/ethnicity, and time use. In sum, we will focus on the context of youth employment, specifically with regard to socioeconomic status.

On the macro level, several economic and social factors affect youth employment, including discrimination and social disadvantage as well as cyclical and structural trends in the economy. On the micro level, youths' individual and family characteristics as well as their regional location influence their labor force participation. Although one might expect that youth from poor families are more likely to work in order to

help support their families, the data show a quite different pattern. First, employed youth are more likely to be middle class, Caucasian, and to live in suburban areas.[4] This is attributable to the fact that most youth work in service-sector jobs, which are highly concentrated in suburban areas, where Caucasian, middle-class youth and their families are more likely to reside. Second, youth employment rates mirror those for adults with regard to race/ethnicity, with employment rates lowest among African American and Latino youth.[5] Last, working youth of today contribute little of their earnings to support their families. Research has shown that youth spend the majority of their earnings on their own needs and activities.[6,7] Although historically, children from poor families were more likely to be employed and to economically contribute to their family,[8] working youth of today are less likely to be poor and they contribute little of their earnings to their families.

LITERATURE REVIEW

Although the U.S. public believes that work is valuable for children and adolescents—teaching them needed skills that will ease the transition from school to work—much debate in research and policy arenas focuses on the adverse outcomes of youth employment. The debate has primarily concentrated on (1) how much work is too much; (2) whether paid work deters youth from other more developmentally beneficial activities; and (3) the effect of early paid work on youths' educational and later labor market outcomes. Thus, the literature on youth employment, similar to the literature on youth development in general, has been plagued by a tendency to emphasize negative outcomes, especially in regard to youth employment.[9]

Considerable research attention has focused on the adverse consequences of employment on youth development.[10,11] Specifically, researchers argue that adolescent employment, particularly that over 20 hours a week or "high intensity," may have negative consequences.[12] Researchers have found that youth paid employment decreases opportunity costs in terms of academic achievement,[13] increases the likelihood to engage in problematic behaviors,[14] reduces time in extracurricular activities for Caucasian males,[15] and reduces time spent with family.[16,17]

On the positive side, researchers have suggested that youth employment may help ease the transition to adulthood. Glen H. Elder, Jr.'s pioneering research sheds light on the relationship between employment and subsequent achievement, finding that work experience among rural farm youth had lasting benefits, such as instilling positive values and building confidence.[18] Similarly, Katherine S. Newman's moving portrayal of inner-city youth employed in low-skilled jobs suggests such experience leads to improved occupational outcomes.[19] Doris R. Entwiste, Karl L. Alexander, and Linda Steffel Olson note that both the beneficial and adverse consequences of early work experience may vary for minority youth.[20] As Jeylan T. Mortimer, Jeremy Staff, and Sabrina Oesterle argue, little research or policy attention has focused on whether youth involvement in paid work might act as a mechanism through which youth "acquire knowledge about the labor force, form occupational values, learn how to behave appropriately, and acquire skills that will facilitate their adaptation to work."[21] In

other words, early work experience may provide youth with a special advantage when they compete for full-time jobs, thus easing the transition to adulthood.

Research on youth employment has been conducted in a variety of disciplines, including sociology, psychology, child development, geography, and economics. Although many of these studies operate in isolation from research in the other disciplines, most of this research broadly examines similar issues—barriers to and predictors of youth employment. Sociologists have focused on the social deterrents of employment resulting from social isolation of minorities in urban areas due to a lack of exposure to regularly employed middle-class role models and/or social networks that lead to knowledge of and access to job opportunities.[22] Douglas S. Massey and Nancy A. Denton have persuasively argued that although both urban African Americans and Latinos experience high levels of residential segregation, African Americans are subject to "hypersegregation," which crystallizes inequality by constraining educational opportunities and may lead to the development of a distinct culture outside the mainstream.[23] Testing this theory, Katherine M. O'Regan and John M. Quigley find that living in a neighborhood with a high concentration of poverty or with an African American population reduces the likelihood of youth employment.[24] Research by geographers and economists has highlighted the "spatial frictions" faced by minorities who are concentrated in urban areas, as employment opportunities are located in suburban areas. Many of these studies have focused on locational constraints on employment options. For example, the costs of commuting or housing discrimination might deter urban minorities from access to employment in suburban areas.[25,26] In sum, a spatial mismatch exists between where workers live and where jobs are available. Although debates continue over the magnitude of this mismatch,[27] the majority of published reviews of the spatial mismatch literature conclude that there exists strong or moderate support for the hypothesis in the empirical literature on adult employment[28–30] (for an exception see Christopher Jencks and Susan E. Mayer, 1990).[31]

Concerns over simultaneity between employment and residential location led researchers to focus on employment among youth living with their parents, as their residential location would be exogenously determined by their parents or guardians. A growing body of research has examined the role of spatial mismatch in youth employment.[32–34] Youth are an especially interesting group to study from this perspective, as the majority of youth are employed in retail and service sector jobs, which are more highly concentrated in suburban areas.[35,36] While urban African American and Latino youth experience high levels of residential segregation, they have little control over the choice of their residence. In addition, they may face fewer transportation options compared with adults, as they have a lower likelihood of possessing a driver's license and of owning a car. In sum, youth are especially susceptible to spatial mismatch.[37] However, the evidence to date on youth experiencing lower employment rates due to spatial mismatch is inconclusive.

In addition, regional location, especially the urban/suburban dichotomy, is highly correlated with family poverty status, family structure, and joblessness. Inner city urban neighborhoods, as compared with suburban neighborhoods, are characterized

by higher concentrations of poverty, female-headed households, and unemployment. For example, in 2000, the poverty rate in central cities was 18.4 percent, more than twice of that in the suburbs (8.3 percent), although the central city/suburban gap has decreased by .5 percent since 1990. In cities that experienced the greatest decline in poverty rates, child poverty rates declined even more sharply. Conversely, cities in the northeast and Southern California experienced increased rates of poverty and higher rates of child poverty, although at a smaller increase than overall poverty rates.[38] Thus, higher rates of overall poverty and child poverty continue to persist in urban versus suburban regions.

These higher rates of poverty are attributed to high levels of joblessness, especially in the manufacturing sector, as work has "disappeared" or moved to suburban or overseas locations.[39,40] This change is exacerbated by spatial changes in the growth of new service sector jobs. The majority of these new jobs are concentrated in suburban areas; thus, urban areas are left with fewer job opportunities.[41] The changing job structure is especially salient for youth who are likely to be employed in service sector jobs, which are concentrated in suburban locations.

Family structure also contributes to high rates of poverty, especially in urban areas. According to recent estimates from the Current Population Survey, 8.8 percent of married couples with two children live below the poverty line, whereas 43.8 percent of female-headed families with two children live in poverty.[42] Thus, children growing up in female-headed families are nearly 5 times more likely to experience childhood poverty than are children in married-couple families. Although small in number, children growing up in single-father families are twice as likely to live in poverty as children with married parents.[43] Family structure may influence youth employment, as single parents may rely more on youth for assistance with caring for siblings and household labor because they do not have a second parent on whom to rely. As discussed above, it would intuitively seem children from socially and economically disadvantaged families might enter employment to provide financial support for struggling families; however, recent evidence shows that these youth are actually less likely to be employed.[44] Thus, our analysis will provide evidence as to whether this is the case or not.

Further, individual characteristics of youth, including age, gender, and race/ethnicity, are related to youth employment. In this chapter, we focus on youth during middle-to-late adolescence (ages 14 to 18). As adolescence is a period of developmental growth characterized by distinct physical, cognitive, social, and behavioral transformations, there is much variability during this span of time. One of the most pronounced characteristics of adolescence is the need for independence from parents in order to establish one's own identity. Erik Erikson characterized this stage of life as "identity versus role confusion."[45] Often, conflict with parents over the desire for independence is a central marker of this developmental period. One way in which adolescents can establish their individual selves is through outside employment.

In addition to age, youths' gender and race/ethnicity are linked with youth employment. For example, researchers find significant time-use differences between boys

and girls, and that these differences increase with age.[46,47] Specifically, Constance T. Gager, Teresa M. Cooney, and Kathleen Thiede Call find that girls spend more time in paid work than do boys in the ninth grade, although this difference disappears by the twelfth grade.[48]

Youths' race/ethnicity also are important to consider because youth employment rates have been shown to mirror those of adults.[49] Newman finds that young African American workers seeking employment face a double disadvantage.[50] Specifically, she found that African Americans seeking jobs at a national fast food restaurant chain in Central Harlem faced disadvantages in the hiring process compared with their Latino counterparts. African American applicants were rejected at a higher rate than Latinos. Eighty-five percent of African American applicants were rejected, whereas 65.2 percent of Latino applicants were rejected. Her research also suggests that youth labor markets in the inner city are evaporating because urban employers have the option of hiring adults, whereas suburban employers in tighter labor markets do not. Again, applicants to the chain restaurant she studied who were under age 22 were rejected at a higher rate compared with their older adult counterparts. Thus, age and race/ethnicity are important factors in youth employment.

The main goal of this chapter is to recognize *both* the individual and structural factors that may influence youth involvement in paid employment, with a specific focus on how poverty, urban location, and family structure are related to youth employment. In sum, we examine who works and who does not work and how employment varies by youth and family socioeconomic characteristics as well as geographic location. Based on our synthesis of theoretical approaches from multiple disciplines, we identify the most important correlates of youth employment. These correlates include characteristics of youth, such as age, race/ethnicity, and gender, and/or characteristics of their families, such as family socioeconomic status, family structure, and regional residence. Family socioeconomic status is measured by family income and Temporary Assistance for Needy Families (TANF) or food stamp recipiency. Family structure is measured as living in a two-parent married structure versus a single-mother or single-father family. Last, regional residence is measured as living in an urban or suburban neighborhood.

In addition, we address several data shortcomings in previous research examining general youth time-use, and specifically, involvement in paid work. First, much of what we know about youth time-use has come from studies that lack complete and accurate estimates of youths' time-use activities.[51,52] For example, studies often rely on adult estimates of children's involvement, rather than on reports from children themselves.[53–56] Second, many studies on involvement in paid work utilize a regional sample (although longitudinal) of mostly Caucasian, suburban, middle-class youth[57] or of African American, urban, lower-class youth[58,59] without examining a comparison group. Thus, we do not know the degree to which involvement varies by race/ethnicity, income level, or regional residence. Although the few studies that do include comparison groups are informative, they often rely on non-representative samples that cannot be generalized to a national population.[60–62] Thus, we present data to show the degree to which involvement in paid labor varies by race/ethnicity,

income level/poverty status, or regional residence by using a nationally representative sample.

DATA AND METHODS

This chapter will summarize data from the Survey of Adults and Youth (SAY), collected as part of the Urban Health Initiative (UHI) and funded by the Robert Wood Johnson Foundation (prior to 2005, The Survey of Adults and Youth (SAY) was referred to as The Survey of Parents and Youth (SPY). The UHI seeks to ameliorate the health, safety, and well-being of children and youth living in America's most economically distressed cities. The sample is a probability sample of the entire United States, in which UHI purposely over-sampled urban areas and six economically distressed cities, thereby resulting in higher percentages of African American and urban families. Thus, the SAY survey was administered to a nationally representative population and over-samples parents and youth living in urban areas in six cities: Baltimore, MD; Chicago, IL; Detroit, MI; Oakland, CA; Philadelphia, PA; and Richmond, VA. SAY, a random digit-dialed survey, includes 4,441 parents and 7,778 youth. Telephone interviews were conducted every 3 years beginning in 1998 and commencing in 2005.[63,64] The present study utilizes data from the first wave of data collected between October 1998 and May 1999.

SAY is unique in that it includes interviews with adults, parents, and youth ages 10 to 18. Most importantly, SAY surveys youth about their involvement in school and nonschool related activities, including paid work, thereby presenting a complete picture to better understand how youth divide their time. Youth were asked to report on their time spent in paid work, housework, and extracurricular activities as well as their demographic characteristics. The parent survey generates information on family socioeconomic status, including family income, welfare recipiency, family structure, and regional location. Our data analysis combines information collected from both the youth and the parental interviews.

Parents were interviewed first, and then youth were interviewed upon permission from their parents. The youth survey lasted approximately 30 minutes, and the parent survey lasted about 20 minutes. The response rate for parents was 89 percent, and the response rate for parents who granted permission to interview a child was 74 percent. The current analysis is limited to youth ages 14 to 18, with an effective sample size of 3,441 parent-child pairs, for whom there are no missing data. No differences between responders and nonresponders were found with regard to urbanicity, region of country, race/ethnicity, and family income.

Variables

The youth employment variable is based on the question, "During the last week, have you earned any money at any job besides housework: yes or no." Additional individual youth variables in this study are age (14 to 18 years), gender (0 = male, 1 = female), and race/ethnicity. Race/ethnicity of the respondent was coded as

1 = Caucasian, 2 = non-Hispanic African American, 3 = Asian, 4 = Hispanic, and 5 = other race/ethnicity.

Family characteristics include income, welfare recipiency, family structure, and regional residence. Parents were asked, "What was your total family income last year?" The response categories include 1 = less than $20,000, 2 = $20,001 to $30,000, 3 = $30,001 to $50,000, and 4 = over $50,000. The use of social welfare services was measured by two questions. The first question regards government assistance and asked, "In the past 12 months, did you or anyone in your family receive assistance from AFDC or TANF?" They also were asked, "In the past 12 months, did you or anyone in your family receive food stamps?" They responded either "yes" or "no" to each question. Due to small sample sizes, we coded family structure as 1 = two-parent married families (may be either biological or stepparent structures), 2 = mother-only families, and 3 = father-only families. Last, regional location was measured as families who live in urban areas versus suburban areas.

We will present descriptive statistics, including means and frequencies, to describe the characteristics of our total SAY sample. Next, we will describe how employed and unemployed youth differ by demographic and socioeconomic characteristics. We perform a Pearson Chi-Square analysis to determine if significant associations exist between youth employment status and each youth/family characteristic.

RESULTS AND DISCUSSION

In Table 8.1, we present descriptive statistics for our main variables. Thirty-eight percent of our sample reported that they had earned money at a job in the past week, and of those, the mean hours of work reported were 15.8 hours.

In terms of individual youth characteristics, the average age of youth in our sample was 15.8 years, and the sample was evenly split between males and females. Forty-three percent of youth in our sample were Caucasian, 39.8 percent were African American, 10.3 percent were Latino, 2.3 percent were Asian American, and 4.6 percent were in the other category. The other category comprises youth who considered themselves Native American, who identified with more than one racial or ethnic category, or who chose the category "other." Approximately 67 percent of the youth we surveyed lived in two-parent, intact families. Most of the youth in our sample were from families who did not receive food stamps or AFDC/TANF in the past year (88% and 93%, respectively). Approximately 20.2 percent of families had incomes below $20,000, whereas 37.5 percent reported incomes above $50,000. Most of the youth lived in urban areas (69.3%), as the SAY survey purposely over-sampled urban areas.

In the next section, we describe how youth employment status varied by key demographic and socioeconomic characteristics. The likelihood of youth employment status varied most by youth age and regional residence, as can be seen in Figures 8.1 and 8.2. In Figure 8.1, for example, we see that age is a key correlate of youth employment status. At age 14, only 24.8 percent of youth reported that they worked at a paid job last week, whereas by age 18, that percentage increased to 60.5 percent.

Table 8.1
Descriptive Statistics of Variables Used in Analysis

Variable	*N*	%	Mean
Paid work (last week)			
Not employed	2130	61.9	
Employed	1309	38.0	15.8 hours
Age			15.8 years
Gender			
Female	1736	50.5	
Male	1705	49.5	
Race			
Caucasian	1479	43.0	
African American	1370	39.8	
Asian American	80	2.3	
Latino	355	10.3	
Other	157	4.6	
TANF/AFDC			
Yes	240	7.1	
No	3159	92.9	
Food Stamps			
Yes	396	11.6	
No	3031	88.4	
Total Family Income			
Less than $20,000	694	20.2	
$20,001–$30,000	518	15.1	
$30,001–$50,000	729	21.2	
More than $50,000	1291	37.5	
Family Structure			
Two parent married	2039	67.2	
Mother only	831	27.4	
Father only	164	5.4	
Residence			
Suburban	1057	30.7	
Urban	2384	69.3	

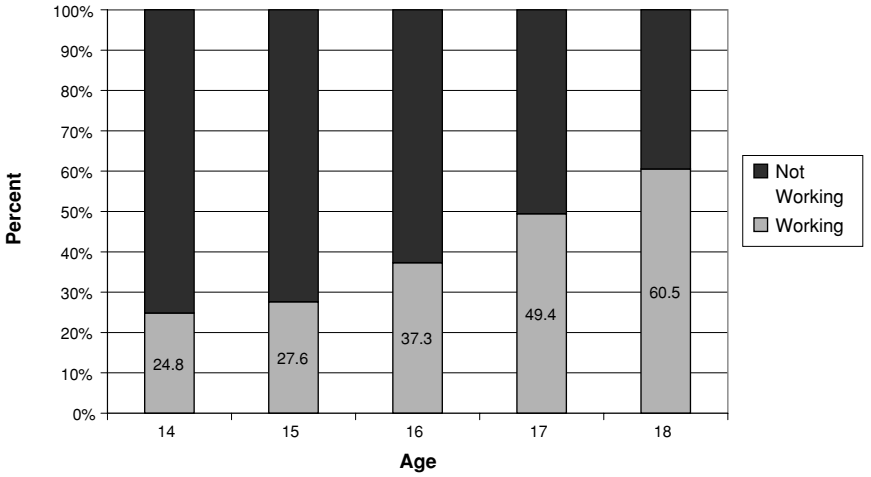

Figure 8.1
Youth Employment Status by Age

Thus, older youth are significantly more likely to be employed compared to their younger peers ($\chi^2 = 235.75$, $p \leq .001$).

Mirroring trends among the adult population, we find that the likelihood of youth employment varied by race/ethnicity ($\chi^2 = 59.94$, $p \leq .001$). Forty-five percent of Caucasian youth were employed, whereas only one-third of African American and Latino youth were employed, respectively. In contrast to rates reported by the Bureau

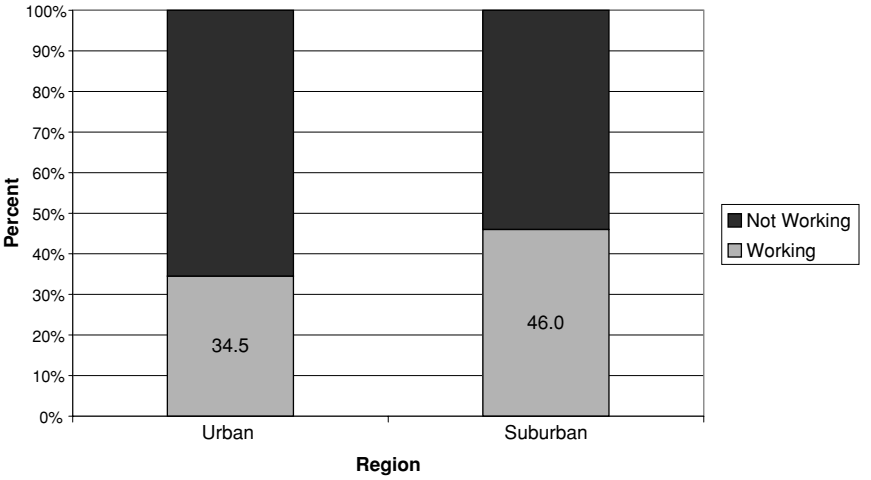

Figure 8.2
Youth Employment Status by Regional Residence

of Labor Statistics, Asian youth in our sample had the lowest employment rates at 28.8 percent.[65]

Our analyses found no significant differences in employment likelihood by gender among the youth in our survey. For both girls and boys, employment rates were approximately 38 percent. However, we did find an interaction between gender and race/ethnicity. Latina girls were significantly less likely to be employed compared with their male peers. Whereas over 62 percent of Latino boys were employed, only 38 percent of Latina girls were involved in paid employment. In contrast, we found greater parity between both African American and Caucasian girls and boys (ranging from 48 to 52 percent); thus, Latino boys had the highest employment rates. This finding is in tandem with recent data from the Bureau of Labor Statistics.[66]

Moving to family characteristics, we found a relationship between youth employment status and family income. A clear positive trend emerges between youth employment and family income. Youth from poor families were less likely to be employed than children from families with higher incomes ($\chi^2 = 15.72$, $p \leq .01$). Thus, although intuitively, we expected youth from economically disadvantaged families would be employed in order to help support their families financially, employed youth were more likely to be from more economically advantaged families.

Next we examined the association between welfare recipiency and youth employment status. Similar to the findings for family income, we found that youth who lived in more economically disadvantaged families, as measured by TANF or food stamp recipiency, were less likely to be employed as compared to youth from families who did not receive these forms of government assistance. Receiving TANF was significantly and negatively associated with youth employment ($\chi^2 = 4.94$, $p \leq .05$). In addition, food stamp receipt was negatively associated with the likelihood of youth employment ($\chi^2 = 7.15$, $p \leq .01$). In sum, youth from more economically disadvantaged families were less likely to be employed than their less economically disadvantaged peers.

We suggested that children from single-parent families may be less likely to work for pay if their parents relied on them for assistance with household labor and care of siblings. We compared youth from two-parent married families (combining stepparents and biological parents) with youth living in mother-only and father-only family structures. Although the data showed a trend toward greater labor force participation among youth from single-parent families, the relationship was not statistically significant ($\chi^2 = 4.42$, $p \leq .10$). It is also interesting to highlight that youth from father-only versus mother-only families did not significantly differ in their labor force participation rate. In sum, we found no association between family structure and youth employment status.

Last, we examined the association between regional location and youth employment rates. As we summarized above, research has suggested a spatial mismatch between youth residence in urban areas and job availability (i.e., service-sector jobs, which are concentrated in suburban areas). This is especially salient for youth who may lack the transportation options of adults (i.e., they are not old enough to have a license and are less likely to own a car). In addition, youth usually do not choose their place of residence. We found a significant association between regional residence

and youth employment status. Whereas 46 percent of the youth living in suburban neighborhoods were employed, only 34.5 percent of urban youth were involved in paid labor ($\chi^2 = 40.92$, $p \leq .001$). Thus, suburban youth were more likely to work for pay as compared to urban youth.

Overall, we found high variation in youth employment status by race/ethnicity and regional location, which begs the question: Which effect better predicts youth employment? In additional research using this data set and multivariate methods, we have examined the simultaneous effects of these individual and family characteristics on youth employment status. Our analyses showed that regional location trumped race/ethnicity in predicting the likelihood of youth employment. In other words, suburban/urban residence was the strongest predictor of youth employment.[67] While we know urban neighborhoods, especially in the cities surveyed, have higher concentrations of African Americans, our findings suggest that location matters more than race, as African American youth living in suburban areas in our sample were no less likely to be employed as compared to their Caucasian counterparts.

CONCLUSION

In this chapter, we have highlighted the important correlates of youth employment status. Guided by spatial mismatch theory and previous research, we have described how individual and family characteristics of youth are associated with their likelihood of paid employment. We found that youth employment was more likely among older adolescents, Caucasians, and Latino boys. In terms of family characteristics, we demonstrated that low family income, and TANF and foods stamp recipiency were associated with a lower likelihood of participation in paid work among youth. However, we did not find that gender or family structure was significantly associated with youth employment status. Most notably, we found that living in an urban setting was associated with a lower likelihood of youth employment.

Our findings support previous research on spatial mismatch and labor market outcomes for youth.[68,69] For example, Steven R. Holloway and Stephen Mulherin found that growing up in a poor neighborhood during adolescence can lead to lifetime labor market disadvantage.[70] They suggest that such disadvantage is partially attributable to limited opportunity to accumulate early paid work experience. The disadvantage attributable to spatial mismatch between urban youth residence and suburban job opportunities has implications for policy regarding youth employment, especially in the era of welfare reform. Over the past few decades, policymakers have attempted to ameliorate urban/suburban differences by stimulating development within urban neighborhoods in the form of empowerment zones and spatially targeted job training programs. Policy also has focused on dispersing concentrations of urban poverty through programs such as Moving to Opportunity (MTO). Despite some successes in reducing the concentration of urban poverty during the 1990s, our data suggest that urban/suburban inequality persists in the area of youth employment.

Recent changes enacted through the reauthorization of welfare reform in 2005 may exacerbate the problem of spatial mismatch, as the Federal government has renewed the 50 percent requirement. Under reauthorization guidelines, 50 percent

of TANF families must participate in a combination of work and other activities that lead to self-sufficiency. New guidelines also propose that this percentage will increase annually by 5 percentage points until it reaches 70 percent in 2007.[71] As adults on TANF, many of whom are concentrated in economically disadvantaged, urban neighborhoods, face greater pressure to secure employment, the prospects for youth in these same neighborhoods will likely decline. Therefore, policies are needed that specifically target job training for youth, especially those in urban neighborhoods.

First, interventions at the local, state, and federal levels must address the limited transportation options of inner-city youth. Recent demonstration projects have shown that providing direct transportation is essential for connecting inner-city residents with suburban job opportunities.[72] However, transportation alone cannot solve the many issues involved in moving youth to job opportunities far from home. Private companies, especially those who employ large numbers of service workers, such as fast-food restaurants, retail stores, and hotels, can intervene by recruiting and investing in young workers. The recent ordinance passed by the Chicago city council that "Big Box" stores must pay workers hourly rates greater than minimum wage is an interesting example of how local government can force private companies to invest in their workers.[73] Thus, we suggest that interventions are needed from both public and private entities in order to close the wage gap and better prepare youth for future employment.

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CHAPTER 9

MORAL CAPITAL: SINGLE MOTHERHOOD, EDUCATIONAL ATTAINMENT, AND PERSONAL RESPONSIBILITY

Judith Hennessy

> The American dream that we were all raised on is a simple but powerful one—if you work hard and play by the rules you should be given a chance to go as far as your God-given ability will take you
>
> –Bill Clinton 1993

Recent decades have witnessed dramatic changes in women's lives including higher employment rates among mothers and more women pursuing college degrees. A related change, with significant consequences for low-income and impoverished women is the 1996 welfare reform. The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) abolished Aid to Families with Dependent Children (AFDC) and created Temporary Assistance to Needy Families (TANF). In establishing TANF, legislators ended low-income mothers' entitlement to public assistance, required paid work in exchange for continued state assistance, and restricted support for postsecondary education.[1]

Prior to the 1996 PRWORA legislation, mothers of small children were exempt from working as a condition of receiving welfare assistance, and cash assistance was available to students enrolled in postsecondary education through the Job Opportunities and Basic Skills (JOBS) program. In contrast, the shift to a "workfare" policy emphasizes moving recipients into the workforce as quickly as possible, lowers the child age exemption to infants as young as 3 months in some states, limits job skills training and education to specific employment categories and imposes time limits on education.[2]

Research on the workforce participation and earnings of low-income women finds that poor single mothers often leave welfare for low-wage jobs and experience considerable hardship both on and off welfare.[3] Other research illustrates the struggles

of welfare recipients to pursue higher education under TANF. These studies note that the emphasis on increased participation in paid work and restrictions on educational attainment hamper poor mothers' ability to reach long-term self-sufficiency and instead trap them in low-wage jobs.[4]

Studies documenting the struggles of poor women to make ends meet have rightfully taken a prominent place in research on impoverished and working-class women. However, this research has largely overlooked the moral dilemmas facing low-income single mothers. I address this understudied, albeit important aspect of low-income single mothers' struggles to raise children in an era of changing work and family relations and shifts in public assistance for impoverished families. I use interview data to examine the broadly shared, normative, cultural models salient to a group of student and nonstudent mothers in the wake of welfare reform. We see how low-income mothers, who are solely responsible for providing and caretaking, use widely shared understandings about work, family, and educational attainment to make decisions about work and family and resist stigmatized identities of poor single mothers on public assistance.

MORALITY AND WORK AND FAMILY DECISIONS

Despite the growing number of women who participate in paid work, few studies have explicitly attended to the *moral dimension* of combining paid work with caring for children. The few studies that do focus on the moral facets of work and family decisions explicitly posit that people's worldviews and actions regarding work and family responsibilities are not only or even primarily economic, strategic, or reactive but rather are imbued with moral significance and emotional salience.[5] However, research on the moral dimension of work and family has focused on middle-class cultural models.[6] This literature has not given systematic attention to the moral identities and dilemmas of single mothers struggling to provide for their children with low-wage jobs and/or welfare assistance nor those who find their path out of poverty obstructed by restrictions on educational attainment.

However, morality is no stranger to studies of poor women on welfare. A few influential works on welfare policy and poverty portray the problems of the poor as individual idiosyncrasies or pathologies.[7] Much of this literature blames the poor for their disadvantage and fuels racially charged stereotypes of poor single mothers. The dominant image of the "welfare mother" is that she resists supporting her children through paid work and "chooses" to remain on welfare, thereby transmitting her lack of initiative and motivation to her children, Moreover, the public response to poor single mothers' decisions about work and family differs markedly from the widespread social approval of middle-class mothers who "opt out" of careers to care for their children.[8] For low-income and impoverished mothers, reliance on public assistance to support one's family represents moral failings, while participating in paid labor is a sign of personal responsibility.[9]

Studies show that poor mothers may resist stigmatized identities and maintain status as good mothers by drawing upon dominant cultural models of motherhood

where children's needs must come first.[10] However, poor single mothers raising children do not derive the moral credit earned by middle-class mothers through their self-sacrificing devotion to children. Indeed, with the advent of welfare reform, poor mothers are *required* to work and find their pursuit of education obstructed by welfare policies that privilege "any job" over a college degree. For mothers on welfare, "good mothers" put their children in daycare and go to work.[11]

Thus, the moral imperative imposed upon poor women is labor force participation (rather than caregiving or education) that designates them as worthy of state support. As we shall see, when paid work becomes an obstacle to responsibility for children, and/or a college degree, many mothers resist this definition of moral worth. In contrast to the rhetoric and assumptions of welfare policymakers, poor mothers find moral worth in responsibility for children and long-term self-sufficiency through education.

Moral Dimension of Paid Work

The strong work ethic that characterizes U.S. culture—anyone who is willing to work hard can get ahead and reward is commensurate with effort—remains a widely shared, powerful, and moral imperative.[12] The flip side of this ideology is that those who fail to get ahead—poor single mothers—are blamed for their own misfortune presumably because they lack attachment to mainstream values.[13] Thus, attaining self-sufficiency through paid work not only provides the material means to alleviate poverty but also signals membership in a moral community.[14]

Even though few families in today's society consist of a stay-at-home caregiver and male breadwinner it still resonates as a dominant cultural ideal.[15] In contrast to men's male provider role, women's moral obligation, indeed *sacred calling*, has rested in motherhood and marriage.[16] For women with children, excessive devotion to a career is a sign of self-centeredness and failure to be a good mother.[17] This presents a particularly cruel paradox for poor mothers on welfare. Poor single mothers who reject jobs that conflict with caring for children are punished under TANF by mandated reductions in cash and other welfare benefits. Thus, waged work, not child rearing is the socially approved path to membership among the deserving for poor women.[18]

Moral worth constructed in these terms imposes the masculine family ethic of good provider on poor women as their means of fulfilling a positive family role.[19] Paid work, long a symbol of men's moral obligation to their families, is now a sign of virtue for low-income mothers who rely on the state to meet their family obligations.

Education as a Cultural Ideal /American Dream

Educational opportunity reinforces the dominant ideology of the work ethic in U.S. society: the opportunity for all to succeed through their own efforts. This ideal—the American dream—is reinforced by the U.S. public's expectation that the educational system provides the means for all to believe in and pursue this ideal.[20] As Senator Olympia Snowe of Maine asks: "Who would dispute that education is the great

equalizer in our society that can give every citizen in our nation—regardless of race, gender, income or geographic background—the same opportunity to succeed?"[21]

However, welfare reform policies hinder the achievement of this ideal through increased work hours and restrictions on educational activities for recipients who desire to pursue postsecondary education.[22] Women's' advocates oppose TANF's mandatory work participation rates and argue for giving states flexibility to design programs that allow more education and training opportunities.[23] A few states, notably Maine's Parents as Scholars program (PaS), use state funds to allow welfare recipients to continue postsecondary education, freeing them from compliance with restrictive federal rules. The result is increased wages and economic well-being for former welfare recipients.[24]

Moreover, the benefits of postsecondary education extend beyond income. Postsecondary education is associated with enhanced self-esteem and self-confidence and increased gains in the educational attainment of children.[25] Former welfare recipients with college degrees are also more likely to stay employed and not return to welfare[26] underscoring the contradictions in proposals for increased mandatory work hours and limits to postsecondary degree programs.[27]

In the analysis that follows, educational attainment figures prominently in constructions of personal responsibility and moral worth as a group of low-income single mothers articulates work and family responsibility and the promise of education according to widely shared cultural ideals.

METHODS AND DATA

Participants in this study are low-income single mothers, both on and off TANF who received social welfare services from a local Community Action Center in 1998–1999, the first 2 years of welfare reform. Eight mothers were currently attending college in pursuit of undergraduate or graduate degrees. All respondents had earned a GED or high school diploma. The women range in age from 20 to 47 years (mean 31), and the racial and ethnic characteristics of the sample include one Latina, one Black, and 18 whites. Only two respondents had never received AFDC or TANF. Eight respondents were receiving TANF cash benefits at the time of the interview, and four had left welfare within a year of the interview.

The data consist of semistructured interviews that ranged from 45 minutes to an hour and a half and were conducted in the fall of 1999 through January 2000. Interviews were tape recorded and then transcribed verbatim and coded into appropriate theoretical categories. All names used are pseudonyms and any identifying information was omitted to respect the confidentiality of respondents.

This study focuses on an understudied group: poor, predominantly white single mothers that reside in a rural Northwestern United States college town. The mothers in this study face few of the problems associated with the urban poor and single motherhood: waiting lists for subsidized housing, unsafe neighborhoods, low-quality child care and substandard schools. Moreover, the state that is the site of this study is characterized by a history of relatively generous public assistance.[28] Therefore, this

sample stands out as a relatively "privileged" group compared to other studies of women on welfare in terms of resources. This group of poor single mothers—college students and noncollege students—can be examined as a "best case scenario" of low-income women who confront work and family decisions with greater resources than the urban poor, yet fewer resources than middle-class women.

My initial research goal was to investigate the material well-being of low-income women in the early days of the reform. I was interested in whether poor women were better off under TANF than the AFDC program. The "success" of welfare was widely promoted by policymakers due to the drop in the welfare caseload and the rising employment rates of former welfare recipients. As I listened to participants, what emerged was a far more complex story of how low-income single mothers view "success" in their ability to meet their work and childrearing responsibilities. I hope, through this rather unique group of women, to make visible the powerful, normative cultural models—so taken-for-granted as to appear invisible—that shape and constrain the "choices" of low-income women as they raise their children, go to work, and pursue educational goals. These findings are not intended to be statistically generalizable to a larger population, but may offer insight into similarly situated cases.

FINDINGS

Two Groups of Mothers: Employed Non-student and Student Mothers.

I first examine how non-student mothers make sense of their experiences as workers and mothers within the constraints of poverty and public assistance.

Personal Responsibility

Most of the women in this sample had extensive work histories. They provided ample evidence of the existence of a strong work ethic without the "push to work" provided by TANF.

Nancy is a 24-year-old never-married single mother of two small boys, ages 7 years and 18 months. Nancy currently works for a local telephone call center and described her job as, "There is no where to go. It is just right now paying the bills"

In this interview Nancy makes it clear that her participation in paid work is not the result of any incentives provided by the state. She is not a recent convert to personal responsibility and always worked except for a short period of time. Nancy, although not a student mother, includes educational attainment as a means of shouldering personal responsibility in opposition to reliance on public assistance.

> I have *never* not worked. Except for the time when my mom sold her business until he [her youngest child] was 4 months and that was the only time I had never not worked since I was 16 years old, and it was terrible. I had never been that broke in my life and now it is like, all right, I am working and paying my bills, and I am still broke but my bills are paid. And before I was broke and my bills weren't paid . . . You have to work 20 hours per week in Washington, but I would not just not work. I'd go nuts. I don't want to be on assistance. My goal is to finish school and you know, to have a degree.

According to Robert Wuthnow, "most people work in order to give a culturally legitimate account of themselves, only one possibility of which is to say they are attempting to earn money."[29] I found this in Nancy's account of her work history. Without work "she would go nuts" but work is also defined in opposition to public assistance. Work for Nancy, although she is "still broke" creates a positive moral identity in opposition to mothers on welfare.

Responsibility for Children

Tammy, a 32-year-old mother of two school-age sons, receives TANF and works as a hotel maid. She told me how she had been separated from her children for about 6 months when she and her husband were living in a car and were "into drugs and alcohol." Four years ago she left her husband and moved here from another state with her children to be close to family. She told me that she has "been totally clean for four years . . . I have come a long way from where I was."

Tammy struggled with her desire to model the importance of paid work for her children and her belief that children need the supervision of a parent.

> I don't know, but I just think it is really hard when people say that [the children are old enough to care for themselves]. I mean they need more space, but they also need mom there too, and if it is just a single parent they need somebody there to say you know, this is wrong, this is right. . . .

Both caring for and providing for children are part of Tammy's worldview of her moral obligation as a mother. Tammy feels a need to be home with her children to provide moral guidance and she had reported earlier that her participation in paid work provides a good example for them. Her reliance on welfare and single motherhood status amplify the moral salience of personal responsibility through paid labor. Employment outside the home establishes an identity in contrast to the "welfare mother." Yet Tammy also sees her responsibility to her children in light of her view that to be a "good mother" is to be there for children when they get home from school. Tammy resists the notion that her primary obligation to her children is to provide financially—she is instead torn between two conflicting models of what responsible mothers *should* do.

STUDENT MOTHERS

I now turn to student mothers who combine work, school, and motherhood. This group of women although burdened by additional demands on time, receives additional resources from their pursuit of education. Student mothers derive symbolic resources given the ideological currency of pursuing educational attainment, and material resources from loans, grants, work-study, and university facilities. Drawing on moral capital obtained from widely shared approval of education, student mothers use this to display superior character, forging identities as good mothers and individuals who are trying to get ahead. As they apply new interpretations of moral worth

they distance themselves from welfare policymakers and redefine their situation in opposition to welfare policies that restrict their access to education and their ability to reach self-sufficiency and care for their children.

The widely shared value of education in addition to the added burden in terms of time commitment and constraints by the welfare system generates resistance to work requirements. Here we see how high regard for the promise of education shapes student mother's choices about work and motherhood, identities as deserving, and undermines the legitimacy of the welfare system.

Student Status As Moral Capital

Betty a 25-year-old never married student mother was in her last semester of college courses. She found that trying to fulfill the work requirement was very difficult with the demands of school and family. She expressed the distinction between students and others as those who are "trying" and those who are not and would benefit from work requirements.

> I actually think that this new program [TANF] is beneficial except for us students. It did not take into effect those students who are going to school, are single moms and are supposed to work . . . I think that they need to reevaluate the Work First part of it as far as the students go. I think that it really is beneficial for those who aren't working. I think that they need to take into consideration those who are already *trying to be self-reliant* and they are punishing those people more than anything.

Betty clearly believes that student status demonstrates her moral worth and the fact that she is complying with the spirit and substance of welfare reform's call for personal responsibility in her quest to become self-reliant. Her pursuit of education sets her apart from others who are not trying to get ahead.

With so many mothers in the labor force, many mothers experience difficulty balancing work and family responsibilities. Therefore, requiring single mothers to work seems more "normative" than constraints on education. In fact, as more mothers entered the workforce, welfare assistance to poor mothers was increasingly perceived as a benefit not available to other working families who struggle with work and family conflict.[30] Thus, reference to the difficulty of combining single motherhood with work does not provide the same degree of moral currency as does a desire to make a better life for oneself and children through education.

Betty expresses the sentiments of many mothers with the conflict between her choice to complete her education and the requirements of public assistance. Here Betty relates a conversation with her caseworker about having to go to the welfare office for an eligibility meeting and a conflict with her class schedule.

> And I have had to call and say I can't make it because I have class. Well she told me you have to have your priorities in order. Well I'm sorry. Welfare is not my priority, school is. This is what is going to get me off the system, not coming to a meeting.

Personal Responsibility through Education

As I listened to mothers talk about their educational goals, they were very aware of the relationship between educational attainment and their ability to financially support themselves and their children in the long run. As Vivyan Adair argues "post-secondary education can unlock the door to economic opportunity and thus enable disadvantaged women to live lives of dignity, supporting and nurturing their children."[31] The lack of support for postsecondary education by the welfare system presented a direct challenge to respondents' efforts to obtain a better life.

Student mothers also distinguished between good jobs that would allow them to "get ahead" and provide for their families and low-wage work that was often seen as an obstacle to that goal. Their current work situations were secondary to their educational goals, and the twenty-hour work requirement was often described as impeding the promise of upward mobility through education. Carol, 37 years, divorced with a 6-year-old daughter expressed her frustration with the work requirement.

> When you are a single parent having to work that 20–25 hours that is tough when you are a single mom trying to go to school. I think that thing should be done away with. I mean if you are going to school and you are really trying I don't think you should be penalized because you are trying to get ahead. . . . You can't support a family on minimum wage, you know so that is what they are doing, they are forcing all these women . . .

For Carol and others, work requirements force women to "choose" low-wage jobs.

Student mothers must at times choose between family and school commitments. Here Betty, in language almost identical to the way she described her allegiance to her educational goals, discusses her need to miss class to care for her ill daughter.

> It is rough sometimes especially when she is sick. Most of my instructors have been pretty okay with it but sometimes they are just like, "you have to figure out your priorities." And well I did, and it's her and I am not going to be in class today.

Betty does not hesitate when asked to choose between her priorities. Yet, her educational commitments and family commitments are not as separate as they appear, as ultimately her educational attainment will allow her to get a job and create a good life for herself and daughter. But when asked directly Betty defers to the moral imperative demanded of mothers that children's needs come first.[32]

Mary is 36, a full-time student, and mother of two elementary school-age children. The welfare office cut Mary's cash assistance because she did not work the required 20 hours. Mary has "chosen" to reject the welfare office's insistence on waged labor. She exposes the contradiction in definitions of personal responsibility for poor mothers when insistence on paid work hinders education and a single mother's ability to care for children. As a student mother, worn down by the multiple demands of work,

school, and motherhood, Mary stakes a position of moral worth above policy makers who "can't understand."

> I can't do all three, I can't be a mom, and school and work. I just can't. So I deal with the lower payment, with a lower grant, as best I can and wait until the next financial aid comes through . . . They [policymakers] can't understand what it is like to do something like that. . . . I would switch places with them for a day, or a week, in a heartbeat. I go to class for 4–5 hours a day, I come home I sleep for a couple of hours before I pick up the kids at day care, I have 4 hours with them, then their homework, feeding them, cleaning up the house, and then my home work and then up at 7 to get them to school.

Mary also expresses the frustration of many others regarding the lack of support for education.

> For DSHS [Department of Social and Health Services] to not take into account a university education, it is very counterproductive, exceedingly. If you can't get help to get educated. I mean a decent living instead of just a subsistence living, what is the point? You know? I can't help but wonder, what are they thinking?

Generating Moral Capital

Melanie, a 33-year-old single mother of two young children was also a full-time student who returned to school after working as a salesperson in a woman's clothing store. She received a TANF grant and combined that with work-study funds. Melanie viewed the changes brought about by TANF and the behavior of caseworkers as adversaries to her educational goals.

> They [caseworkers] were saying that my education does not mean anything, that it does not count for anything, and that it really isn't going to do you anything, that it is not going to benefit. . . . They are telling me I have to have a job. Education is not counted as job related . . . and that is like excuse me! And that really made me angry, and I wasn't going to let them take that from me

Melanie's decision to go on welfare and complete a college degree was based on her inability to support her two young children on her earnings. In addition, she relied on her mother to care for her children and rarely saw them.

> My son had to stay with my mom because I couldn't afford child care and there was no child care help at all. I really very seldom got to see my son. And you know what is the point of working if you can't be around your kids?

Melanie views her education as fulfilling her family responsibility and frames welfare assistance in moral terms. She borrows from the rhetoric of welfare proponents who insist that poor single mothers meet their family responsibilities through paid work. However, she argues that reliance on welfare—not work—has allowed her

to care for her children and model responsibility for them as she pursues a college education.

> I will be able to show my children, you know. I am on the system to get myself an education and for no other reason. . . . It is to get me where I need to be in order to support myself and my children, *forever*.

Melanie reinterprets welfare assistance as a means of demonstrating for her children the eventual long-term payoff from education. Her goal of self-sufficiency parallels the American dream where individuals are rewarded for their hard work and individual achievement. Melanie uses the high regard for education to reshape personal responsibility to include her ability to support her children with assistance from the state. In contrast to the negative assumptions about welfare dependency, Melanie turns to widely shared understandings about education, caring for children, and paid work to demonstrate her moral worth as a positive role model for her children. In doing so, she like other mothers, sets herself above policymakers in a hierarchy of moral worth based on taken-for-granted ideals that she shares with others in contemporary U.S society.

DISCUSSION AND CONCLUSION

Welfare reform, from the perspective of policymakers, has been successful in moving poor women off the welfare rolls into the workforce. The policy, in practice, emphasizes workforce participation that may or may not lift a mother and children out of poverty, restricts educational pursuits, and insists that poor mothers' responsibility to children lies in their role as providers not homemakers.[33]

This study took place in the first few years following the implementation of TANF as welfare recipients were negotiating the constraints and opportunities of the reformed welfare policy. As we have seen, decisions that poor women make about commitments to paid work and children are ultimately moral decisions that resonate with broadly shared cultural ideals. These ideals include the belief that mothers should be devoted to children, paid work establishes identities free from the stigma of welfare, and educational attainment makes it possible for even the disadvantaged—poor single mothers—to get ahead if they apply themselves and work hard.

The low-income single mothers in this study, students and nonstudents, illustrate how broadly shared, taken for granted understandings about responsibility for children, workforce participation, and education shape poor mothers' work and family decisions. The "choice" to work, pursue educational goals, and/or care for a sick child are not only constrained and enabled by available resources, but also by moral criteria.

The mothers in this study, along with others in U.S. society, share the belief in the promise of education that characterizes the American Dream. Yet, welfare policies challenge this dream by privileging low-wage work over mothers' responsibility for children and hopes for obtaining a college education. When welfare policies penalize recipients for pursuing this dream, they undermine the legitimacy of the system and

generate resistance. Student mothers emphasized their long-term educational goals and responsibility for children in opposition to work requirements that hindered their ability to reach the self-sufficiency promised by welfare reform. Thus, student mothers were able to resist the stigma of welfare, placing themselves above welfare policy makers and other less deserving welfare mothers. I found that poor mothers are not passive recipients of an oppressive social policy environment. Moreover, their resistance is grounded in dominant cultural ideals that the majority of Americans share.

I focus on educational attainment in the early days of the reform because of its salience within this group of women and its power in shaping moral identities and generating resistance. However, as important as education was in the lives of the mothers in this study, we also saw that at times student status conflicted with the demands of motherhood. Dominant cultural models that comprise the moral dimension of poor women's work and family decisions are not gender neutral. When mothers feel their choice is between their responsibility to children and work, or time in the classroom, motherhood almost always wins. However, student mothers also include educational goals as part of their responsibility as mothers to provide for the long-term welfare of children, thus maintaining their status as good mothers buttressed by the moral capital earned through student status.

Greater visibility and explicit recognition of the moral underpinnings of expanding educational opportunity complement the efforts by advocates for increased educational opportunities, good jobs, and greater autonomy for low- income women. It also mirrors the belief by the U.S. public that—*if you work hard and play by the rules* you have the right and opportunity to pursue the American dream. Poor single mothers include themselves and their children in that dream.

NOTES

1. In addition to work requirements, PRWORA restricts cash welfare assistance to a maximum lifetime limit of 5 years (fewer at state option). Under the AFDC program, poor families could receive benefits as long as they met eligibility requirements.

2. Nineteen states and the District of Columbia currently allow postsecondary education to count as work for longer than 24 months—Alabama, Arkansas, California, Colorado, Delaware, Georgia, Hawaii, Illinois, Iowa, Maine, Massachusetts, Missouri, Montana, New Jersey, North Carolina, South Carolina, Vermont, Wisconsin, and Wyoming. Georgia is the only state that allows recipients to enroll in graduate programs. Most states require that students be enrolled in a program that leads to employment, that they maintain a certain GPA and make satisfactory progress toward a degree within a specific period time frame. "From Poverty to Self-Sufficiency: The Role of Postsecondary Education in Welfare Reform," *Center for Women Policy Studies Fact Sheet April 2003*. http://216.146.235.184/report.cfm?ReportID-77 (accessed on February 3, 2006).

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10. Karen McCormack, "Stratified Reproduction and Poor Women's Resistance." *Gender and Society* 19 (5) (October 2005): 660–679.

11. Philip N Cohen and Suzanne Bianchi, "Marriage, Children, and Women's Employment: What Do We Know?" *Monthly Labor Review* 122 (12) (1999): 22–31.

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18. Anne Crittenden, *The Price of Motherhood: Why the Most Important Job in the World Is Still the Least Valued* (New York: Metropolitan Books, 2001); Nancy Folbre, Who *Pays for the Kids? Gender and The Structure of Constraint* (New York: Routledge, 1994), argue convincingly that all women's caregiving labor is undervalued by U.S. society and that the "most important job in the world" is not counted as work, thus penalizing women who overwhelmingly are responsible for the work involved in raising the next generation. Although, women who interrupt careers for childrearing suffer major financial consequences, they still reap moral credit for their devotion to family. Single mothers who rely on public assistance derive no moral credit from the U.S. public and policy makers for their performance of the "most important job in the world."

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27. HR 4241 *Deficit Reduction Act of 2005*, The Library of Congress (November 7, 2005), http://thomas.loc.gov/cgi-bin/query/z?c109:H.4241; The final bill signed into law on February 8, 2006 requires 30 hours of work participation rates for mothers with children over the age of 6, rather than 40 hours as some legislators had proposed; see Kahn, Introduction (7) and Afterword (237–240) in *Shut Out: Low Income Mothers and Higher Education*.

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To our children
Eiler, Elena, and Megan
and
Meghan and Allison
Our concern for their welfare piqued our interest in the welfare of all children.

Contents

Acknowledgments

First, we wish to thank all the contributors to the four volumes for the exceptional caliber of their research. Their dedication and commitment to understanding the causes of child and family poverty is remarkable. It has been a pleasure to work with such a fine group of scholars. It is noteworthy, too, that more than a few of the contributors endured family emergencies and/or experienced personal crises during the research and writing phase, yet remained committed to the project. For that, we are grateful.

We are honored that Diana Pearce is the author of the Introduction for Volume 1: Families and Children. Professor Pearce has written a thoughtful essay weaving common threads among diverse chapters. She is a tireless researcher who has been a pioneer in examining the causes and effects of poverty in the lives of women and children. Not only has Professor Pearce illuminated the way for other researchers in explaining the complex factors influencing women's poverty, she has been an ardent advocate for ending the feminization of poverty.

Thanks to Rachel Sebastian, graduate student at the University of Cincinnati, who assisted with the project. We appreciate, too, the guidance of Elizabeth Potenza, editor at Praeger, throughout the editorial process, Anne Rehill who assisted early on in the project, Nicole Azze, production manager, Vivek Sood and Saloni Jain who oversaw the copyediting. Finally, thanks to Marie Ellen Larcada, who first approached Barbara about editing the four-volume set.

Introduction

Barbara A. Arrighi

> Give me your tired, your poor, your huddled masses yearning to breathe free the wretched refuse of your teeming shore. send these, the homeless, tempest-tost to me, I lift my lamp beside the golden door!
>
> Emma Lazarus "The New Colossus"

Lazarus's words have been welcoming all who enter New York harbor for decades; however, the same cannot be said of the policies and practices of the United States. Over the course of U.S. history, too often, laws have been less than generous for those who were sick, poor, and/or old. For example, as early as 1720 New Jersey enacted a law that allowed ships to be searched for the elderly, especially older widows who didn't have any means of support.[1]

A century later, Liwwat Boke, a German immigrant who lived between 1807 and 1882, reported her observations of the treatment of the poor, sick, and the elderly in her grueling 75-day voyage from Germany to America. Boke wrote: "when the ship reached land . . . no one is let off the ship except those who had paid their travel cost . . . The others . . . had to stay until they were sold . . . No buyers bought the sick, the blind, or the elderly. Healthy persons were bought at once. The suffering and the crippled often lay on the ship two or three weeks until they died. The chosen one is bound in writing on paper for 5 or 10 years; they can't read English . . . Families are broken up, children are lost!"[2] Boke's words describe an American welcome at variance with Lazarus's, yet both capture a part of America: Come able, prepared to work hard, and be self-sufficient.

The notion of self-sufficiency in the United States has its roots in the views of Herbert Spencer,[3] an Englishman, and his followers who, in the 1800s, advocated Social Darwinism—survival of the fittest. Spencer's ideas were imported to the United

States by the likes of William Graham Sumner[4] who believed the fittest humans survive and thrive because of their ability to adapt to their environment. Conversely, those who cannot adapt will not survive. From the perspective of Social Darwinists, any form of external intervention in the struggle to survive operates against natural selection and weakens society. Amos Griswold Warner, perhaps the first to publish a social welfare tome, argued that welfare was an "... expense to the community, and the degradation and increased pauperization to the poor."[5] Warner, like the others, maintained that providing help for those in poverty would be detrimental to society.

Over time, aspects of Social Darwinism have remained part of the national discourse about the poor. Vestiges of it can be found in Congressional and presidential debates concerning welfare, Medicaid, food stamps, and other social programs. Thus, there exists tension between Social Darwinism and the notion of the *deserving* poor that gets played out in policy debates. Should it be government's responsibility to provide for its citizens or just some of its citizens? Who? How much assistance? For example, in the last century many programs were established for those considered to be the *deserving poor.* One program, Aid for Dependent Children, was passed by Congress in 1935 to provide assistance to widows with children. Other programs like Social Security and Medicare were implemented, although not without resistance, to help lift the elderly (a *deserving* group) out of poverty.

The resistance of the United States to become a "welfare state" sets it apart from other industrialized countries, especially concerning families and children. Embedded in the political and economic structures of other countries are pro-family policies that reflect a philosophy that children are societal resources who represent an investment in the future. The policies illustrate a collective belief that whatever the circumstances of birth (whether poor, within or out of wedlock), if the youngest and most vulnerable citizens have a healthy start in life, they will become healthier, productive adult citizens. In turn, healthy citizens foster stronger societies.

The United States, on the other hand, is beholden to the ideology of individualism and vestiges of the survival of the fittest. Encapsulated within both is the belief that if a person has the "the right stuff," success will come. From this perspective, success is primarily dependent upon an individual's gene pool and the will to succeed. Adherence to individualism means societal factors matter only somewhat in one's life—one's present or past socioeconomic status has little or no bearing on future outcomes. Individualism, as such, is compatible with a *blame the victim* stance—the individual is poor because s/he lacks ambition and motivation. Then, too, individualism perpetuates a rags-to-riches mythology that the middle- and upper-class structures are more permeable than they, in fact, are.

If anything the evidence suggests, instead, an increasing gap between the wealthy and poor. The Brookings Institute found that in the 100 largest metropolitan areas the percentage of middle-income neighborhoods declined by 41 percent and central cities, which had a 45 percent share of middle class in the 1970, now had only 23 percent.[6] If, as expected in the next 10 years, over half of the fastest job growth will be in low-wage occupations, moving out of poverty will be less likely for families.[7]

Although the job and city evidence reflect systemic economic conditions beyond individual solutions, during the last two decades, U.S. policymakers have frequently blamed families for their economic downslide. Indeed, policymakers have frequently questioned the values of U.S. families. The rhetoric often reaches fever pitch at the height of political seasons. The closer the race, the more intense the finger pointing. In one presidential election of the 1980s, a vice-presidential candidate even cited the out-of-wedlock TV birth on a sitcom as somehow contributing to the rise of unmarried parenthood. Earlier in the same decade, a presidential hopeful referred to "welfare queens" who were, in his mind, milking the system by staying at home with their children, rather than working in a paid job.

In the 1990s, a Democratic presidential candidate stole the thunder of the Republican Party by appropriating its Welfare Reform platform. The campaign sound bytes implied that families living in poverty were shirking their responsibility and must be made accountable. The title of the legislation eventually resulting from that election: The Personal Responsibility and Work Opportunity Reconciliation Act, arguably reflects the attitude of policy makers. Bill Clinton, who was elected President, in large part, due to his Welfare Reform stance, decreed that people with children who worked 40 hours a week would rise out of poverty.[8] He said: ". . . this legislation provides a historic opportunity . . . by promoting the fundamental values of work, responsibility, and family."[9]

It is true, that millions of people have been removed from welfare within the last decade. It is also a fact that millions of people who were poor on welfare have now joined the working poor ". . . and a portion of them are significantly worse off than before," says Evelyn Ganzglass, of the Center for Law and Social Policy.[10] If, as reported, the median wage of a mom who transitions from welfare to work is about $8.00 an hour, her gross wage (if she worked 40 hours a week) would be $15,406 a year. Although her annual income would then be more than the income ($11,800) of a family receiving welfare, she would still be poor.[11] The difference: Now she has to pay for childcare, if it is available (and not necessarily high quality care), her food stamp allotment will be cut, she will have to rely on food pantries to make up the food insufficiency, she will spend less time with her children and she will now work a *second shift* (paid work on the job and unpaid work at home). For those who earn less than $8.00 an hour, the situation is even more critical. The bottom line is: "using a variety of measures, relatively more U.S. children are born into disadvantaged environments compared to 40 years ago"[12] The safety net essentially has been removed for poor families and it would appear that policymakers on both sides of the aisle no longer view moms and their children as the *deserving poor*.

Every 4 years politicians spend an inordinate amount of time drawing voters' attention to just 3 to 4 percent of the federal budget—the part that addresses the 13 million children who live in poverty (20 percent of whom are under age 6, 20 percent who live in extreme poverty, and the 17 percent of households with children who experience food insecurity)—and vow to hold down the spending on such "entitlements." During the 2004 presidential campaign, a year in which billions of

dollars were unaccounted and/or misspent by independent contractors in Iraq, the focus of the 2004 election once again was family values not government waste.

Political candidates will use "value baiting" as long as it wins elections, but the more important question is: Does the United States value *all* of its families or just some families? What are the values of a nation that allows 13 million children to live in poverty, of which 2 million live in extreme poverty? Currently, U.S. welfare policies focus on the so-called pathology of "needy" families, a term that implies inherent, negative familial characteristics. A more fruitful way to pose the question is: Why are so many families in "need" in the midst of so much plenty? Useful analyses of poverty require examining the systemic constraints that hold families down while at the same time policy measures are passed that allow some families to thrive. A useful analysis includes an examination of the political, educational, and economic institutions within which family life is played out day-by-day.

For example, since 1979 the after-tax income of the wealthiest Americans jumped 370 times that of the lowest income. The change for the wealthy cannot be explained simply by individual characteristics. It represents, in part, systemic tax law changes implemented by Congress. On the other hand, a proposal to raise the minimum wage from $5.15 to $7.25 an hour over the next 3 years—which would have represented a systemic change—was defeated in the Senate in 2006. It is instructive that even if the bill passes it would provide families just over *half* the costs of raising two children. One could ask what kind of values are at work in Congress—a body that has voted 6 pay raises in the last 10 years for its members, while the minimum wage has not been raised once in the same time period.

One way to answer that question is to offer a comparative analysis of the families and children policies enacted by other industrialized societies. Table I.1 illustrates just a few basic forms of assistance that nation states provide for children and families. Although not an exhaustive list, it is revealing. All information was obtained from the Clearinghouse on International Development in Child, Youth, and Family Policies at Columbia University.[13]

Because fertility rates in Western industrialized countries are below replacement level, many of the policies are meant to encourage pro-natalist behavior and therefore, increase the fertility rate. Countries like France, Italy, and Sweden have made deliberate pro-family decisions. Sweden has the most generous benefits for children and families and as a result has the lowest child poverty of all the countries listed. Sweden's 14-week maternity leave and 18-month parental leave with 80 percent of one's pay for 13 months are unparalleled. Sweden also allows parents to have up to 60 days off a year to care for a sick child or if the child's caretaker is ill.

In France prenatal and birthing expenses are paid by the state. Parents have available a 16 week, 100 percent paid leave and time off from work increases with the number of children. Then, too, France has universal, free preschool for 2- to 6-year-olds. In addition to a 5-month leave with 80 percent of one's wages, Italy also provides working mothers a 2-hour rest period per day for the first year of a child's life. Although Germany lags behind the other countries, especially in child care policies and early childhood education (Germany has part-time kindergarten), one policy

Table I.1
Cross National Comparison of Selected Family Policies for Seven Advanced Industrialized Countries*

Country	Maternity	Sick Leave	ECEC[a]	Health	Child Care	Direct Benefits
Canada	Maternity 50 weeks 55% of average weekly (80% for low wage) (Prenatal & postnatal covered)	6 weeks for gravely ill child/spouse/parent	Kindergarten 1/2 day	Universal (Provinces vary in coverage)	"Fragmented Data" Mostly unregulated family day care private pay	(Means-tested) Nat'l Child Benefit and Child Tax Benefit (80% of Fams.)
Germany	14-week benefit (Mom's earn pension 3 yrs. Credit equal to 3 years of work) Parental leave—2 years (income tested)	10 days per year, sick child <12 years old	3–5 years old 1/2 day	Mandated 90% population Preventive health care for children	Subsidized pre-school 1/2 day	Universal until 18 years of age Low-wage more (Child Tax Allow.) (Educ. Tax Allow.)
Italy	5 months paid Job protected	6 months job protected 30% of pay for sick/ disabled child	3–6 years old federal Paid 95%	Universal: children to age 12	Publicly funded/ Operated 3 months to 3 years old	Cash allow. (means-tested)
France	16 weeks (6 Pre-/10 Post-) Increases with no. of children (Universal maternity/ childbirth allow)	5 days for kids < 16 years old	2–6 years old Free	National: children < 19 years old	Public 3 months through 2 years old 1/4 paid by family	Cash (Not means-tested)

UK	26 weeks paid/job protected 26 weeks unpaid/job protected	13 weeks ill child Parental leave	Creating universal schools 3–4 year olds Part-time	National health	Few children in out-of-home care	Child benefit Work tax credit
US	No national maternity	12 weeks family leave unpaid Job protected (Companies with 50 or more employees)	No national Head Start (Means tested)	No national Medicaid <19 year old (Means tested) SCHIPS children	Subsidized (Means Tested)	Means-tested: Food stamps Public housing Earned income credit Child care credit
Sweden	14 weeks parental 2 weeks paternity Parental leave 18 months (80% of wages for 13 months)	60 days for ill child or ill caregiver	Publicly funded (municipalities must provide)	National for children	Universal	Housing allowance Child allowance

*Early Childhood Education and Care.

Source: The Clearing House on International Development in Child, Youth and Family Policies US, (2004 Germany) (2005 Sweden, Canada, France, Italy, UK).

worth noting is a 3-year state contribution to mothers' pension funds when mothers choose to stay home with their children for up to 3 years.

The table shows that the United States' closest ally, the United Kingdom, has a limited family-friendly system. Even at that, it is the United States that stands out as having the fewest family-friendly policies. The United States has no maternity leave per se. The Family Medical Leave provides for 12 weeks unpaid leave; however, the policy applies only to companies that have 50 or more employees. The United States has no national health care system, no national day care, and no national early education program except Head Start (a means-tested program unless a child is disabled). The United States does have Medicaid (a means-tested health care program) and a federal/state children's health insurance plan (SCHIP) for low-income children not covered by other health plans. Not only does the United States stand alone in the paucity of programs, but what programs do exist are not universal, as many are in other countries. One program that has been touted as a success by U.S. policy makers is the Earned Income Tax Credit (EITC) that allows low-income families to receive a portion of their taxes back. Though welcomed by those who can take advantage of it, families living on the edge have severe cash flow problems and should not be made to wait for a tax return to be able to pay for rent, heat, or groceries. One study found evidence that, in fact, 83 percent of families use the EITC to pay for their family's basic needs.[14]

Although the U.S. federal government has been reluctant to institutionalize universal family-friendly programs, some states are taking the lead. For example, California has enacted a paid 6-week leave at 55 percent of wages for births or illness. Unlike the U.S. Senate, California passed a measure to raise the minimum wage by $1.25 over the next few years. Other states have put minimum wage initiatives on their ballots. Massachusetts recently passed legislation to create statewide universal health insurance. A few states are considering paid leave for parents to attend children's school meetings and proposing tax credits to employers who offer family time off.[15]

The contributions of the authors in this text represent disparate analyses of systemic fault lines beneath families living on the edge—issues addressing the creation of better housing for families, research about how children in foster care have fared since the implementation of Welfare Reform, teens and inadequate shelter life, the unmet needs of children who are refugees, as well as the structured educational disparities in the public schools in the United States, especially for poor minority students. Although seemingly disconnected, taken together, the collective analyses shed light on a pattern of systemic failure to support children and families, especially those living in poverty. Each author offers recommendations for future directions.

Although ethnographic methods provide qualitative evidence, Armaline's analysis of an emergency shelter addresses the intersection of structured inequalities—race, class, and gender—for teens without homes. Families, especially single moms and kids, make up 40 percent of those without homes. Armaline reports that two systemic factors have precipitated increased homelessness: rising unemployment and the continued elimination of low-income housing stock in cities.

However, at the shelter level, Armaline finds that staff members treat the *social* problem of homelessness as the *individual's* trouble, clearly demonstrating a lack of what Mills refers to as sociological imagination. Thus, the focus of shelter treatment for teens is a program designed to facilitate the child fitting in and getting on track. Rather than addressing the causes and conditions of poverty—the extra familial, the staff's focus is on the teens' *unproductive responses*—the intra—to poverty. In this way the system remains intact, unchallenged and the individual is to be changed.

Wells analyzes the effect of welfare reform for families living in poverty in Cuyahoga County, specifically, those coping with issues of foster care. Wells notes that the child welfare system isn't in business to enhance the lives of families and children, but rather exists simply for the purpose of child protection. Wells' research finds a pattern: foster care children tend to be from impoverished homes with more than 75 percent falling below the poverty level. The mothers lacked transportation, a high school diploma, and have insecure housing arrangements. Before welfare reform, over 124,000 families received cash assistance; 4 years later, a little over 34,000 did. While politicians, policy wonks, and pundits extolled the declining welfare numbers, families suffered.

It is well established that child welfare policies aren't enacted to revolutionize the economic and political systems. If the system is ok, then it must be the individual who needs changing. If policy makers and social workers begin with the premise that the poor need to be changed, then mining for familial pathology yields individual problems (private troubles) and individual solutions. Welfare Reform of 1996, touted as the panacea to end poverty by making families responsible, limited assistance to families and shifted much of the fiscal responsibility for the poor to states. If Cuyahoga County is any indication, it hasn't made the lives of poorly educated women and their children any better. In fact, from Wells' analyses, it appears that under welfare reform in Cuyahoga County, foster care has been significantly extended for low-income children because fewer resources are available to help stabilize the families.

Henrici, Angel, and Lein's chapter uses an ethnographic study (part of a three-wave survey of 2400 families) and the interview of one participant to illustrate the multiple variables—education, health, housing, employment, child care, transportation issues—that often are the reason families stay impoverished. It could be viewed as an elaboration of issues families in Wells' study might have faced before becoming completely destabilized. The low-wage jobs that exist for poorly educated single mothers end up being more costly to them than beneficial because of the lack of child care and transportation. There are costs, too, from the physical and emotional demands of low-wage service jobs. Then, too, low-end jobs often require irregular hours, increasing the difficulty of obtaining child care. The authors maintain that in the face of the obstacles that Teresa (the interviewee) and others who share her experience, it is difficult to achieve familial stability. With the federal and state budget cuts to means-tested programs, the authors are warranted in their concern about the risk of intergenerational poverty.

Using a random sample of families in six California counties who reached their maximum time on Temporary Assistance for Needy Families (TANF), Gilbert-Mauldon, London, and Sommer ended up with 1,058 respondents. The researchers uncover the

complexity of poverty and multiple variables that impact families' ability to escape it—physical and mental health factors, family members with health issues, no public transportation. The researchers found that 60 percent of those without any barriers to employment—physical and/or mental health factors, transportation, housing issues, child-care problems—were employed. They found, too, that the more barriers, the less likely respondents were employed. Only 9 percent of those with four barriers were employed at the time of Wave 3 of the study. The authors conclude that CalWorks—California's welfare program provided a "cushion" for families who reached the 5-year limit of TANF, but have barriers to employment that California recognizes including: having a disability, caring for an ill or incapacitated person in one's home, being a victim of domestic violence, residing in a high-unemployment reservation or rancheria, or participating in a teen–parent welfare program. Gilbert-Mauldon, London, and Sommer's research is rich in the data they present to the reader, but a key factor in their study is that state and federal legislatures enact policies that impact families in need and decide a course of action based on the ideology of individualism or civitas. California has opted for less individualistic policies and implemented more humanistic policies for their families than those that exist at the federal level.

Curley's chapter analyzes the issue of concentrated neighborhood poverty. Federal programs in the 1970s provided the means for families living in poverty to move to white higher-income neighborhoods and had a positive effect on educational achievement for children and employment patterns for the mothers. The premise is that neighborhood matters. Curley's study presents more recent efforts, specifically, a five-city program implemented by HUD called: Moving to Opportunity (MTO) that relocates families to better neighborhoods and HOPE VI, a program initiated in 1993 to redevelop "failed" housing projects. Curley's findings illustrate how complex poverty is. While there is evidence that a "better neighborhood" improved mental health, there has been little positive impact on other basic needs areas and, to some extent, may have even had a negative effect on social networks and health of boys. However, Curley notes that the children may be the ultimate beneficiary of HOPE VI and MTO.

Three chapters provide analyses of public education in the United States, but from different vantage points. Tajalli's chapter offers an historical analysis of education as a source of inequality; Flores provides some historical background for her discussion of the No Child Left Behind Act of 2001. Finally, Duncan and Wolfe's chapter is a treatise on public education, but especially for black children living in poverty.

Tajalli examines the systemic inequities of public education and provides a discussion of the ideological roots of public education—from ideas of liberty and social justice to what he sees as failed neoconservativism. He points to the narrow, market-oriented approach today in public education in which blacks and Hispanic students are not segregated by law but by wealth. Blacks and Hispanic students are concentrated in high-poverty schools that have escalated de facto segregation and the inequities of public education.

A comprehensive analysis of the No Child Left Behind Act of 2001 is provided by Flores. A careful historical overview of public education in the United

States reveals that the major purpose was to ameliorate poverty and crime. Initially, it was offered to young children and then to adolescents as means for assimilating recent immigrants. Some children were excluded, some marginalized. By 1954, the Supreme Court ruled that segregation was illegal and Flores chronicles the subsequent legislative initiatives over the years to right the historical wrongs. For example, 12 years after Brown versus the Board of Education, President Lyndon Johnson signed a law authorizing federal funds to aid students deprived of an education. One program instituted was Head Start. Then in the 1980s, "A Nation at Risk" reported the deficiencies of public education, but little was done to effect change.

In 1994, President Clinton signed the Improving America's Schools Act to improve education for disadvantaged children. And in 2001, President Bush's No Child Left Behind was enacted to close the achievement between children's whose parents are poor and children whose parents are middle class. However, down Flores points out that the effect has been for teachers to teach to the test, watering down academic content. She reports that there is some evidence that students are not becoming better readers, but are learning a limited vocabulary and basic level reading skills. Flores also critiques the voucher system for those wishing to transfer from a low-performing school as not sufficient for full tuition of higher quality school.

Duncan and Wolfe' have written a cogent analyses addressing the state of public education in the United States especially as it continues to disadvantage black children living in poverty. The authors cite numerous variables including: funding inqualities, the lack of black educators, white flight to private schools, under-qualified teachers, dated curriculum, lack of modern technology even when it's available, resegregation within schools and within courses, adultrification of young black boys, and underfunding of No Child Left Build. Finally, the authors pay homage to the remarkable feat of countless unsung heroes whom they refer to as "gap closers"—those who are able to elicit academic excellence from students who have been summarily "written off" by the educational system.

Finally, in an insightful and thorough discussion of the difficulties that refugee parents and children face while attempting to adjust to life in the United States, Xu and Pearson examine Somali and Somali Bantu families in Denver, Colorado, in 2004. The difficulties stem not only from the differences between Somali and United States culture (though many), many of the problems stem from the inadequacy of U.S. policies for aiding in the settlement of refugee families. Refugee families are expected to become employed and self-sufficient within the first 8 months of their arrival as refugee cash assistance and refugee medical assistance are provided up to that point. Although families struggle with English, after 8 months, they must obtain Temporary Assistance for Needy Families. Xu and Pearson note that children's needs and needs assessment are not spelled out in the refugee resettlement program. The authors note that the number one priority for refugee resettlement is employment. The emphasis on employment harkens back to the notion of individualism and the need to be self-sufficient; however, is it a realistic expectation for those who have been traumatized to the point that they have sought refuge in a foreign country? Is

it a realistic expectation for those who have language barriers and dramatic cultural differences?

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CHAPTER 1

(Re)Conceptualizing Adolescent Homelessness: Misdirection of the State and Child Welfare

William T. Armaline

Conventional definitions of homelessness (roughly, those without consistent shelter of their own) are at best incomplete in defining the conditions of adolescents[1] who populate city streets and shelters. Studies of homelessness typically focus on adult and family populations, without giving much attention to the unique experience of unaccompanied minors whose homeless experience may also be defined by periods of exposure to child welfare agencies. The inadequacies of conventional approaches to homelessness became quite clear to me while conducting qualitative research at an emergency youth shelter for adolescents (Faulk House). Drawing from relevant literature and ethnographic field work conducted at Faulk House emergency shelter, I address the following questions here concerning adolescent homelessness and the connection between marginalized adolescents and the state: *What would a useful, accurate conceptualization of "adolescent homelessness" include? How might this inform child welfare policy and the role of child welfare agencies in the treatment of marginalized youth?*

I (re)conceptualize adolescent homelessness as a (re)produced social problem that may be primarily understood as an expression of intersecting structured inequalities (along lines of class, "race,"[2] and gender). The defining characteristics of adolescent homelessness are tied to and shaped by child welfare policies, an interaction with or aversion to child welfare agencies, and patterns in child removal. Data collected at Faulk House shelter supports the (re)conceptualization offered here, as it is consistent with the narratives and observations of shelter residents and staff. Further, data from Faulk House and recent studies of the foster care system suggest that child welfare systems (the state) take an approach of child "protection," implicating adolescent homelessness as the result of individual pathologies (of guardians or youth involved). Finally, I argue that this approach is problematic in that it fails to 'treat,'

and potentially exacerbates adolescent homelessness as a *social* problem linked to (re)produced inequalities.

Existing demographic information and academic research on youth and adult homelessness tend to employ a conventional, or "literal" definition of homelessness as, "those who sleep in shelters provided for homeless persons or in places, private or public, not intended as dwellings."[3] While many of these studies[4] point to the importance of researching and alleviating literal homelessness, (1) conventional definitions of homelessness are conceptually insufficient to explain the full range of experiences unique to ambiguously labeled "homeless" adolescent populations; (2) the experience of adolescents and adults differ in their connection to structured inequalities and their options out of poverty and marginalization, which exclude (for the most part) entrance into the formal labor market.

LITERAL HOMELESSNESS IN THE UNITED STATES

Families (particularly single women of color with children) and children are still the fastest growing homeless populations in the United States and are generally the largest poverty-stricken groups.[5] Under the current federal administration homeless populations have expanded largely due to rising un/underemployment rates and elevated housing costs.[6] In an atmosphere of state fiscal crises and the funneling of federal spending away from social services toward "national security" and the military industrial complex, the G.W. Bush administration has done little to combat the rising number of dislocated adults, families, and children. For example, the department of Housing and Urban Development (HUD) received an increase of $35 million while Congress simultaneously cut public housing operating funds by 30 percent in mid-January of 2003. "To give a sense of how much that means in Washington budgetary terms, $35 million is equal to the money set aside to help keep insects from crossing the border."[7] In sum, conditions for those who are homeless or "at-risk" are becoming more and more difficult in the context of rising poverty and shrinking welfare benefits.[8]

Meanwhile, many efforts have been made on the part of local and state politicians to sweep homelessness under the rug in many large U.S. cities such as New York, Chicago, and Seattle.[9] Problems faced by homeless populations have "not provoked the outcry that the rise in homelessness did in the 1980s . . . You don't see homeless people as much as you did in the '80s because the one great policy initiative of the past 20 years has been to move them from grates into the newest form of the poorhouse, the shelter."[10] As a result of antivagrancy laws, many U.S. cities have also detained and/or incarcerated homeless populations, keeping them (temporarily) out of the public eye at public cost.

Children make up 40 percent of the nation's "literally" homeless population, and for the time they remain without homes or families, and for indeterminate periods of time after, homelessness may be the defining feature of their lives.[11] Studies of homeless families by the Department of Education and by those in the field of social work suggest that homeless children face a number of challenges both academically

and socially.[12] These challenges include "exhaustion, lack of time and a place to do homework, coordinating school schedules with work schedules, instability, out of school periods, frequent changes of school, and stigmatization,"[13] not to mention any number of potential problems associated with extreme poverty (such as not having resources for nutrition or medical care). Further, homeless youth are disenfranchised by the competitive/corporate structure of schooling, which systematically discriminates against poor and transient groups of youth.[14] For example, contemporary educational policies such as those outlined in the No Child Left Behind Act[15] emphasize "high-stakes" and proficiency testing as primary measures for educational credentialing. Where success on these tests is dependent on a consistent exposure to test-related curriculum, cultural capital, and household resource, they have been shown to disenfranchise poor youth—especially in non-"white" communities.[16] Youth without consistent shelter often spend periods of time out of school, transfer schools more often than other youth, and experience the multitude of problems related to severe poverty, educational credentialing, and establishing self-sufficiency.

Literal homelessness can then be viewed as a barrier to youths' educational and economic success, and a contributing factor to the reproduction of socioeconomic inequality. As such, "literal" youth homelessness is an important issue for sociological inquiry geared to inform and influence social policy.[17] It is somewhat simple to recognize poverty and homelessness among young populations as "bad" for the well-being of affected communities. Still, efforts to define and theoretically conceptualize youth or adolescent "homelessness" as a unique social phenomenon that goes beyond "literal" homelessness have proven difficult and largely unsuccessful in various fields of research. Logically, this contributes to our collective inability to address it.

A CHALLENGE TO CONVENTIONAL EXPLANATIONS OF "LITERAL" HOMELESSNESS AND POVERTY: MATTERS OF AGE AND STATE INTERVENTION

Sociological work on the topic of youth homelessness, specifically those unaccompanied by or separated from parents, is virtually nonexistent. "There is relatively little written [on homeless children], and the studies that do exist refer primarily to children living with their parents in shelters."[18] Media coverage and mainstream studies of homelessness largely fuse adult, youth, and family populations into a single category that typically describes "street" populations. In what is still considered a fundamental work on adult homelessness, Snow and Anderson[19] investigate how different groups of adults become homeless, and how each group deals with the realities of homeless life and rationalize their own existence on the street. Their work highlights the issue of inadequate resources and ineffective social programs for those affected to obtain and sustain shelter. For instance, Snow and Anderson point to a lack of reasonable employment and the various barriers that homeless adults encounter in getting and keeping jobs. While their research and others like it provide insight for understanding adult homelessness, the experience of homeless youth must be seen quite differently.

To a degree, the socioeconomic situation of impoverished youth can be related to the problems of un/underemployment and poverty among adult guardians. In other words, it points to the connection between poverty and homelessness for all of those unable to afford sustainable housing. But this approach cannot explain the experience of youth who, once disenfranchised from home and school, cannot look to the formal labor market for options out of poverty. Instead, legal minors turn to, or are taken by state agencies through the child welfare and juvenile justice systems, or must survive through methods of street life.

The study of inequality as it affects homeless children and adolescents fundamentally challenges some previously conventional approaches to stratification and poverty. Mere age prohibits most youth from gaining legal, economically sustainable employment. Consequently, the socioeconomic situation of most youth is not a function of their individual participation in the labor market. This should be seen in contrast to: (1) conventional approaches to inequality that reduce socioeconomic or class mobility to "a matter of individual responsibility,"[20] and (2) "culture of poverty" explanations of inequality suggesting that populations such as the "urban poor" develop culture in opposition to conventional employment,[21] and thus remain impoverished. The erroneous suggestion that poor populations have a culture that values poverty, denigrates hard work and education, and values welfare benefits over jobs is insufficient in explaining socioeconomic inequality among youth *or* adults. These previously conventional arguments place little importance on the effects of institutional constraints, such as the class/"race"/gender-oppressive structure of public schooling,[22] public assistance programs,[23] the criminal justice system,[24] and child welfare policy[25] on marginalized populations. The experience of "homeless" youth cannot be explained through a perspective of inequality centered on participation in the labor market, and one's willingness or cultural susceptibility to work. Instead, an appropriate conceptualization of youth or adolescent "homelessness" must begin with an approach that recognizes the structural barriers involved in escaping both "literal" homelessness and poverty.

The experiences of minors with poverty and "homelessness" are unique in that their exposure to social institutions and position within the political economy are significantly different than adults. Poverty and "homelessness" among youth are more likely expressions of the socioeconomic conditions of their families and communities rather than of individual behavior and employment. In addition, *poor or "homeless" minors are more likely than adults to encounter state welfare agencies due to child welfare and child "protection" policies*.

At this juncture, the experience of unaccompanied minors, particularly adolescents, may be separated from that of accompanied youth (families). Youth in homeless and/or impoverished families are still under the legal custody and protection of their parent(s) or guardian(s). In this sense their experience with social welfare agencies and their socioeconomic position are directly mediated by their adult guardian(s). In short, they are much less alone in their dealings with life in and outside of streets and shelters. The failure to differentiate between accompanied and unaccompanied homeless minors is problematic in that many residents populating youth shelters

were removed from their previous homes or the street, and placed in shelters by state agencies.

Further, once removed by or placed under the custody of the child welfare system, the experience of *adolescents* may differ greatly from that of younger children and infants. Adolescents can be, and typically are, placed in a variety of disciplinary or "treatment" institutions that cannot or do not house younger children such as group homes, juvenile detention, "independent living" arrangements, and shelters for unaccompanied youth. Adolescents are also much less likely candidates for adoption,[26] ensuring longer periods of exposure to shelters and temporary "placements."

A working definition of "adolescent homelessness" should apply to the unique social situation of adolescents in the context of inequality. The socioeconomic situations of all youth are not simply functions of personal choice. They are more often and more likely to be expressions of the socioeconomic position of their guardians and communities. Unlike adults or entire family units, homeless minors may be taken out of the home or off the street, via law enforcement, social workers, and the child welfare system. Adolescents have unique experiences with the child welfare system, particularly regarding their limited chances for successful, permanent adoptive placements. In sum, unlike its adult, family, or much younger counterparts, *adolescent* homelessness should be defined by a lack of housing and the exposure or aversion to child welfare agencies and state custody. As the site of my research, Faulk House shelter is one such agency.

DATA COLLECTION METHODS: THE STUDY OF STATE WARDS

Faulk House shelter is located in an economically depressed neighborhood of color (primarily African American and Puerto Rican) in a mid-sized New England city. The shelter, run collaboratively by a charitable organization and the state's Department of Child Welfare (DCW), is designed to house up to 14 children at a time from ages 12–17 who have been displaced by the state (removal) or by circumstance ("off the street"). Because of its state regulated partnership with DCW, all Faulk House residents must be (re)entered into state custody.

I gathered data as a volunteer at Faulk House shelter. Work as a volunteer included participating in youth programs and spending time with staff and adolescents in activities, field trips, mealtimes, and most all other daily routines. This provided a wealth of data on "the physical and institutional setting in which [homeless adolescents] live, the daily routine of their activities, the beliefs that guide their actions, and the linguistic and other semiotic systems that mediate all these contexts and activities."[27] I used participant observation to develop intimate knowledge of state and shelter policy, how it is or isn't actually applied, and the environment it creates for adolescent residents. Further, intimate qualitative data was most appropriate for understanding the history and experiences of residents from direct observation/interaction, rather than from secondhand surveys and records.

These qualitative data were collected over the course of approximately 9 months (about 250 hours) at Faulk House shelter. To avoid the ethical problems involved

with more covert research,[28] I conducted research "in the open" as a graduate student interested in shelter life and in volunteering for the youth program. Time sampling (conducting fieldwork on a variety of times and days) was used to collect a more exhaustive set of observational data.

In the interest of ethics and sound methodology, any field study of minors deserves particular consideration. Studies on youth in various settings have employed the use of relatively nonauthoritative adult roles such as volunteers or classroom participants.[29] This helps to reduce the power disparity that affects interaction between the youth informant and adult researcher, and increases access to observing and partial inclusion into adolescent "peer culture."[30] In playing my role as a volunteer at Faulk House, I avoided taking on the disciplinary responsibility of a staff member (with obvious safety-related exceptions). This undeniably decreased the level of authority that the youth residents attributed to my role in the shelter. Such practices are also consistent with feminist methodologies that recognize the importance of identifying, addressing, and minimizing the collection and reporting biases caused by differential "positionalities" between researchers and informants.[31] As also suggested by feminist methodology, researchers must be constantly "reflective"[32] and conscious of these disparities in the collection and reporting of data. Reflective practice was particularly useful in determining when and how to approach residents with questions (especially concerning histories and traumatic experiences), and in determining how, and whether to report particular data based on personal and professional ethical standards.

In total, I was able to observe and interact with 26 shelter residents over the course of my research. While I was unable to conduct formal interviews with shelter residents (state law), informal interviews were conducted with all residents through conversations over meals, recreational activities, and general "down time" in the shelter lounge or on the shelter playground. Many of these conversations were fruitful and typically instigated by residents. In these scenarios, conversations about the everyday interests of the adolescents would often expand into discussions of their histories and shelter experiences. Further, these scenarios presented environments in which residents were not "put on the spot" as subject to a questioning authority figure, producing what seemed to be more candid and culturally situated interactions. In the interest of ethical methodological practice, a great deal of discretion was used in recording data on some interactions. Though this meant not using some interesting and useful data, it seemed questionable to violate even informal agreements of personal confidentiality (marked by comments like, "no one really knows this," or "you're not going to tell anyone, right?" or "I don't really talk about it") with those potentially marginalized by their need for care and support.

Power differentials and issues of "positionality" were less problematic in the observation of shelter staff. Many of them were young adults (six women/three men)—some even graduate students in the field of social work. In addition to informal interaction with and observation of the staff, I employed eight semistructured interviews, informed by previous observational data to probe for staff member accounts of particular social events that were unavailable or previously unobservable.

The semistructured, in-depth interviews with Faulk House youth staff, the shelter social worker, and program coordinator reinforced and supplemented data collected through participant observation and informal interviews with all informants.

FAULK HOUSE APPROACH TO ADOLESCENT HOMELESSNESS: "PROVIDING STRUCTURE"

For purposes of this study, the experiences of Faulk House residents and the knowledge of shelter staff may be used to inform a sociological (re)conceptualization of adolescent homelessness. In contrast, an analysis of Faulk House shelter curriculum illuminates the state definition and approach to adolescent homelessness employed by child welfare agencies. Specifically, I maintain that Faulk House Shelter propagates a curriculum of "treatment" emphasizing "structure" and "consistency" in terms of discipline in daily life.

This emphasis became clear in several conversations and all interviews with staff about their jobs, and the attempt to "give something positive" to their adolescent clients. The program coordinator explained:

> I think what most of us try to do is show the kids how much better it is to live in a structured environment. Structure is good, 'cause these kids don't have any structure, because if we can form a routine with them and make it comfortable, I think they open up a lot more . . .'Cause I think they don't have that where they're coming from.

The basis for addressing the problems of homeless adolescents according to Faulk House is not only to supply physical necessities (food, shelter, etc.), but also to provide the "structure" that adolescents may not have experienced in their previous environments. As the shelter social worker explained, "a lot of the kids really have not had that (structure) through a lot of the placements they've lived, either there hasn't been good family life or good supervision in the home." Faulk House shelter provides "structure" through operating as a "quasi-total institution"[33]: providing routinization, strict boundaries, and evaluation of individual behavior within the institution without providing complete, or "total" social control.[34]

Shelter staff and policy manuals presented this approach as a strategy to provide predictable and safe environments for youth to learn responsibility and self-discipline. According to one Faulk House staff member,

> It's not like we lock 'em down, but we lock 'em down. You know, they don't get a chance to go out and do, you know, like a regular 15 year old—get to hang with their friends with your friends and at like this time come back. Because we're so structured and our job here is like to keep 'em safe. That's my first main goal is to keep them safe. And I think that's like every staff. We're so concerned with them being out there, that, you know, I think it's on us that we come down so hard. Because we don't want them to be out there, you know, because we don't think it's safe out there or whatever.

As temporary guardians for residents, the shelter must ensure safety for the adolescents it houses as an organizational necessity. Most staff members seemed to internalize the policy goal of "protection" as a response to the great deal of abuse some residents experienced before entering the shelter. Part of the shelter's effort to protect its residents is to condition them to avoid interactions that may "get them into trouble." Theoretically, residents learn to avoid potentially abusive relationships or interactions with those who may be a "bad influence." Further, "providing structure" serves the purpose of social control in providing predictability for shelter staff and safeguards for the shelter and the Department of Child Welfare (DCW), who are both liable for the well-being of youth residents.

Most importantly, the shelter's approach to treatment and operation reflects an image of adolescent homelessness as an *individual* rather than *social* problem.[35] During a conversation about the shelter's client population at the intake desk, two staff members discussed their perspectives on treatment and the child-care "system":

> Staff 1: "These kids [residents] think that none of us had problems. The system makes them think that they've had the worst life. That's what be messin' them up, yo . . . My foster daughter tries that shit at school—saying some things about her mother and stuff to the school and to me. I tell the school, 'she may not have had control of what happened to her then, but she'—you have control over what you do right now—that stuff [life before state custody] is over. So you follow the rules and take responsibility for what you do!"
>
> Staff 2: "It's like some of these parents just be droppin' their kids off."
>
> Staff 1: "YES. It's the parents, they drop off their kids and go on with their lives like they don't have any . . . I was eighteen when I had my daughter. You have nine months—you know that shit is coming. I worked three jobs to make sure that my daughter didn't grow up on welfare. The system doesn't teach them anything, they just go around in circles, it's a cycle. The skills they learn, they need . . . they don't learn that stuff really. They don't have the life skills."

Though the staff members identified that residents may find themselves in a "cycle," they clearly emphasized the individual behaviors of adolescents and their parents in explaining their path into and out of marginalized positions. This perspective mirrors the dominant ideology on child care where "in contemporary U.S. society, both being employed and caring for children are seen as individual responsibilities."[36]

In addition, "taking responsibility," hard work, and picking up "life skills" were seen as the lessons residents "need." According to program manuals and staff accounts the discipline and "life skills" learned at the shelter are to "get the kids on track" for finishing school, working a job, or living in their new placement. Part of providing "structure" is to teach shelter residents to restrict, redirect, and routinize their individual behavior in ways that conform to the demands of school, work, and life. From an institutional policy standpoint, this reflects an approach to treatment or "care as instruction,"[37] where residents are meant to develop particular skills in addition to receiving provisions of biological necessity and physical protection. Through efforts to "keep kids safe" and to provide "structure" to the lives of residents,

shelter curriculum emphasizes the individual behaviors of residents and previous guardians as the defining factors behind residents' marginalized positions.

In the following section I problematize this approach as inappropriate and ultimately ineffective, and as connected to the larger movement toward child "protection" as the primary strategy of child welfare systems in caring for (typically) impoverished youth. Drawing from data collected at Faulk House and from contemporary research on public assistance and foster care, a more accurate and appropriate conceptualization of adolescent homelessness comes into focus.

(RE)CONCEPTUALIZING ADOLESCENT HOMELESSNESS

Connections: Structured Inequalities, Literal Homelessness, and Child Removal

As noted above, "literal homelessness" provides us a starting point, but is insufficient in capturing the unique nature of the adolescent experience as described in the sections above. In contrast to adults, minors may enter "shelters provided for homeless persons" through a forceful and lawful removal from their home and guardian(s).

In the United States, the social problems of youth and adolescent (literal) homelessness, child abuse, and general child "protection" are simultaneously addressed and constructed mainly through the state (DCW) and child welfare agencies (Faulk House). Adolescents removed from the home (voluntarily, by court order, after being arrested, or found without housing by public authorities) generally enter a series of state, or state-sponsored institutions designed to temporarily or permanently house them. During their displacement, adolescents within the system remain under state custody, supervised in a variety of institutional or foster care settings, until they are either returned to their previous guardians, age out of the system, or until parental rights are terminated (resulting in permanent state care or adoption). This is the case for all adolescents within the child welfare system, whether removed by the state based on substandard living conditions (as one form of "neglect" or parental negligence), removed as the result of physical or sexual abuse, abandoned by guardians (also "neglect"), left unattended after the imprisonment of parents, or willfully turned over to state custody on their own or guardian's behalf.

Patterns in child (including adolescent) removal are strongly connected to patterns of inequality and literal homelessness. Child welfare policy has formed in concert with economic welfare reform to shrink antipoverty and family preservation programs while increasing the rate of parental rights termination and the removal of minors from poor, especially African American families.[38] This exacerbates the oppressive effects of economic and racial inequality for the affected families and minors. Perhaps "the fundamental flaw" of the child welfare system is its formation as a child protection agency.[39] In the name of protecting children from neglect, unfit housing, and/or abuse, minors are removed from the home and placed within the child welfare system.

Many of the conditions from which minors are "protected" may actually be symptoms of poverty, rather than poor parenting, degenerate culture, or parental

immorality. Dorothy Roberts explains how "most cases of child maltreatment stem from parental neglect,"[40] and those cases of "neglect" typically result from conditions of poverty. Poor parents who are economically unable to provide enough food, clean and safe housing, medical care, child care while away at work, transportation to school or other appointments, or proper clothing for their children (forms of "neglect") may have their children removed and/or parental rights terminated by child welfare authorities. Poor parents also lack the economic cushion to handle personal crises that more affluent parents would have. These crises may include, "becoming sick or injured or losing a job; splitting up with a spouse or partner; developing a drug or alcohol or gambling problem—[all of which] can result in a child being suddenly without a home."[41]

Several Faulk House residents had experienced literal homelessness and/or child removal as the result of such "neglect." Katrina, a 16-year-old African American, entered Faulk House when she was found to be caring for her younger sibling in the absence of parents who had both recently gone to prison for drug-related offenses. Talking one day in the lounge, she told me how she was "picked up":

> It wasn't even that late or nothin'. My older brother had come around [to their house] and we had some of our people over—a party or whatever. I guess it was too loud, cause our neighbor—nosey, for real!—whatever—called the cops. The cops came and everyone took off. When the cops were like, 'where are your parents?'—Well, it was only me and my little brother staying at the house so they took us. My mom wanted me to watch him and the house and everything so we didn't get all split up.

Katrina had no relatives capable of caring for her (her aunt, battling a drug addiction, was not seen fit by Katrina or DCW to take custody) and chose to take care of her siblings so not to be "split up" or placed in foster care. Upon entering state custody, Katrina bounced in and out of Faulk House shelter while her younger siblings were placed in separate foster homes.

The connection between poverty and the increased likelihood of imprisonment in the United States is widely documented.[42] Several studies also point to the operation of institutional racism in the U.S. criminal justice system, and the intersection of "race" and class in the increased likelihood for (especially poor) people of color to experience imprisonment.[43] Thus, the likelihood for Katrina and others like her to experience literal homelessness as the result of imprisonment may be connected to the intersection of racial and class inequalities. Katrina entered state custody because of her family's lack of human and material resources to care for her and her siblings following the imprisonment of their parents. Her entrance into state custody was as much a matter of poverty, and potentially institutional racism, as "neglect."

Also consider the case of Maria, a small, quiet, 13-year-old Puerto Rican girl from an area neighborhood, who stayed with her grandparents out of economic necessity and in an attempt to continue attending her middle school while living with her own family. Upon inspection by state social workers, the home of Maria's grandparents

did not meet the size requirement necessary for the amount of people in the home (they were already caring for at least one other grandchild). As a result, Maria was removed from the home and placed under state custody. As explained by a staff member,

> It's a shame because, [the grandparents] are good people. They come to visit her like, every other week—you know, when they're allowed. They're already taking care of some of her cousins—that's the thing, they didn't have enough room in the house. DCW says you have to have so many rooms for so many kids. They've been trying to find a bigger place, but it's hard 'cause, you know, they're older and don't make much money.

Over the course of a year, efforts by Maria's grandparents to meet the standards of DCW continually failed—she remained in Faulk House for the entire duration of my research. The ability for Maria's parents and grandparents to care for her (to state standards) was limited by *poverty*. She entered and stayed in a shelter for homeless adolescents because her grandparents could not afford a large enough home. In any case, Maria was removed from what all accounts described as a "caring home" as a result of poverty, masked and labeled as parental "neglect." Again, Maria's case illustrates the connection between structured inequalities and both the experience of literal homelessness and life under state custody in shelters and state agencies.

In addition, both "race" and socioeconomic status affect the likelihood of child removal in a more direct sense. Poor, especially African American, parents are more likely to be reported to child welfare authorities for parental neglect or mistreatment.[44] This is primarily due to increased, and, in many ways, oppressive exposure to the state through welfare authorities, social workers, and the police. Further, poor parents are less likely to exercise their legal rights through the assistance of private attorneys.[45] In contrast, problems concerning child care among more affluent and/or "white" families are more often treated as "private matters."[46] In the child welfare system's definition and detection of inappropriate living conditions for minors, "poverty—not the type or severity of maltreatment—is the single most important predictor of placement in foster care and the amount of time spent there."[47] This applies not only to foster care, but also to placement in other child welfare institutions more often experienced by adolescents such as group homes and emergency shelters.

Even forms of maltreatment such as physical, mental, or sexual abuse may be primarily connected to poverty and access to resources—the same factors that contribute to literal homelessness. For instance, "poor parents can't afford to seek counseling, hire a nanny, or take a vacation"[48] in order to alleviate stress (only made worse by poverty), or to treat psychological conditions that may contribute to such abuse. One's socioeconomic condition (affected by class inequality and through structured racial and gender inequality) affects the likelihood of abuse to take place, and state reaction to that abuse.[49] Further, Hill[50] points out that though African American youth are disproportionately taken into state custody via the child welfare system, "black families do not maltreat their children more often than white families . . . and, when

class and other risk factors are controlled for, blacks have *lower* rates of abuse and neglect than whites." Again, we see how structured inequalities—including institutional racism—contribute to the state removal of adolescents who are disproportionately poor and/or youth "of color."

We may also consider the role of gender inequality here: take for example, the case of a mother whose male partner abuses her and her children. The mother's ability to remove herself and her child from the potentially dangerous environment is based on her own resources, web of support, and the degree to which she depends on the support of her abusive partner. This was the case for the Smith sisters (one 13 and one 16), who I grew to know through the duration of my research. Over the course of 2 years they were beaten and sexually abused by their stepfather and his acquaintances, who paid the stepfather for access to the sisters. Their mother was both economically and chemically dependent (he supplied drugs for her addiction) on the stepfather, who also physically abused her. The younger sister on one occasion showed me the scars from falling off the motorcycle of her "boyfriend" (an acquaintance of the stepfather). Here we see first, the great adversity faced by homeless adolescents, which understandably fuels policy initiatives toward child "protection." Second, and more importantly, we see how gendered inequality (manifested in the poverty and gendered oppression of women and single mothers) influences the ability of parents to care for their *own* children, increasing the potential for child removal, and/or entrance into literal homelessness.

We must also consider how the reduction of social services and public assistance may also decrease many parents' ability to care for their children or deal with environments and effects of abuse. The connection between systemic/institutional racism,[51] socioeconomic inequality and patterns of child (including adolescent) removal goes beyond the policies of the child welfare system to include recent cuts and revisions of welfare benefits by the state:

> The federal welfare law contains funding provisions that are more likely to disrupt than strengthen poor families. It leaves federal funds for foster care and adoption assistance as an uncapped entitlement while reducing and capping federal funds for cash assistance to families and for child welfare services that support families . . . A child welfare agency faced with a family whose TANF benefits have expired may choose to place the children in out-of-home care rather than find the funds needed to preserve the family.[52]

Because of reduced welfare benefits, already poor families lose more resources needed to provide adequate childcare. Rather than providing parents and families the support needed for family preservation, the state expends *eleven times* more funding toward removing minors from the household on the basis of parental "neglect."[53] Instead of treating the causes and conditions of *poverty* through providing benefits, educational training, or health services, the state often responds to the situation of poor families by simply removing minors from the home, often resulting in the termination of parental rights.

The "Runaway" Question

Do cases of "runaway" or previously *un*impoverished youth challenge the model for adolescent homelessness under construction here? One body of literature, commonly mistaken for the study of homeless youth, is the sociological, social-psychological, and criminological study of "runaways," or "runaway adolescents." This literature is of limited use here for several reasons: (1) only about 2–11 percent of literally homeless adolescents (on the street or in shelters) are runaways;[54] (2) many studies of runaways actually concentrate on runaway behavior, or the phenomenon of leaving the home;[55] (3) it would be a grave mistake to approach adolescent homelessness as a behavioral issue—for most literally homeless adolescents, a moment of *choice* may not have led to their compromised position. As Schaffner explains, "the experience of poverty, disadvantage, and need will influence the New York City (homeless) street survivor differently from a Palm Beach teen crashing at a friend's pad."[56] Both of these adolescents would exhibit "runaway behavior," though only the one living on the street would be conceptualized here as "homeless" because their impoverished position did not allow for other options for survival outside of street life or entrance into state custody.

It should also be noted that not all literally homeless adolescents come from impoverished homes, particularly in the case of some long-term runaways. Yet the general patterns of literal homelessness, and the likelihood for adolescents to become and remain literally homeless and to depend on welfare support structures (the outcomes of runaway behaviors) are strongly linked to socioeconomic factors. Once detached from other support systems (if they previously existed), all literally homeless youth may face similar barriers to succeeding in the worlds of school and work while literally homeless, or while in state custody. Further, for those who manage to stay on the street, the street experience for adolescents is mediated by an aversion to child welfare agencies. That is, rich or poor, they are only on the street for as long as they can slip (consciously or unconsciously) under the radar of police and social workers.

Literal Homelessness and State Custody as Overlapping Experiences

Where "neglect" is increasingly used as the grounds for child removal/entrance into state custody, it is also the grounds for taking in (literally) homeless adolescents or potentially removing them from (literally) homeless families. As explained in previous sections, literal homelessness typically includes those who stay in emergency shelters designed for homeless populations. At Faulk House (as with any other shelter in its resident state), any unattended minor *must* be reported to DCW. In fact, most Faulk House residents were actually placed at the shelter by DCW rather than entering from "the street." In short, for many shelters and agencies like Faulk House, entrance into a shelter means entrance into the child welfare system.

The overlap between literal homelessness and state custody is also reflected in the correlations found between histories of foster care and literal homelessness. A report by the National Alliance to End Homelessness found from an analysis of previous

studies, records of foster care histories, and surveys of homeless populations in several urban areas (Chicago, NYC, etc.) that:

> There is indeed an overrepresentation of people with a foster care history in the homeless population. The research also demonstrated that childhood placement in foster care can correlate with a substantial increase in the length of a person's homeless experience and that people who are homeless frequently have had multiple placements as children, both in foster care and in the homes of families and friends (unofficial placements). The Alliance also discovered that homeless people with a foster care history are more likely than other people to have their own children in foster care.[57]

Put simply, entrance into state custody does not ensure an exit from literal homelessness.

It is also a common mistake to assume that the current methods employed to house state wards (typically foster care) ensure the safety and well-being of young clients. Recent events suggest that foster care populations may suffer different rather than fewer problems than those who are literally homeless. For example, reports in 2003 showed that Florida's agencies could not even find entire populations of their state wards after reports of abuse and poor records.[58] Thus we cannot simply assume that entrance into state custody ensures long-term escape from poverty, abuse, or a return to literal homelessness. If one were to follow a conventional definition of homelessness as it applies to adolescents, entrance into state custody, foster care for example, would indicate the temporary or permanent end of one's homeless experience. I suggest instead that an adolescent's involvement with child welfare agencies is a *defining characteristic* of their homeless experience and of "adolescent homelessness" as a social phenomenon. From this perspective, it is also possible to view adolescents who are *removed* from the home as part of the adolescent homeless population.

Child Welfare Policy and Adolescent Homelessness

Adolescents, especially those from poor and/or African American families, may be removed from the home and placed in shelters (like Faulk House) or other institutional arrangements created to house adolescents during their displacement. As already suggested, it is possible to include adolescents who are removed from their home as part of the homeless adolescent population in their (often) sharing of the overlapping experiences of state custody and literal homelessness. *Therefore, in an effort to "protect" adolescents from inappropriate living conditions the state, by removing adolescents from the home, while cutting antipoverty/economic welfare programs,*[59] *may actually CREATE adolescent homelessness*.

The reasons behind adolescent poverty and homelessness are thus mystified through public policy in "protecting" children—treating the problem as the pathology, immorality, or cultural deficiency of parents rather than as a social problem of extreme and oppressive economic inequality. This is *not* to suggest that all adolescents are

removed from the home unjustly, or that none benefit from home removal or shelter under state custody. Instead, it suggests that the public response to adolescent homelessness and "child welfare" as a *social problem* is at least misdirected in not recognizing poverty and structured inequalities as the key contributing factors to the marginalized position of many families and youth.

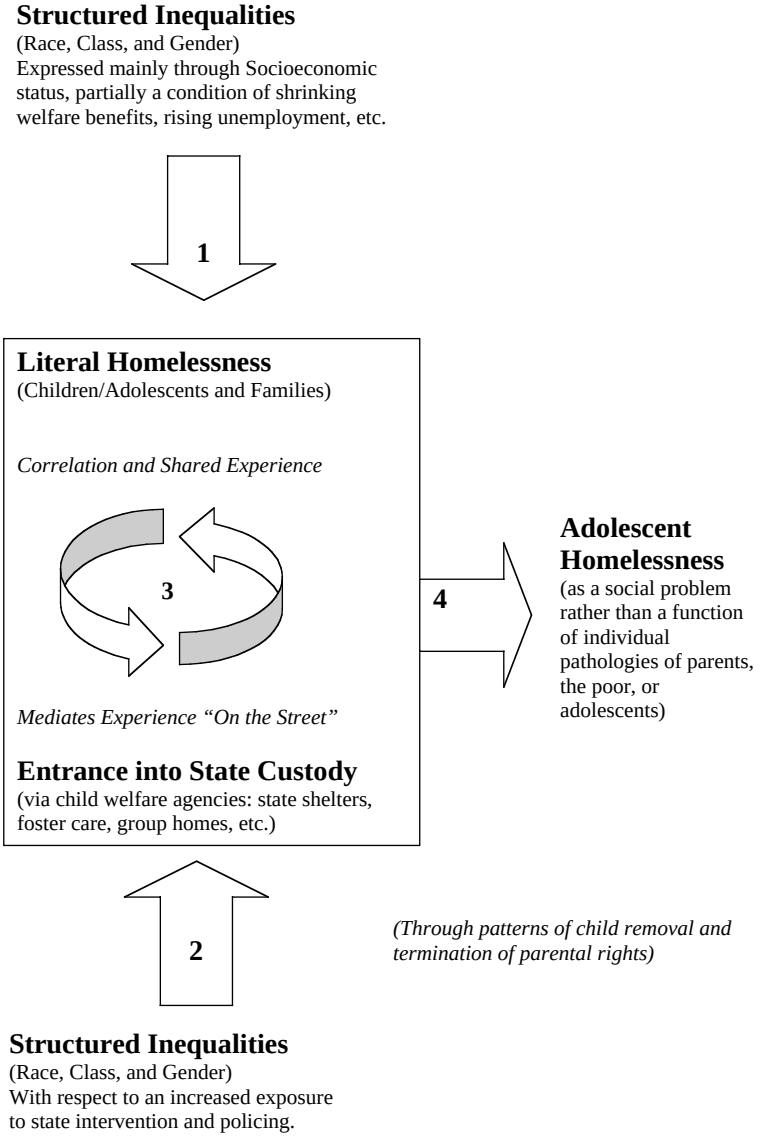
This misdirection is clearly manifested in the curriculum of Faulk House emergency shelter that emphasizes providing "structure" to residents through routinizing and evaluating their behaviors while also "keeping them safe" from outside influences (such as previous guardians, friends, etc.). Again, this is not to suggest that the shelter "does no good," or that shelter staff are not dedicated, or are lazy, or naïve. Like the rest of us, they are forced to work within the restraints set by structure and policy. In fact, many Faulk House shelter staff expressed the desire to "do more for the kids" but were restrained by rules (some of which were broken by giving residents personal money, buying them clothes/supplies with personal money, etc.), time, and resources. Nevertheless, the problematic features of child "protection" are heavily manifested in the policies and curriculum of Faulk House. Faulk House curriculum attempted to address adolescent homelessness as a function of the individual behaviors of residents and previous guardians rather than as related to poverty, social exclusion, and inequality.

A NEW MODEL

The preceding discussion underscores the need for the concept of adolescent homelessness to go beyond the previous, conventional interpretations of "homelessness" to include the role of the state and child welfare system. The public response to adolescent poverty in the United States may effectively create adolescent homelessness, as conceptualized here, among many of those already marginalized in an attempt to protect adolescents from environments characterized as unfit. Further, adolescent homelessness is more an expression of structured inequalities, child welfare policy, and the problems faced by impoverished populations than simply a problem of pathological parenting, degenerate culture, or parental immorality.

As I have argued here, adolescent homelessness as a (re)produced social problem may primarily be understood as an expression of structured inequalities (socioeconomic, raced, and gendered). A visual illustration may be useful in understanding the complexity of this argument (see Figure 1.1), with numbers corresponding to the ones below):

(1) Structured inequalities (primarily raced, classed, and gendered) expressed in part through socioeconomic status and as a result of the related conditions of shrinking welfare benefits, rising unemployment, and rising housing/living costs serve as primary determinants of literal homelessness for adolescents and families. Remember that the socioeconomic position of adolescents, and their ability to maintain consistent and satisfactory living conditions, are mainly expressions of the socioeconomic conditions of their families and communities.



(2) Structured inequalities also determine the likelihood of adolescents' removal from the home, placement under state custody, and the length of time spent in state custody.

(3) We have already explored the strong correlation between literal homelessness and entrance into state custody. An understanding of literal homelessness and child welfare/child removal policies illuminates the overlapping experience of adolescents on the street and in state placements. Many of those youth who spend time in state custody have or will experience extreme poverty and/or literal homelessness. Also, the literally homeless experience of adolescents is mediated by their (or their guardians') ability to

avoid state actors, thus avoiding state custody. In sum, it is questionable whether or not these make up two discernable populations.

(4) Finally, I argue that adolescent homelessness may be defined as a fluid condition, caused primarily by structured inequalities, and manifested primarily in the correlating experiences of literal homelessness and entrance into state custody.

Child welfare policies, and the structural arrangement and curriculum of agencies such as Faulk House, do not reflect the *causes* of adolescent homelessness and the reality of the adolescent homeless experience as a fluid condition and social problem. As a result, these policies ultimately fail to address adolescent homelessness, reflected in its perpetuation and the growing caseloads of social workers nationwide. Further, contemporary policy approaches contribute to the ideological "victim blaming" also attributed to welfare reform.[60] The positions of homeless adolescents and their families are defined and addressed largely in terms of their personal behaviors and deficiencies rather than in terms of their marginalized positions within systems of inequality—both mystifying social reality and legitimating their suffering under the rubric of individual responsibility and rational choice. Again, current state/child welfare policies may actually *increase* populations on the street and in state systems as a result of cutting antipoverty programs and focusing on the reactionary measures of child removal and imprisonment rather than on preventative measures such as family and community preservation and reinvestment.

Employing the conceptualization of adolescent homelessness offered here would first contribute to a theoretical lens for critical analysis of relevant public policies. This (re)conceptualization of "adolescent homelessness" may be more theoretically useful in studying marginalized youth/adolescents that simultaneously populate the street, shelters, and child welfare system. Finally, this conceptual framework could inform child welfare policy in avoiding behavioral pathology models that target parents, kids, and marginalized populations rather than structured inequality and its many symptoms.

NOTES

1. I (subjectively) define "adolescents" as between the ages of 12 and 17. For those 18 and above, the homeless experience changes with regard to state agencies as a result of reaching legal adulthood.

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CHAPTER 2

CHILD WELFARE AND WELFARE REFORM: A STUDY OF ONE COMMUNITY

Kathleen Wells*

This chapter focuses on one group of economically impoverished children, children involved in the child welfare system, and examines how such children in one community fared under conditions of welfare reform. To do so, it presents a general overview of a program of research on this issue and speculates as to its significance for child welfare policy.

POVERTY AND CHILD MALTREATMENT

A large number of factors are associated with the likelihood that a child will be maltreated, that is, neglected, physically abused, sexually abused, and or psychologically maltreated. These factors pertain to characteristics of the parent, the child, and the interactions between the two; the social and institutional networks in which they are embedded; and the social structure of which parents and children are a part.[1] One of the central conditions that characterize maltreating families, however, is poverty.[2] Although most poor parents neither abuse nor neglect their children, poor children are more likely than are nonpoor children to be reported to authorities as possible victims.[3] For example, the risk for poor children of being reported is 6.8 that of nonpoor children.[4]

Children who have been found to be maltreated, moreover, come from those who are "among the poorest of the poor."[5] For example, when maltreating parents who received public assistance were compared with their nonmaltreating counterparts, it was found that they were more likely to be living in crowded households, to inhabit substandard housing, and to have gone hungry.[6] More than half of all maltreated children are considered to be neglected, that is, their basic needs for food, shelter, protection and supervision, health care, and education have not been met.[7]

Not surprisingly, therefore, the majority of maltreated children who have been separated from their parents and placed in foster care come from families headed by poor, unmarried mothers eligible for receipt of public assistance.[8] Indeed, unstable parental income has been associated with placement of children in foster care.[9]

While it is clear that poverty does not cause child abuse and neglect, most scholars agree with the conclusion drawn by Pelton[10] that poverty provides the ground in which abuse and neglect may flourish, and that the factors that mediate the relationship between poverty and maltreatment "have more to do with the ability or inability to cope with poverty and its stresses than with anything else (p. 42)."

CHILD MALTREATMENT AND THE CHILD WELFARE SYSTEM

United States policy mandates a broad range of goals for child welfare agencies that provide services for families who maltreat their children.[11] Agencies are expected to promote children's well-being, to keep them safe from harm, to provide them with stable families, and to enhance the well-being of their families.[12] Families who have maltreated their children typically receive either in-home services such as parenting classes or mental health outpatient treatment, or out-of-home services such as placement of their children in foster care.

However, the child welfare system in the United States is not designed currently to promote child and family well-being broadly defined or, for that matter, to address poverty. Over the past several decades it has evolved from a system intended to help parents to care for their children through the provision of supportive services to one that is dominated by its child protection function.[13] As a result, most of the work of state or county child welfare agencies is devoted to screening reports of child abuse and neglect, investigating the veracity of such reports, and providing services to children identified as abused or neglected, as defined by state law.[†]

CHILD WELFARE AND PUBLIC WELFARE POLICY

Over the past decade, child welfare policy has become more punitive toward biological mothers of children in foster care than in the past.[14] For example, the Adoption and Safe Families Act of 1997 built upon prior child welfare legislation but emphasized that a child's health and safety is of critical concern in determining whether reasonable efforts to preserve the child's family or to reunify the child with his or her families have to be made. It also identified circumstances in which such efforts are not required. The act specifically mandates that the rights of parents of children under age 10 who have been in foster care for 15 of the most recent 22 months be

[†] This is a daunting task. The number of reports is substantial. In 2002, for example, approximately 2.6 million reports of abuse and neglect were filed (representing 4.5 million children); 67 percent of those reports were investigated; 27 percent of the reports were substantiated (found to be true) and 4 percent were indicated (found to be possibly true); and 59 percent of those received some kind of child welfare service.[15] In that same year, approximately, 303,000 U. S. children entered foster care. A total of 532,000 children were in care on September 30, 2002.[16]

terminated. Consequently, reunification of children with their parents hinges upon the speed with which parents can safely resume the care of their children.

Public welfare policy evolved also during this same period of time. It has changed from a system intended to improve the material conditions of impoverished parents, typically single mothers, through the provision of cash grants and other forms of concrete assistance to one that promotes work. For example, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193), commonly known as welfare reform, was designed to promote paid employment among those who had historically relied on cash assistance; to make work pay by promoting welfare recipients use of all of the government benefits for which they were eligible; and to promote the formation of two-parent families. Two primary features of this legislation were the elimination of the entitlement to cash assistance that had been available under the prior welfare policy[17] and the restriction of the access to cash assistance to 60 months.

THE PROBLEM

At the time welfare reform legislation was being debated, some child welfare advocates raised the concern that its effect on families at high risk of involvement in the child welfare system or on families already involved in the child welfare system would be negative.[18,19] The concern grew out of the recognition that a majority of families involved in the child welfare system were also recipients of cash assistance[20] and, as a result, child welfare families would be affected by welfare reform. Moreover, these families were known to have severe, complex, and chronic problems, such as drug addiction[21] and domestic violence,[22] in addition to poor parenting skills. Some expected these problems would make it difficult for parents to obtain and retain paid employment with the level of support that was anticipated and within the proscribed period of time.[23] Given the strong link between poverty and child maltreatment, the over-arching worry was that if poverty increased, so too would child maltreatment and, in particular, placement of children in foster care.[24]

Several hypotheses were advanced regarding the mechanisms through which loss of income[25] or poverty would increase abuse and neglect.[26] However, the specific ways in which welfare reform would affect the child welfare system were unclear. Federal welfare reform legislation made few specific changes to child welfare policy, and the States were allowed considerable latitude as to how to implement the federal legislation. As a result, the effects of reform could be expected to depend on how legislative mandates to promote work, to protect children, and to preserve families were implemented in a specific economic, social, and policy context.[27]

THE PROGRAM OF RESEARCH†

In 1998, we launched a program of research to address the concern that welfare reform would negatively affect children at risk of involvement in the child welfare

† This chapter's description of the research program relies on the prior work of the author and her colleagues.[28]

system.The research program was an in-depth case study, a study that relied on multiple methods, of the child welfare system in one large urban county—Cuyahoga County, Ohio. As such, findings from this program cannot be used to show definitively that welfare reform caused the findings obtained.

This community exemplified the social and economic trends observed in other northern industrial cities over the past 30 years: loss of heavy industry and associated jobs; loss of population, particularly two-parent families, to the suburbs; and continued racial segregation of housing.[29] Cuyahoga County is the largest of Ohio's 88 counties. It has a population of close to 1.4 million.[30] It is dominated by its largest city, the City of Cleveland, where approximately one third (34.3%) of county residents live.[31] Despite the economic growth and the decrease in poverty that occurred in the county during the 1990s, the social and economic conditions in Cleveland had become depleted. For example, in 1999, 48 percent of city children were living in single-parent households; 38 percent of city children were living in poverty; and 65 percent of all births were to women who were unmarried prior to the birth of their child.[32] In 2000, 51 percent of city residents were African American.[33]

The program was comprised of four interrelated but separate components: a Policy Study, a Caseload Study, a Cohort Study, and an Interview Study conducted in collaboration with the Cuyahoga County, Ohio Department of Children and Family Services, the community's child welfare agency. These studies allowed, in turn, an examination of the implementation of welfare reform in the county; of whether child welfare caseloads increased; of whether rates of reunification of foster children declined; and of the nature of the needs and resources of biological mothers with children in foster care under conditions of welfare reform in the community under study.

At the time the study began, it was affected by State of Ohio welfare reform implementation legislation.[34] This legislation indicated the State's concurrence with the federal welfare reform legislation and, in some places, contained more restrictive requirements.[35] For example, under the State's program, cash assistance was limited to 36 months rather than the 60 months allowed under federal law, though after 2 years parents could apply for an additional 2 years of aid. Each county in the State was to devise a plan to implement the State's welfare reform plan so that all county plans could be responsive to local conditions. This county-by-county flexibility was a major feature of reform in Ohio.[36]

In light of the socio-economic conditions and the legislative mandates affecting the county, we reasoned that if welfare reform were going to have negative effects on families involved in the child welfare system, we should be able to detect these effects in Cuyahoga County, Ohio.

CASELOAD STUDY

Aim

This study was intended to describe how the child welfare caseload changed under conditions of welfare reform in order to provide a context for the other studies in the program. At the time the study began, it was unclear as to how welfare reform might

affect specifically the child welfare system. Reform might affect the population of families at risk of abuse and neglect and promote an increase in the number of child abuse and neglect reports. Alternatively, reform might affect the way in which the system responded to those reports and promote an increase in the number of children with substantiated reports referred to county foster care. To examine whether any such changes occurred, we examined Cuyahoga County child welfare caseloads from January 1995 through August 2001, an 80-month period of time of which 33 months were prior to welfare reform and 45 were after.

Methodological Approach

Study questions were examined with a time-series design (see Wells, Guo, Shafran, and Pearlmutter 2004 for study questions and other methodological details of this study.)[37] This is a quasi-experimental design in which an individual or group is measured at regular intervals and in which an intervention such as welfare reform is introduced during the measurement period.[38] In this analysis, the number of cases for each child welfare variable under study was counted for each of 80 months and plotted on a graph.

Study data came from three administrative data bases: the Cuyahoga County Department of Children and Family Services data set that contains basic demographic and service-use data for children and their families; the State of Ohio Income Maintenance System administrative data set that contains information on monthly cash assistance payments; and the State's Unemployment Insurance administrative data set that contains wage data, with the exception of data from employers outside Ohio, from those who are self-employed, and from those who are engaged in informal work.

Study data were analyzed with two statistical techniques–"curve smoothing,"[39] a procedure to remove random fluctuations so that actual decreases or increases in monthly counts plotted over time are easier to identify, and an autoregressive regression model using maximum likelihood estimation.[†] In these analyses, there were three independent variables: the number of recipients of cash assistance, 5 months prior to the current month; a dichotomous variable indicating whether the current month is a pre- or a post-welfare reform month; and the current month's unemployment rate. The dependent variable was the count of the child welfare variable of interest in the current month.

Key Findings

During the months under study, the Cuyahoga County cash assistance caseloads declined, the unemployment rate remained relatively low and steady,[‡] and the child

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[†] This technique allows an assessment as to whether a dependent time-series variable for a given month is related to an independent variable for that same month, after controlling for a third variable.

[‡] There was a steady decline from January 1995 through August 2001 in the number of recipients of cash assistance in Cuyahoga County. For example, in January 1995 there were 124,527 recipients; in September 1997 there were 95,796 recipients; and by August 2001, there were 34,061 recipients. By way of contrast, the unemployment rate in the county remained relatively steady throughout the study period.

welfare caseloads showed evidence of increasing child maltreatment in the community.[40] Between January 1995 and August 2001, there were increases in the number of children with substantiated reports referred to protective supervision, and in the number of children with such reports referred to foster care on a monthly basis. For example, between May 1995 and January 1996, there was a decline in the number of children with substantiated reports; after that month, the number of children each month varied between 336 and 370 until September 1997. After 1997, the number of children with substantiated reports varied, but the trend was upward so that by June 2001, the number of children with substantiated reports was 593. The statistical analysis of these data showed that this increase was related to the decrease in cash assistance counts in Cuyahoga County to a statistically significant degree ($p < .001$).

COHORT STUDY

Aim

Although it is useful to document the changes in Cuyahoga County child welfare caseloads under conditions of welfare reform, such data do not reveal whether length of stay in foster care is increasing or whether it is related to children's mothers' access to cash assistance or to wages. The Cohort Study focused on this issue.

The Cohort study examined three cohorts of children and their biological mothers: one cohort of children entered foster care prior to welfare reform, one entered foster care after the onset of welfare reform, and the third entered foster care after welfare recipients could begin to lose cash assistance in the county under investigation. This study tested whether a mother's economic circumstances delays the speed with which her children in foster care return home and, if negative economic circumstances are related to such a delay, whether the relationship is greater after welfare reform than before (see Wells and Gao 2006 for a list of specific study questions and other methodological details of this study.)[41]

Methodological Approach

We sought to achieve this aim with a staggered multiple-cohort design, a nonexperimental design which compares cohorts gathered at different times.[42] The study population of 2,128 children is comprised of all children entering foster care in Cuyahoga County between October 1 and March 31 for the following years: 1995–1996; 1998–1999; and 2000–2001. Each child also had to be age 16.5 years or less, from a single-mother home, and in foster care for the first time. Of these, 1,560 are in the study sample or 73 percent of the study population.

Children in the study samples were placed in foster care at different points in time during the three 6-month enrollment periods. They also remained in care for differing lengths of time. To manage this variability, we selected the 12 months after each child's entry into foster care as the period in which to examine reunification speed. This period of time is compatible with the permanency-planning deadline established under the Adoption and Safe Families Act of 1997.

After securing appropriate contracts and confidentiality agreements, we linked data from the three administrative data sets that we used in the Caseload Study. Study data are examined using event history analysis in general and the Cox proportional hazards model in particular.[43] In this study, the event of interest is reunification. Study data met the statistical requirements for use of the Cox model and the analysis was not threatened by multicollinearity among the independent variables.

Key Findings

When the three cohorts of foster children were compared, children who entered foster care after welfare reform are reunified with their biological mothers more slowly within 12 months of their placement than are children who entered care before reform. For example, children in the first post-welfare reform sample ($n = 522$) were reunified at a speed that is 42 percent slower than were children from the prewelfare reform sample ($n = 378$) ($p < .05$), after controlling for other variables with which speed of reunification has been associated in prior research.[44] Children from the second post-welfare reform sample ($n = 657$) were reunified at a speed that is 48 percent slower than were children from the prewelfare reform sample ($p < .01$), after controlling for other variables in the analysis described above.

In addition, after welfare reform, compared to before, a higher percentage of children are first placed in foster care, a higher percentage remain in care for more than 12 months, and a lower-percentage exit care within 12 months in the care of guardians. For example, before welfare reform, 37.3 percent of children were in care for more than 1 year compared to 45.7 percent and 53.4 percent (for post-reform samples 1 and 2, respectively), after reform.

Both before and after welfare reform, however, family income has a strong relationship to the speed with which children are returned home. For example, children whose mothers lose a significant amount of cash assistance, defined as a mother's first loss of $75 (or more) in cash assistance after her child's placement and before reunification or until her child has spent 12 months in foster care, whichever comes first, are reunified more slowly than are children whose mothers received cash assistance and did not lose such cash assistance ($p < .001$), after controlling for other variables in the analysis. The rate is 86 percent slower for the former than for the later group. Alternatively stated, 87 percent of children whose mothers received but lost a significant amount of cash assistance were in care 12 months after placement; this percentage differs dramatically from the percentage of children whose mothers received cash assistance but did not lose a significant amount of cash assistance—41 percent—at that same point in time.

INTERVIEW STUDY

Aim

While it is useful to know whether children's mothers economic circumstances are related to the speed with which they return home within the first year of placement,

these findings do not reveal the full nature of mothers' economic circumstances, the obstacles they face to employment in the low-wage labor market, or suggest the full effects of mothers' economic circumstances on their children, as depth and duration of poverty has been linked strongly to poor child outcomes.[45]

The Interview Study focused on this issue by addressing the following questions: (1) What is the prevalence of mothers' material hardship and obstacles to employment? (2) Is maternal substance abuse either alone or in combination with other obstacles to employment related to a lowered likelihood that mothers are employed? (3) Is a mother's substance abuse related to the speed with which her child is reunified primarily through the effect such abuse has on a mother's loss of cash assistance? (4) What do mothers report that they need in order for their children to be returned to them, and what do they recommend regarding improvement of welfare and child welfare services? (see Wells, Gao, Shafran, and Pearlmutter 2004 for a more detailed articulation of this study than is presented here.)[46]

Methodological Approach

These questions were addressed with a subset of children and their biological mothers drawn from the Cohort Study's second post-welfare reform sample—those mothers who were 18 years of age at the time of data collection and who spoke English. Of the 436 mothers in the population, 178 provided informed consent to participate. The remaining 258 mothers were not interviewed for the following reasons: interviewers could not contact them, despite information as to their location ($n = 126$); interviewers (and the child welfare agency) lacked information regarding their locations ($n = 72$); interviewers did not contact mothers because the data collection period had ended ($n = 37$); or the mothers refused to be interviewed ($n = 23$). Thus, the study sample was 54 percent (178/327) of those eligible to be interviewed.

Study data were obtained from two sources: an in-person interview and administrative data pertaining to mothers' wages, use of cash assistance, and use of and treatment for substance dependence. The interview contained multiple measures drawn from those used in the Michigan Women's Employment Study,[47] the Illinois Family Study,[48] and in other components of our research program because these studies relied on concepts under examination in this investigation (see Wells and Shafran 2002 for a full description of the measures used in this study.)[49]

Interviews took place, on average, within 3 months after the mothers' children's placement in foster care. Each mother was interviewed once by one middle-aged female interviewer whose race matched her own. Interviewers were trained by principal investigators. Each interview lasted approximately 2 hours. Each mother received a cash payment of $40 for participation in the study.

Research question 1 was examined with descriptive statistics; question 2 with logistic regression analysis to determine whether employment outcomes differ for mothers with substance use alone or in combination with other obstacles to employment;

research question 3 was examined using event history analysis; and research question 4 was examined with content analysis.

Key Findings

Mothers with children in foster care are economically impoverished. Over three quarters (81.1%) had incomes that fall below the poverty level and over half (58.6%) had incomes that fall below the extreme poverty level. Thirty percent had no wages from work in the year after their children's placements and 47 percent had average total monthly wages of less than $500. About half (49.1%) had at least one significant material hardship beyond insufficient income from wages such as food insecurity, substandard housing, housing insecurity, and economic insecurity, variously defined.

Mothers also had multiple obstacles to employment and to a greater degree, on some obstacles, than do mothers in the general welfare population. Of the eleven obstacles studied, the most common obstacles to employment, in order of magnitude, were transportation (74.1%); lack of a high school education or a General Educational Degree (48.1%), and a substance use problem (48.1%).

Mothers with co-occurring obstacles to employment, especially obstacles posed by substance dependence, are less likely to be employed (at least 10 hours per week) than are mothers without such problems. For example, mothers with co-occurring substance use and human capital barriers (i.e., women with two of the following three barriers to employment—education, work, or job experience) were about 93 percent less likely to be employed than were mothers who did not have those barriers ($B = -2.65$, $\text{Exp}(B) = .07$, sig. $< .05$). Mothers with co-occurring substance use and mental health barriers were about 84 percent less likely to be employed than were mothers who did not have those barriers ($B = -1.81$, $\text{Exp}(B) = .016$, sig.$< .01$).

Moreover, children whose mothers abuse substances are reunified more slowly within 12 months of their placements than are children whose mothers do not; however, the effect of substance abuse on reunification speed is mediated through its effect on loss of cash assistance. Statistical analyses support the hypothesis that although a mother's substance use influences the rate at which her child returns home, the effect operates mainly through the effect a mother's substance use has on her loss of cash assistance postplacement. (See Wells, Gao, Shafran, and Pearlmutter 2004 for a more detailed discussion of this analysis.)[50]

Three quarters of mothers expected their children to return home, but stated that they needed concrete material assistance pertaining to, for example, housing and transportation in order for reunification to occur. Difficulties meeting the child welfare agency's expectations centered on lack of financial resources, conflicts between work and caring for others, and substance dependence.

Conclusion

Taken together, the findings from these studies suggest that child welfare families deteriorated under conditions of welfare reform in the county under study. I draw

on several strands of evidence to support this conclusion—increases in child welfare caseloads; decreases in the speed with which children, once placed in foster care, are returning home; mothers living in extreme poverty; and mothers' loss of cash assistance slowing the speed with which their children in foster care return home. In addition, substance use emerges as a critical problem for this population. Indeed, the child welfare system has become the de facto substance abuse treatment system for very poor mothers.†

Alternative interpretations of these findings are, of course, possible, because the studies are not experiments. One such explanation is suggested by the policy study. In that study we found that although foundational aspects of the State's welfare reform strategy had been implemented, some elements had not.[51] For example, by mid-2000 only five of the eleven neighborhood-based centers through which services were to be available to county mothers were in place.[52] Moreover, at this same point in time, the mechanisms through which public agencies were to coordinate their efforts on behalf of impoverished parents were cumbersome, at best. As a result, subgroups that required services from more than one service system such as poor addicted mothers with children in foster care were unlikely to receive the help that they needed to ameliorate the problems that brought them to the attention of the child welfare system and to find or to keep paid employment. Thus, child welfare families may have deteriorated under conditions of welfare reform because services were unavailable or insufficient.

Nonetheless, mothers state that they need concrete help and study data to support their claim. However, the kinds of help needed—transportation, housing, or a living wage—are beyond the purview of a public child welfare agency. As a result, it is not surprising that recent calls for reform of the child welfare system emphasize the importance of integrating services to protect children with those designed to support their families.[53] What may be at issue is not only mothers' abilities to regain custody of their children but also their status in society. Without minimizing mothers' strengths[54] or the risks some mothers may pose to the safety of their children, it is important to recognize the extent of their victimization. "Perhaps the Declaration of Human Rights, designed to fight discrimination and oppression throughout the world, is the appropriate framework in which to develop a response to this highly disadvantaged population."[55]

NOTES

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† Recent research suggests why prototypical treatment programs do not work well for this population. Substance dependence among women develops in response to preexisting anxieties, phobias, or psychiatric disorders and in relationship to significant incompletely or, more relationship difficulties. As a result, their neuropsychological functioning is impaired and the likelihood that they will recover quickly from addiction is low.[56]

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CHAPTER 3

Navigating the Welfare Time Limit in California: How Do Families Fare?*

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The welfare reform law of 1996, PRWORA (the Personal Responsibility and Work Opportunity Act), which authorized the new TANF (Temporary Assistance to Needy Families) program, was heralded as a route to self-sufficiency for millions of low-income families who had been languishing on the welfare rolls. Government was no longer to be complicit with a culture of despair and victimhood, within which—it was said—entire generations grew into adulthood dependent on government aid, with no prospects of decent employment and its attendant benefits. Rather, state welfare agencies would, by prodding, encouragement, training, practical assistance, and ultimately through sanctions and grant terminations, help welfare recipients step from dependency onto the escalator of gainful employment. They would gradually be carried upward toward economic self-sufficiency, self-respect and full participation in the American economy, and in the process transform the prospects for their children—a transformation which was, in the minds of many, the most cherished hope but also the greatest and riskiest challenge of welfare reform.

In the 10 years since PRWORA passed, all 50 states have renovated their welfare programs to conform to the TANF mandates, and in the process greatly reduced their caseloads. State policies differ widely, most especially in how they include (or do not) families who seem reluctant or unable to step onto the employment escalator, or who fall off it, or abandon it. When states provide additional supports beyond the minimum mandated by PRWORA, these are often justified as aid to the neediest children, rather than to adults.

In this chapter we use data from one such relatively generous state, California, to explore how parents and children fare as they pass through the federal 5-year welfare time limit. We look at parents' abilities to provide for their children: What barriers do they face in navigating the world of work, and what supports does government

provide for them? Are they employed, and how much are they earning? A child's well-being is intimately tied to his or her family's resources: How much money do families have, before and after reaching the time limit—is it enough to escape poverty? What does this income translate into, in terms of quality of life: Does the family have adequate housing, enough food, and basic utilities; can they get medical care when needed? And finally, how are children themselves faring: Are they healthy? Do they have regular medical care? As teenagers, how are they coping with the transition to adulthood?

Yet showing, as we do, that these post-time limit children typically live in deep poverty, often experience material hardship, and encounter a rocky adolescence is perhaps not of great value to policymakers. After all, this has always been true of children in families that receive welfare—by definition, welfare serves those at the bottom of the income distribution. The critical question for policy-makers is how to promote self-sufficiency through TANF policies and still protect children whose parents cannot step on, or stay on, the escalator. That is our focus here: We classify families as those who are relatively self-sufficient, those who are struggling, and those with so many barriers that they are not likely to succeed, and follow their well-being into the next year as they cross the time-limit threshold. By situating the study in a state—California—that has chosen to continue some support to needy families who have exhausted their TANF entitlement, we explore the protective possibilities offered by such policies.

WELFARE POLICY NATIONALLY AND IN CALIFORNIA: AN OVERVIEW

The work-first, time-limited approach mandated by TANF is intended as only a bridge, or a boost, for families needing short-term help to navigate some kind of temporary health or employment setback or family disruption. It was thought that the 5 years of assistance provided by the law would be enough to address deeper-seated barriers to employment among needier families. Children, in this framework, would benefit directly as their parents' earnings increased and indirectly by seeing their parents (and, by extension, themselves) as part of the economic mainstream. The assumption built into TANF that within 5 years almost all families can earn enough to not need welfare was the most controversial aspect of the law.

The dire predictions of PRWORA's harshest critics have not been borne out, but neither have predictions that facing a time limit would generate greater prosperity among welfare leavers. The number of families receiving TANF declined 57 percent between August 1996 and June 2005,[1] but this change in caseload has not universally been associated with greater well-being among families. For example, the Urban Institute's National Survey of America's Families found that while work and median earnings among welfare recipients increased after 1997, poverty remained high—69 percent were still in poverty in 2002 (though families in "deep poverty" declined from 60 percent to 42 percent).[2] Only 57 percent of welfare leavers were working in 2002, at median hourly earnings of $8, and 26 percent returned to welfare within

2 years of exiting (up from 20% in 1997). Receipt of federally funded food stamps and health insurance did increase among welfare exiters between 1999 and 2002—28 to 35 percent for food stamps and 40 to 48 percent for health insurance—indicating that as TANF implementation progressed, state human service agencies became more adept at helping exiting recipients access the programs for which they continued to be eligible even after leaving welfare.

CalWORKs, California's welfare program, serves a broad swath of needy families. The program has a vigorous employment focus: recipients are expected to address and overcome, not be deterred by, their own difficulties in finding and keeping work. Funding is available, although perhaps not always sufficient, to address mental health, substance abuse, and domestic violence problems as well as to cover practical needs for childcare and transportation. Parents can receive up to the full 5 years of lifetime aid permitted under TANF.

Within its strong employment focus, the state permits up to ten reasons for a CalWORKs exemption—which stops the time-limit "clock"—and six more reasons for an extension to the time limit.[3] California policy-makers have also adopted policies and programs to aid needy families that become ineligible for the full TANF grant. After timing out, parents can enroll their children in a state-funded child-only program (called the Safety Net), which provides roughly the equivalent of a child-only CalWORKs grant. Families sanctioned for noncompliance can also receive a child-only CalWORKs grant.

The diverse program elements in CalWORKs, along with the state's complex demography, combine to create a very heterogeneous (and large) caseload.[4] CalWORKs recipients are almost as likely, as not, to speak English, and there is a wide variety of languages spoken by the non-English speakers. Economically, the caseload is diverse as well. For instance, in the agricultural Central Valley many parents receive large CalWORKs grants during the winter when there is no agricultural work available, and minimal grants (or none) during the peak harvest months when they are fully employed.

THE RESEARCH BEHIND THE FINDINGS

Given the complexity of the CalWORKs program and its interplay with the state's demographic and economic diversity, the legislature mandated an evaluation of the consequences of the time limit for recipient families (and for state and county agencies and budgets), which provided the survey data used in this chapter. A random sample of timing-out families was selected from the welfare rolls in six California counties, with two-parent and non-English-speaking families over-represented. The six counties were: Alameda (covering most the eastern edge of the San Francisco Bay, including the city of Oakland); Los Angeles (with one-third of the population of the state); Orange (a geographically small, prosperous county south of Los Angeles); Riverside (a desert county that is rapidly becoming home to many who work in Los Angeles); Sacramento (home to the state Capitol, with a substantial rural/agricultural population) and Tulare (in the Central Valley, and heavily dependent on agriculture).

These counties, which together account for more than half of California's welfare caseload, reflect the geographic, economic and demographic diversity of California.

Ultimately 1,797 individuals agreed to join the study and were interviewed by telephone between June 2004 and August 2005, the months just prior to the month we expected them to have accumulated 60 months of aid.[5] The majority of respondents to this initial survey were then reinterviewed some 6–9 months later, with a reinterview response rate of 79 percent.[6] Confining the two-interview analyses to respondents interviewed in English, Spanish, or Vietnamese[7] and living with their own children in the same family type in both interviews leaves us with 1,043 respondents for all the analyses reported here (unless indicated otherwise). The data are weighted to be representative of participants in any one of the six focus counties.[8]

In addition to recording basic household demographic information, we asked these parents to explain their welfare status at each interview (whether they were still getting CalWORKs, had gone to the Safety Net, or were off cash aid entirely); and we asked about their current and recent employment, including their hours worked, wages and total household cash income (excluding food stamps). All measures in this chapter, including employment, earnings and CalWORKs receipt, are self-reported by survey respondents.

The survey results indicate that our respondents included some relatively self-sufficient families who in other states would have been excluded from assistance (and welfare studies) because of their more-than-minimal earnings. Parents were working "full-time"—31 or more hours a week currently or during in the previous year—in 32 percent of our respondent families.[9] At the other end of the spectrum, 48 percent were not working at all and had not worked in the preceding year. In many other states these families would have long since disappeared from welfare rolls because of stricter sanctions and time limit policies.

These two completely disparate groups—one not working at all, the other employed essentially full-time—together comprised 80 percent of the sample and, presumably, of the timing-out caseload. Most of the remainder (14%) had "low work hours"—less than 20 hours a week, or 30 hours between two parents.[10] The final 6 percent were a heterogenous left-over group with "intermediate" work hours—single parents currently working between 20 and 30 hours per week and two-parent families in which both parents currently worked part-time totaling more than 30 hours per week.

BARRIERS AND EMPLOYMENT

Previous research from across the country provides ample evidence that many welfare recipients face substantial barriers to work. A Chapin Hall study found that four out of five welfare applicants in Wisconsin reported one or more employment barriers and more than half reported having two or more.[11] Hauan and Douglas reported that among welfare workers in six states, the most common barriers to employment were the presence of health (21%) or mental health (30%) problems; having a child with special needs (29%); having no high school diploma or GED

(40%); having limited work experience (22%); issues with unstable housing (22%) or transportation (27%) and childcare problems (34%).[12] Similarly, Zedlewski found that among welfare recipients nationally, 42 percent did not have a diploma or GED, 35 percent were in poor health and 30 percent had not worked in recent years.[13] This evaluation, based on National Survey of American Families data, indicated that 44 percent of welfare recipients reported two or more barriers to employment.

These studies indicate that employment barriers typically not only persist over time but are in fact correlated with reduced work participation.[11,13] Courtney and Dworsky[11] find that those with more barriers were statistically less likely to be currently employed 3 years after applying for aid. Sixty percent of those reporting no barriers were currently employed at Wave 3 versus 35 percent among those with two barriers, and 9 percent among those with four barriers. After controlling for other personal liabilities, Hauan and Douglas[12] find that only limited education or work experience, poor physical health, childcare issues, or being pregnant had a negative effect on actual employment. Nationally, although those facing barriers increased their employment after the implementation of welfare reform (from 5% in 1997 to 20% in 1999) their work participation decreased to 14 percent in 2002 when the economy weakened.[13]

Unlike many other states, California permits exemptions to the welfare time limit for five possible employment barriers: having a disability that limits work; caring for an ill or incapacitated person residing in the home; being a victim of domestic abuse; residing in an high-unemployment Indian reservation or rancheria; or participating in a teen-parent welfare program (i.e., being a teen parent). We inquired about the first three conditions, confining the questions about domestic violence to the last year, defining "disabled" as a health problem that limited the respondent's ability to work, and asking about caregiving responsibilities for ill or impaired household members that affected the respondents' ability to work We also tried to identify the presence of a likely learning disability, and asked whether any of five mental health problems had, in the past year, interfered with the respondent's ability to work, go to school, or care for children, namely: depression, anxiety, a stressful event (which does not include divorce or childbirth), alcohol use or drug use.[14]

Our survey data confirm that many of California's long-term welfare recipients face health, mental health, caregiving, or other challenges.[15] Twenty-three percent of respondents suffered from a disabling physical or mental health problem that limited their ability to work.[16] Caregiving often imposed barriers: 11 percent had one or more children with a health problem sufficiently severe to limit their parents' ability to work, and 4 percent were limited by caring for a disabled or impaired family member. Eleven percent of respondents had experienced domestic violence in the preceding year. Thirty-four percent reported at least one mental health barrier—depression, anxiety, thoughts of a stressful event, alcohol use, or drug use—that interfered with work, home or school (and that did not trigger a positive response to the preceding question about disabling health conditions that limit ability to work). Finally, we found 15 percent with a likely learning disability.

As Table 3.1 shows, respondents working at least 31 hours a week (called "full-time" in the table) had fewer barriers than those working fewer hours. Conversely,

Table 3.1
Incidence of Barriers to Employment, by Hours of Work at Wave 1

Percent in each category reporting the following:	Hours of Work: Full-time workers (30+ hrs/wk)	Low or zero work hours (≤20 hrs/wk)	Intermediate work hours (21–29 hrs/wk)	Total
Has 0 or 1 reported barrier (of 9)	82.2 (Group A)	56.4 (Group B)	67.0 (Group D)	65.4
Has 2 barriers (of 9)	9.6 (Group D)	17.0 (Group B)	18.4 (Group D)	14.7
Has 3 or 4 barriers (of 9)	6.9 (Group D)	18.2 (Group C)	12.8 (Group D)	14.2
Has 5 or more barriers (of 9)	1.3 (Group D)	8.4 (Group C)	1.8 (Group D)	5.7
Sample Size (unweighted)	309	672	62	1043

employment was less among those confronted by more barriers. However, a substantial number of people had relatively few (fewer than three) reported barriers and were nevertheless working only a few hours a week or not at all. Their employment may have been inhibited by external barriers, such as lack of jobs, or lack of appropriate child care, or, perhaps, by personal or family-related barriers that our interview questions did not capture.

The distribution of barriers among the 48 percent of respondents not working at all currently or in the preceding year was very similar to the barriers facing people that worked limited (under 20) hours. These distributions are not shown separately in the table because, being similar, the two categories were combined into "little or no work." Within this combined category, 78 percent were nonworking and 22 percent worked limited hours.

Although each welfare participant's life is unique, we combine the information about barriers and employment to create four family "types," that chart different paths through the critical juncture of the 60-month time limit:

- Those who are relatively self-sufficient, with few barriers and substantial work effort—identified as Group A;
- Those who report few barriers, but with zero or low work hours (defined above)—identified as Group B;
- Those who face multiple barriers and zero or low work hours—identified as Group C; and
- A residual category (mixed) who work intermediate hours (defined above) and face any level of barriers—identified as Group D.

Each of these types of recipients appears in the political rhetoric and debates surrounding welfare and describes a substantial number of welfare participants. Group A, comprising 26 percent of the sample, met our work criteria for full-time and has no, or only one, employment barrier. Group B, the second and largest group with 45 percent of the sample, had zero or "low" work hours (defined above) and two or

Table 3.2
Incidence of Barriers to Employment, by Hours of Work at Wave 1

Percent in each category reporting the following:	Barrier Group				
	Few or no barriers, high work hours (Group A)	Few or some barriers, low work hours (Group B)	Many barriers, low work hours (Group C)	Mixed barrier profile, moderate work hours (Group D)	Total
A health-related barrier that interferes with work					
Own limiting health condition	8.4	21.3	52.1	22.1	23.1
Caregiving for a child with a limitation	2.6	7.2	29.1	16.7	10.8
Caregiving for another family member	2.4	3.8	5.8	5.9	4.0
Domestic violence by spouse/partner in past year	3.1	7.8	30.0	15.7	11.2
At least one mental health barrier—depression, anxiety, recall of a stressful event, alcohol use, or drug use—that interferes with work, home, or school.	8.2	20.7	94.8	53.1	33.7
Likely learning disability	2.2	10.7	35.0	31.7	15.1
Sample Size (unweighted)	309	156	516	62	1043

fewer barriers. Some of this group might have been unable to find work; some may have had significant personal barriers not captured in the available data, and some may have chosen to care for their children, pursue education, or simply stay at home rather than work.

Group C includes recipients who *both* faced multiple (three to nine) barriers to work *and* had zero or low work hours; this group is 16 percent of the sample. All the evidence—descriptions of their health, mental health, and caregiving obligations, as well as their limited or nonexistent participation in the world of work—points to these parents as unusually challenged, even among long-term welfare recipients. Three-fourths of Groups B and C (78 and 77 % respectively) were not working when interviewed and had not worked during the previous year. Finally, the fourth, residual group (Group D) comprises the 6 percent with "intermediate" work hours and a further 7 percent who worked full-time despite having more than three barriers.

As Table 3.2 shows, health and mental health problems are the most common barriers reported by parents in all of these groups. Among Group C respondents, who by definition have three or more barriers, 52 percent were limited in their own health, 29 percent were limited by their children's health problem, 6 percent were caring for an adult household member, 30 percent reported domestic violence in the past year, 95 percent had one or more mental health problems that interfered with work and were not already listed as a limiting health impairment, and 35 percent had a likely learning disability. Among Group B respondents, with fewer problems on average (48% have zero barriers, 29% had one, and 23% had two), 21 percent were also limited in their own health, and 21 percent reported, in addition, a limiting specific mental health problem.

These groups differ in important ways apart from work and barriers—in marriage/cohabitation, ethnicity and language, and education (Table 3.3). Group A respondents, those with few barriers and substantial work, were nearly one-third married or cohabiting, which is double the proportion in the sample overall. Marital status correlates closely with ethnicity: Group A included many Vietnamese speaking Vietnamese (22%, compared to 8% of the entire sample), and Spanish-speaking Latinos (15% compared to 10% overall). These non-English-speaking respondents had somewhat less education than other groups; 39 percent of Group A lacked a high-school diploma and 25 percent had attended any college. Group C, in contrast, was almost all English-speaking (92%) and relatively well-educated, with 42 percent having attended college (and one-quarter of these obtaining a degree). Group C parents were almost all single (95%).

Put differently, the demographic characteristics of these long-term welfare users—their marital status, their ethnicity and their education—are powerfully tied to their employment and the barriers they face. Just over half of the married/cohabiting respondents were in Group A and very few were in Group C. Single-parent respondents were about as likely to be in Group A as in Group C (one-fifth of each). Vietnamese and Spanish speakers were far less likely to be in Group C compared to white and

Table 3.3
Demographic Characteristics for each Study Group at Wave 1

Percent in each category reporting the following:	Barrier Group				
	Group A Few or no barriers, high work hours	**Group B Few or some barriers, low work hours**	**Group C Many barriers, low work hours**	**Group D Mixed barrier profile, moderate work hours**	**Total**
Marital Status					
Single	67.7	90.0	95.0	85.7	84.5
Married or cohabiting	32.3	10.0	5.0	14.3	15.5
Race/Ethnicity and Language					
White, English speaking	14.3	18.7	22.3	22.2	18.6
African American, English speaking	24.2	36.0	34.3	32.8	32.3
Latina, English speaking	19.8	21.5	19.6	26.3	21.3
Latina, Spanish speaking	14.7	10.7	4.5	6.7	10.2
Vietnamese, Vietnamese speaking	22.1	3.1	3.0	5.0	8.3
Asian or other race/ethnicity, English speaking	3.7	9.6	15.9	6.5	8.7
Education Level					
High school dropout	38.6	39.7	36.4	32.6	38.0
High school diploma or GED	36.3	34.5	21.9	31.1	32.5
Some college or college degree	25.0	25.8	41.7	36.3	29.5
Sample Size (unweighted)	309	156	516	62	1043

African American English speakers, which may reflect different cultural or interpretational responses to the survey questions. Among these long-term users of welfare, more than one-quarter have some college education, but college-educated parents faced more employment barriers than average.

HARDSHIPS AND INCOME AT FIRST INTERVIEW

A central focus of the interview was whether respondents were able to secure a materially stable life for themselves and their children. We asked whether, during the past year (or since the last interview) the family experienced any of 12 "material hardships." We asked whether they: lacked the money needed for (a) their rent or mortgage, (b) paying utility bills, (c) buying food, (d) paying for basic things; (e) shared housing to cut cost, (f) had to move when they did not want to, (g) had their utilities shut off, (h) had their car repossessed, (i) used a food bank or (j) soup kitchen, or (k) borrowed from family; and finally, (l) did they or someone in their immediate family not get medical care when they needed it? We found these indicators of economic stress or hardship to be very widespread (data not shown): virtually all (97%) of our respondents reported at least one within the previous year. About one-third (32%) had two or fewer, 30 percent had three or four, and nearly 40 percent reported five or more hardships. The most common were borrowing money from family (59%), lacking money for utilities (54%) or basic things in general (52%), and using a food bank (45%).[17]

As Table 3.4 shows, Group C, with many barriers and low or no work, stands out as having had many more problems than other groups. The high-barrier low-work families reported 5.5 hardships each, on average, compared to 3.1 problems per family in Group A, 3.7 in Group B and 4.1 in the residual Group D. Because the other three groups largely resembled each other, they are combined in Table 3.4. The biggest proportionate differences were in the rates of not getting medical care when needed (reported by 24% of Group C and 9 percent of others, usually about an adult family member); having had a car repossessed (32% compared to 15%); not having had enough money for food and/or using a food bank (56% versus 35%, and 69% versus 37%), utility shut-offs (35% compared to 21%) and having been compelled to move (29% compared to 19%).

Many of these hardships are likely to have been detrimental to children. Children notice when their family lacks (or, perhaps even worse, loses) basic amenities—utilities are shut off, a car is repossessed, there is not enough food in the house. The dislocations that come with moving—particularly moves that are compelled rather than voluntary—can be very stressful and has been shown to be detrimental to children's future well-being.[18] Knowing that a family member has an untreated medical problem can also be upsetting for children.

The problems just discussed are tangible indicators of a difficult and stressful life. A more widely accepted, although less direct, metric of life's quality is family income, which we report next. We calculated the ratio of the respondent's reported monthly household cash income from all sources (although not in-kind assistance such as food

Table 3.4
Incidence of Material Hardship and Average Numbers of Hardships at Wave 1, Many Barrier/Low Work Group compared to All Others

Material Hardships	Group C: Working little or not at all, and three or more barriers	All other respondents
Housing		
Could not afford rent in last year	49.6	40.7
Currently share housing	22.1	20.6
Had to move in past year	28.9	18.5
Utilities		
Could not afford utilities in past year	64.9	48.8
Utilities shut off in past year	35.3	21.0
Transportation		
Car repossessed in past year	32.2	14.6
Food sufficiency		
Could not afford food in past year	56.3	34.9
Use food bank in past year	69.4	36.6
Use soup kitchen in past year	19.7	9.8
Health Care		
Someone in family did not get needed medical care in past year	24.4	8.8
Other Hardships		
Not enough money for basic things in past year	72.6	47.1
Borrowed money from family in past year	73.3	55.9
Average number of hardships in past year	5.5	3.6
Sample Size (unweighted)	168	875

stamps, housing, or child care) to the federal poverty threshold for each household size.[19] Respondents' household incomes were categorized as less than 50 percent, 50–99 percent, 100–149 percent, 150–200 percent, or more than 200 percent of the poverty threshold. (In 2005, the federal poverty threshold for a single-parent family with two children was $15,735 annually.)

Just as with the material hardship measures, we found large differences between groups. As Figure 3.1 illustrates, virtually all respondent families lived in poverty, and many were below 50 percent of the poverty threshold. Indeed, the majority of families in Groups B and C reported incomes lower than half of the federal poverty threshold.

As would be expected, poverty was most closely tied to employment, but less tied to the number of barriers respondents faced. Whereas the measure of hardships showed the low-barrier groups (Groups A and B) better off than others, the poverty measures showed the most-employed groups (Groups A and D) substantially better off.

In addition to household-level income and hardships, the survey provides some specific information about children's well-being. Figure 3.2 shows that one-quarter (26%) of the families had at least one child who had a "health condition, disability,

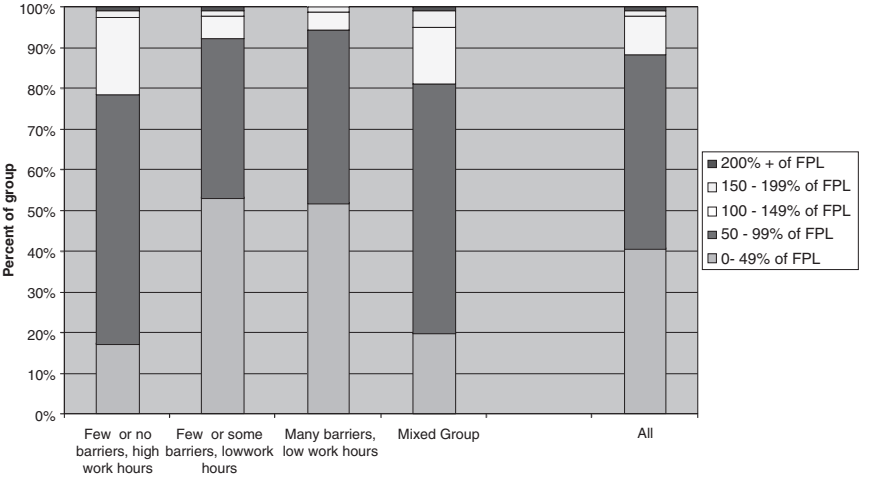

Figure 3.1
Family Income as a % of Federal Poverty Level (FPL) at Wave 1 by Work/Barrier Group

or behavioral condition that limit[ed] the kinds of things or amount of things that they [could] do, such as playing, going to school or participating in family activities;" a quarter of these families (6% of all families) had more than one such child. Among the conditions asked about, the most commonly reported (though not shown here) were asthma or allergies (16 percent of the sample), Attention Deficit Disorder (9%), behavioral or emotional problems (8%) and developmental delays (6%). In sum, child health problems were common and often serious among long-term welfare users.

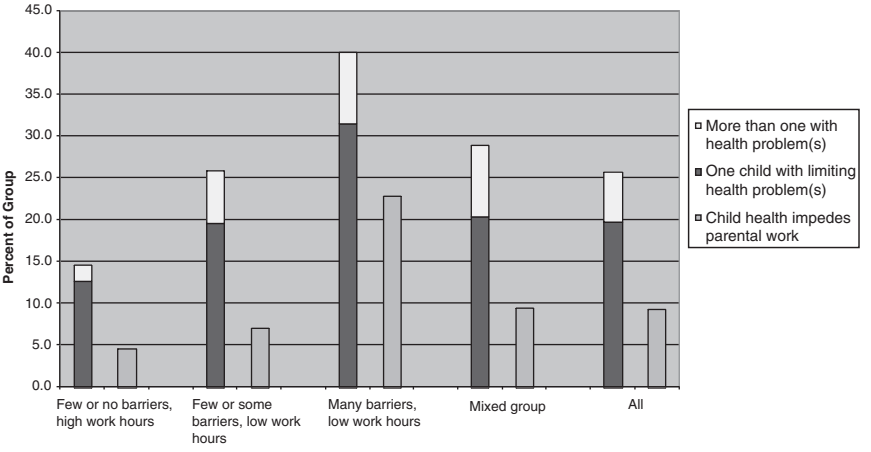

Figure 3.2
Child Health Problems, by Work/Barrier Group

Over a third of these parents—9 percent of all respondents—reported that their child's health problem interfered with their or their spouse's ability to work, so that they could not work at all (3% of the sample), could not work the hours needed (3% of sample), or encountered some other impediment (the final 3%). Child health problems that interfere with work were included in the list of employment barriers, so it is natural they were the most prevalent in the many barriers/low work Group C. Among these families, 32 percent had one child with a limiting condition and 8 percent had two or more, for a total of 40 percent in this group—more than double the rate of 15 percent in Group A. These health problems interfered with work for 23 percent of Group C compared to 5 percent of Group A. Eleven percent of Group C parents had a developmentally delayed child, 8 percent a child with loss of sight or hearing, 19 percent a child with emotional or behavioral problems sufficient to limit their activities, 17 percent a child with ADD and 26 percent a child with asthma or allergies (results not shown here).

HOW DID FAMILIES FARE AFTER REACHING THE TIME LIMIT?

A central part of the analysis was to investigate whether, after the time limit, families became worse off. Reaching the time limit means, in most states, that the entire family becomes ineligible for welfare unless they qualify for an exemption (which, as noted earlier, most states do not offer apart from the exemptions mandated by TANF). In California, families may qualify for the Safety Net if their incomes are low enough. Safety Net grants are lower than regular CalWORKs grants by the amount associated with the (now excluded) adults in the family. The program, therefore, was intended to protect children from extreme poverty but, on the other hand, to ensure that there was some consequence of reaching the time-limit.

We compared numbers of hardships and the prevalence of specific hardships from the first survey to the second, for each group and for the sample as a whole. The results (Figure 3.3) were strikingly similar at the two interviews. Families with full employment and few barriers reported an average of 3.1 hardships at Wave 1 and 3.0 at Wave 2; the low-employment/few barriers group had on average 3.7 hardships, the low-employment/many barriers group 5.5, and the "Mixed" group had 4.1, followed by 4.0, hardships. In short, while individual families fared better or worse in the second year, overall rates did not change.

The income-to-poverty ratios were also remarkably constant across the two interviews. As Figure 3.1 shows, at the first interview 41 percent of the entire sample were below half the poverty level, with 17 percent, 53 percent, 52 percent and 20 percent (respectively) of Groups A, B, C, and D at that level. At the second interview the rates were virtually identical: 40 percent of the sample and 17 percent, 52 percent, 50 percent and 23 percent (respectively) of Groups A, B, C, and D were below half of the poverty threshold.

The only area in which we see any cross-wave differences are in reports of behavior problems among teenagers, which are very prevalent in these families. At the first interview, 29 percent of parents had a teen that had been suspended or expelled from

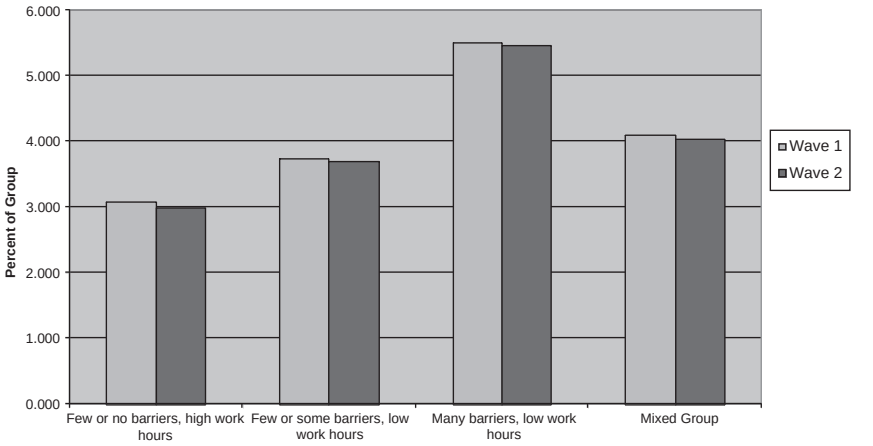

Figure 3.3
Average number of hardships in 12 months at Wave 1 and Wave 2, by Work/Barrier Group

school, 13 percent had a teen in trouble with the police, 2 percent had a teen (age 17 and under) drop out of school, and 4 percent had a teen that got pregnant or got someone pregnant (results not shown here). Figure 3.4 and Figure 3.5 show group differentials between Waves 1 and 2 in school suspension/expulsion and run-ins with the law, behaviors which appear (based on their higher frequency) to be the more sensitive

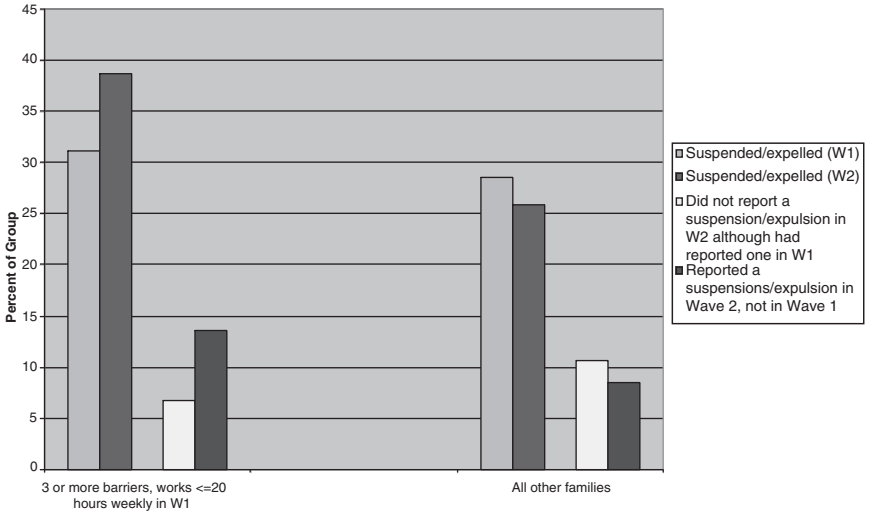

Figure 3.4
Teens Ever Suspended or Expelled, by Work/Barrier Group

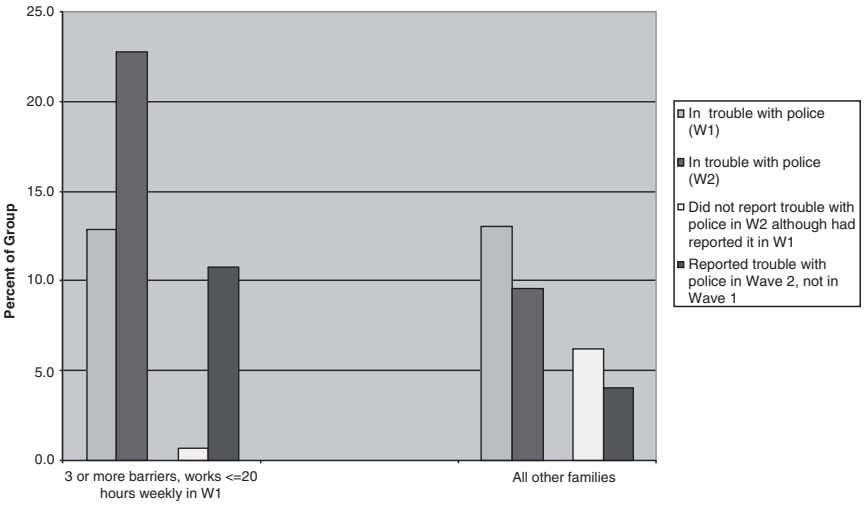

Figure 3.5
Teens Ever in Trouble with Police, by Work/Barrier Group

indicators of well-being among these school-age teens. The other two, rarely reported, problems do not differ significantly across time or across the key study groups.

While in the aggregate these two measures of teen behavior did not change significantly between the two interviews, Group C (those with many barriers and low employment) once again looked different from the rest: Rates did rise significantly from one interview to the next. In the first interview, 31 percent of Group C teens had ever been suspended or expelled and 13 percent had been in trouble with the police. At the second interview these rates had increased to, 39 percent and 23 percent respectively, with many parents newly reporting one of these problems in Wave 2.[20]

These results suggest that the passage of time leads to more negative outcomes for teens in the most-disadvantaged group. It is not clear from these data whether the deterioration was associated with timing out, or simply that the teenagers were growing older and engaging in more risky behavior. In either event, parents and teens in this group clearly face unusual challenges.

CHANGES IN EMPLOYMENT AND EARNINGS

An important result of this study of California families is that in most respects they were not economically worse off after reaching the 60-month time limit. Neither their incomes nor the hardships they reported changed in the aggregate between the months just before the time limit, and a few months after. Individual families became better off or worse off, but overall the measures of hardship and the income-to-poverty ratios hardly changed.

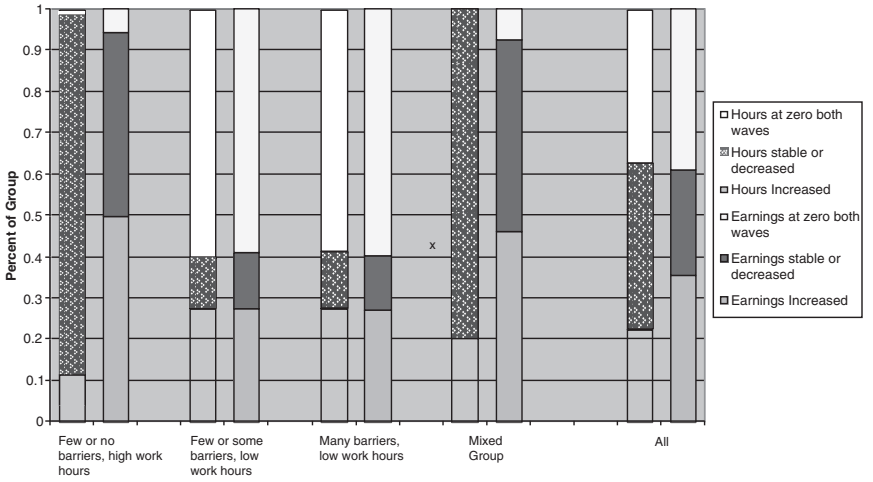

Figure 3.6
Changes in Hours and Earnings, by Work/Barrier Groups

This is a remarkable finding, given that in most states, reaching the time limit leads to a substantial reduction in income for at least some groups of recipients. To understand what happened in California we look first at hours of work and earnings. As noted earlier, many CalWORKs recipients are not employed[21] and most remain so after timing out. Figure 3.6 shows the extent of changes in earnings and hours between the two interviews. Nearly two-fifths of all respondents reported no hours worked (39%) or no earnings (37%) at both Wave 1 and at Wave 2. About one-fifth (22%) reported increased hours, and a larger number (35%) reported increased earnings, suggesting that some respondents enjoyed pay raises between the two interviews.[22] Some worked fewer hours at Wave 2 (21%) and a similar proportion (21%) reported lower earnings. Stability was more common than change: 57 percent had the same hours as before (typically zero), and 44 percent had the same earnings. On average, there was only minimal change in respondents' hours worked by about 30 minutes weekly (those working more balanced out those working less). Earnings, however, increased by an average of $102 per month in the whole sample, or $174 a month for respondents working at either interview. The earnings increase juxtaposed against almost unchanged work hours implies that average wages were higher at the second interview. Wages might have risen for those working at both periods or the people working more at Wave 2 might have been somewhat different from those who reduced their work hours after Wave 1.

Most respondents in the high-employment groups (Groups A and D) saw changes in their hours or earnings. Among Group A respondents, earnings rose for 50 percent and declined for 31 percent, and the average Group A family had $58 more in earnings per month. Group A hours rose for 12 percent and dropped for 38 percent, and dropped overall by 8 hours per week, even while their average earnings rose.

The large majority of Groups B and C were not working at either of the interviews (60% of Group B and 59 % of Group C). However, some previous nonworkers did find jobs and others increased their hours, with the result that 27 percent of each Group worked more hours at Wave 2, and only 9 percent of Group B (6% of Group C) worked fewer hours. Earnings changed at the same rate as hours—27 percent of both Groups were earning more and 12 percent of Group B (13% of Group C) was earning less. The workers in these Groups (respondents with hours or earnings at one of the interviews) worked considerably more at Wave 2 than Wave 1—an average of 15 hours more per week. Among workers, earnings rose substantially, by $351 monthly in Group B and an even larger $430 monthly in Group C. (Averaged across the workers and non-workers, Group B enjoyed an earnings gain of $132 and Group C an earnings gain of $173.) It is noteworthy that despite facing at least three work barriers, Group C had a larger gain in earnings than Group B, facing two or fewer barriers—perhaps because Group C was the best-educated group, with 41 percent having attended college.

Group D respondents, who are a mixture of those working an intermediate amount at Wave 1 and those with many barriers working full-time, are the only group with a (very small) loss in average earnings, of $14 per month, and similar numbers increased as lost earnings (46 and 43%, respectively). This group worked, on average, 9 hours less per week, so the fact that their earnings did not fall noticeably suggests that, like Group A, the average wage for this group may have been higher in Wave 2 than Wave 1.

Given that many in Groups B and C remained at zero hours of work, and that earnings dropped markedly for the full-time workers in Group A, a strict time-limit policy such as awarding few exemptions and terminating aid entirely to all others might have led to substantial reductions in family income. This, however, did not happen. Rather, California's welfare policies seem to have cushioned these families as they reached the 5-year TANF time limit.[23]

WELFARE RECEIPT AT SECOND INTERVIEW

Welfare for many families is a fluctuating source of income, higher when earnings are low, and minimal or zero as earnings increase. Families working full-time, with relatively high earnings, are especially likely to become ineligible for aid if their earnings increase even slightly. This fluidity was evident at the very start of the study: between the time when families were selected for the study and the first interview conducted some weeks or months later, ten percent of the sample left aid. Among the few barriers/high work group, 22 percent had exited by the time of the first interview. Almost everyone (85%) off aid in Wave 1 was still off in Wave 2.

All the respondents who were still on welfare at Wave 1 (90% of the entire sample) had already, according to the welfare records when they were selected for the study, accumulated nearly 60 months of cash aid. Following state policy, as they approached the time limit their files would be reviewed to assess whether an exemption was warranted (either prospectively or retrospectively) to stop the CalWORKs clock.

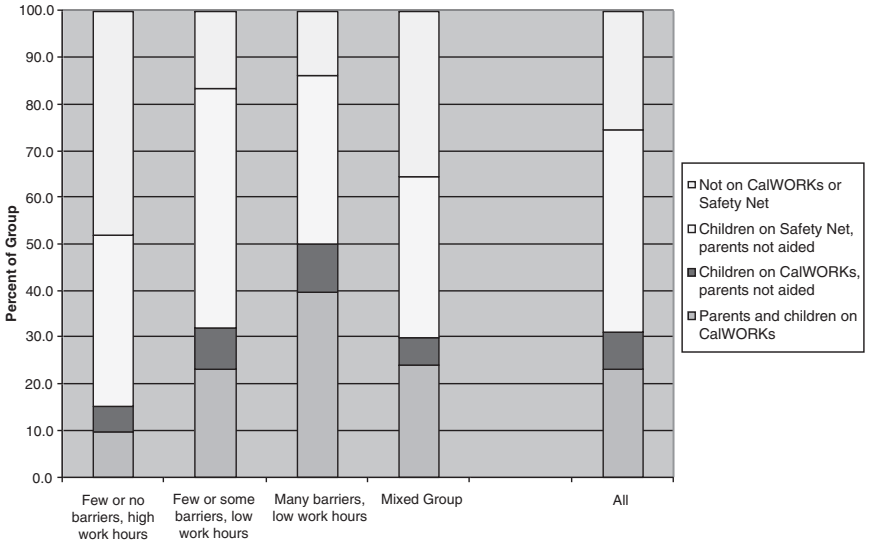

Figure 3.7
Welfare at Wave 2 by Work/Barrier Group among the Aided at Wave 1

Recipients not given an exemption or extension could also be aided through the Safety Net program, which has the same grant levels and eligibility thresholds as CalWORKs but excludes timed-out adults from the assistance unit. Additionally, some respondents' CalWORKs clocks had been stopped because the parents were excluded from the assistance unit and the family received a child-only grant (the same dollar amount as under the Safety Net).[24]

Thanks to these three routes to continued aid, 69 percent of the sample (and 77% of those on aid at Wave 1) were on aid at the second interview. As Figure 3.7 shows, the largest portion, 40 percent of the entire sample, were on the Safety Net, while 21 percent were on full-family CalWORKs because of an exemption or extension and 8 percent were on child-only CalWORKs. Given the large number that switched into the Safety Net from CalWORKs, it is not surprising that 45 percent were receiving a smaller grant than at Wave 1.[25]

Assistance was common across the entire sample, although there were also large differences between groups, as Figure 3.7 shows. Even among the highly employed Group A, only about half of families who had received CalWORKs at Wave 1 (48%) were off aid entirely in Wave 2. The aid received by Group A came mainly from the Safety Net (36%), although 10 percent still qualified for full-family CalWORKs. In contrast, families in Group C, with the most barriers, were the most likely to be on full-family CalWORKs (40%). Only 14 percent were off aid entirely. Group B, with fewer barriers but also little or no work at Wave 1, had relatively fewer on full-family CalWORKs (23%) and more on Safety Net or child-only CalWORKs (60%).

DISCUSSION

Five themes stand out in this study of families reaching the 5-year welfare time limit in California. First, even before reaching the time limit, virtually all these families faced serious difficulties in their lives, difficulties that are both causes and consequences of poverty. Some of these difficulties appear in this study as "barriers to work," others are counted as "hardships." Both barriers and hardships were widespread among this sample of families approaching 5 years of aid. More than half (57%) faced at least one personal or family-related barrier to employment, such as their own work-limiting health problem, caregiving responsibilities for a child or adult family member with a limiting health problem, a recent experience with domestic violence, a likely learning disability, or a mental health problem that interferes with work or school. Not considered here are barriers that are associated with the economic or service environment, such as a poor local job market, inadequate public transportation, or insufficient child-care options.

The hardships we asked about—including not enough food, utility shut-offs, unstable and crowded housing, difficulty or delay in getting necessary medical care—were experienced by almost all of these families; the average rate was four such problems per family. Furthemore, many children in these families suffer from serious health problems. Teenagers, too, appear to be a high risk for behavior problems, particularly in the many barrier/low-work families. Teens' behavior problems in this group of families were the only indicators that showed significant deterioration from Wave 1 to Wave 2. This does not necessarily suggest any negative consequences of the time limit, but rather, probably highlights how behavior risks increase with age among this group.

The second theme is the striking diversity among these families in the nature and extent of difficulties they faced, and in their work participation. Barriers, while common, were far from universal: 43 percent reported no employment barriers, but at the same time, nearly 20 percent reported three or more. One-third (32%) of the sample worked full-time or close to it, but half (48%) were not working at all and had not worked in the preceding year. The extent of barriers to employment is not nearly as correlated with employment itself as one might expect, particularly given that many of the barriers were defined as interfering with work. Even among people with similar levels of barriers to work, some did not work at all, while others worked full-time.

Our third point is that the time limit does appear to have had the desired effect on work participation among recipients. Most of the gain in work hours is due to the entry into employment of parents who before were working minimally or not at all. However—our fourth point—upon reaching the 5-year time limit, only one-quarter of all families (25%) actually left cash aid. This is the result of an anomaly in the California program, whereby the children of parents who time out can continue to receive aid through the state-funded Safety Net program. Indeed, nearly half (43%) of families that reached the time limit transferred to the Safety Net program, a further 8 percent received child-only CalWORKs (for children whose parents were sanctioned

off CalWORKs or others whose parents do not qualify for reasons other than timing out), and nearly one-quarter received full-family CalWORKs. Many of these families continued to combine cash aid with earnings; overall there was a modest gain in average monthly earnings and a minimal gain in weekly hours worked. For those who worked very little or not at all at Wave 1, timing out appeared to have a larger impact on work, with an increase of about 6 hours per week. One-quarter of those who were not working at Wave 1 were working at Wave 2.

Our fifth and final point is that the Safety Net has had the desired effect, to protect children (and, by extension, their parents) from economic destitution. Families had the same average incomes (when scaled to the poverty threshold) at Wave 2 as at Wave 1. The average number of hardships within each group and across the entire sample was also no different at Wave 2 than at Wave 1. This is a critically important result: the welfare time limit as implemented under CalWORKs moderately increased work effort and earnings and did not increase average levels of hardship or drive families deeper into poverty.

As we mentioned at the beginning of this chapter, it is not news that many TANF families nearing the time limit have employment barriers and face substantial material hardship. Our analysis demonstrates that reaching the CalWORKs time limit may not be tremendously detrimental to families, even those that are not stepping onto the employment escalator, due to the safeguards put in place in the CalWORKs program—exemptions/extensions for families who face certain barriers, and for the rest, the state-funded Safety Net program that allows children to remain on aid even after their parents time out.

For those in the most dire situations, with many employment barriers and low work effort at the onset of the time limit, there is no question that use of both these safeguards protected family well-being. However, even among the group with few barriers and high employment, Safety Net use was substantial and points to the fragility of the labor market in moving even the most able to the point of self-sufficiency. One can only speculate about what would have happened to all exiting CalWORKs families in the absence of the Safety Net. The very presence of this program could have led families to different employment and welfare choices than they might otherwise have made. However, given the reliance on Safety Net benefits by nearly half of those who timed out, and the extent of employment barriers among the CalWORKs adults who reach the time limit, it seems likely that this support was critical for protecting California's children against severe poverty and hardship.

NOTES

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represent those of the William and Flora Hewlett Foundation, The Regents of the University of California, WPRP, its advisory board, or any State or County executive agency represented thereon.

1. US Department of Health and Human Services (2006), "Welfare Rolls Continue to Fall: 2nd Quarter Data Ending June 2005 Show Another Decline in Caseloads." USDHHS News Release, February 9, 2006.

2. Urban Institute (2006). "A Decade of Welfare Reform: Facts and Figures." June 2006.

3. Sarah E. Crow and Jacquelyn Anderson. 2006. *Working Against the Clock: The Implementation of Welfare Time Limits in California.* Oakland, CA: California Policy Research Center, Welfare Policy Research Project (available at the WPRP website: http://wprp.ucop.edu). This report, the first from WPRP's time limit study, has on page 19 a table summarizing the four federal and ten state exemptions. The report provides extensive discussion of the exemptions, including California's unique exemption for court-ordered child support payments.

4. With approximately 24 percent of the nation's welfare caseload but only 12 percent of U.S. the population, California has a much higher per-capita welfare participation rate than other states. See National Conference of State Legislatures, available at http://www.ncsl.org/statefed/welfare/caseloadwatch.htm for welfare caseload data.

5. All had accumulated at least 54 months of aid when they were interviewed, and most were in months 57–59. A few we were not able to interview until their actual month of timing out, or even one month later. This is not a serious flaw, however, because most of the questions pertain to the period immediately prior to the interview, when they had not yet timed out. Additionally, although all were on CalWORKs when they were selected to participate, by the time they were reached for interview about eight percent had left the program and were not on aid. They had not yet timed out, but had left voluntarily.

6. A portion of the full sample had not completed their second-wave interviews when this chapter was prepared.

7. The full study included shorter simultaneously-translated interviews in dozens of other languages, which omitted many of the questions analyzed here

8. As noted, the six counties together comprise more than half the state caseload. In order that the results simply not be driven by the Los Angeles sample we do not weight counties proportionate to their populations but instead give each county equal weight in calculating sample percentages. Supplementary analyses show that the results do not vary greatly under other weighting schemes.

9. Two-parent households are considered working full-time if at least one person worked this much.

10. The complete definition of this group is: a single parent was working less than 20 hours and not working full-time in the previous year; two parents were were working less than 30 hours between them and neither had worked full-time in the past year.

11. Mark Courtney and Amy Dworsky. "Those Left Behind: Enduring Challenges Facing Welfare Recipients." Chapin Hall Center for Children, University of Chicago. Issue Brief #107, May 2006.

12. Susan Hauan and Sarah Douglas. 2004. "Potential Employment Liabilities Among TANF Recipients: A Synthesis of Data from Six State TANF Caseload Studies." US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, October 2004.

13. Sheila Zedlewski. 2003. "Work and Barriers to Work among Welfare Recipients in 2002." *Snapshots of America's Families III Number 3*. Washington, DC: The Urban Institute.

14. Our sample excludes teen parents, and also residents of Indian Country, so we did not ask in the surveys about those CalWORKs reasons for exemption.

15. These data refer to barriers that survey respondents faced at Wave 1 of the survey.

16. The health limitations measure is coded 1 if the respondent reported "an ongoing physical, mental, or emotional problem that limits [her/him] in the kind of work or amount of work that [s/he] can do."

17. These percentages refer to the two-wave sample of 1,058, but the entire Wave 1 sample had very similar distributions.

18. Nan Astone and Sara McLanahan. "Family structure, residential mobility and educational attainment." *Demography*, 31(4) (1994): 575–584.

19. The poverty thresholds are typically measured for families rather than households. Because we examine household rather than family income, we may be somewhat underestimating "official" poverty rates for this group.

20. Between the two interviews some 12-year-olds became teens and some 17-year-olds became adults, so the target population changed slightly. When parents are reporting about the same children (the majority of cases), there should only be additional problems reported, and none disappearing, between the interviews, because these are lifetime measures. However, in these as in all other survey questions, some respondents misreport, whether because of stigma, forgetfulness, or because an event no longer seems to fit the question (For example, a teen who dropped out before Wave 1 might not be reported as dropping out if she returned to school before Wave 2). As Figure 3.2 shows, responses did change and, populations differ between Wave 1 and Wave 2, the changes do not always add up to the new rate at Wave 2.

21. Recall that 48 percent of the sample was not working at Wave 1 and had not worked in the preceding year.

22. To minimize the impact of small changes, single parents with changes in hours under 4 hours or changes in earnings under $50, and couples with changes in hours under 8 hours or changes in earnings under $100, were considered to have unchanged hours or earnings respectively.

23. A rigorous assessment of post-time-limit cash aid is beyond the scope of this chapter; the fluidity of individuals' welfare participation and their many possible reasons for welfare exit or re-enrollment make the statistical issues quite daunting.

24. Parents and caregivers are excluded from the assistance unit if they themselves are aided through SSI, if they are sanctioned for program noncompliance, and for a few other reasons. Respondents enrolled in child-only CalWORKs at Wave 1 were counted as "on welfare," not off welfare.

25. Grant levels vary greatly with earnings as well as between programs, and many respondents' earnings fluctuate, so 26 percent had higher grants in Wave 2 and only 3 percent had the same grant.

CHAPTER 4

Women and Children in the Health Care Gap

Jane Henrici, Ronald J. Angel, and Laura Lein

In this chapter we consider the insecurities of health care access tied to changing gender roles and family patterns. From our examination of the current socioeconomic context and our data, we find current American policy and practice and its decreasing lack of support for health care for women and their children problematic and in need of change. At the same time that a rising percentage of women in the United States now must work for wages to sustain themselves and their children, many nevertheless go without adequate health coverage and care. This situation relates to two existing gender gaps within the larger socioeconomic context.[1] Both of these gaps affect women as well as other family members including children, and are particularly pronounced for women of color and their families.[2]

The central issue is that for the last several decades the cost of health care has increased at a rate far greater than that of food, transportation, housing, and the rest of the package of consumer goods that a family needs to survive. Meanwhile, as health care has become more expensive it has also become more essential to guaranteeing optimal health at all ages. Modern medical care is expensive largely because it is effective. Unfortunately, even though adequate health care coverage is necessary for a healthy and productive life, a growing number of American families face the possibility of short-term or longer-term gaps in coverage. Faced with the growing costs of group plans many employers have stopped offering health insurance altogether or they require their employees to bear a larger portion of the cost. For many working and middle-class Americans these health care insecurities are a new and discomforting phenomenon, but for minority Americans, the poor and single mothers with children these insecurities are not new. If anything, the vulnerability of these traditionally vulnerable groups has only increased as federal and state governments grapple with the growing cost of public health care.

Single-parent households with children face particular vulnerabilities in health care access as the result of a combination of factors, each of which presents a family with barriers to care and, taken together, place the health of many poor adults and children in jeopardy. Single-parent households tend to be headed by an unmarried female and are disproportionately poor and members of ethnic and racial minorities. Escaping from this situation through employment remains an elusive goal for these families. Most minority single mothers can find work only in the low-wage service sector in which they are not offered benefits and in which employment is episodic and insecure. In this chapter we explore these themes using as a focus a case study of one mother who was part of a large-scale, multidisciplinary study of women, children, and poverty in three large American cities.[3] We conclude that given the inadequacy of the public health care financing system of the United States and the lack of possibilities for work-based health care coverage for poor families, the health care needs of both poor and middle-class families can only be addressed through a system of universal health care coverage.

The original study from which our in-depth examination of one family is drawn was motivated by a desire to understand the potential consequences of the changes in welfare that were introduced by Congress in 1996 on the lives of children and their caretakers in impoverished families. The Personal Responsibility and Work Opportunity Reconciliation Act of (PRWORA) made welfare time-limited and placed new pressures on couples and women on welfare to leave the rolls and find employment. At the same time that welfare reform introduced more stringent work requirements for single women and couples, the nature of low-wage jobs continued to place employer-sponsored coverage out of reach for both women and their male partners. As a consequence, poor families remained dependent on Medicaid and the State Children's Health Insurance Program (SCHIP). What we found in the study is that although almost all young children in families below 200 percent of the official government poverty life qualify for public coverage based on their family's income, obtaining and maintaining coverage for all children in large families required constant effort on the part of parents; and, even when they expended that effort, most families experienced periods in which some children, often the older ones, were without coverage. The adults in these families were rarely able to obtain coverage of any sort for themselves and, as a consequence of inadequate and incomplete health care, their health and productive capacities were undermined.

In what follows, we examine the multiple themes of gendered work, single motherhood, and the impact of both on access to health care.[4] As we will see, poverty and its negative health consequences are not evenly distributed throughout the population; certain segments of the population defined in terms of gender, race, and ethnicity are the most vulnerable.

THE FEMINIZED WORKFORCE AND WAGES

The term "feminized workforce" is used to describe the current dominant work and wage system in which low-wage employment rises within industries and in forms

that preferentially select for women and hire all workers with an emphasis on flexible hours, unstable contracts, and no benefits. The gender gaps that affect the health of children of poorer women appear both in the lower salaries that women receive so that they are limited in their ability to pay out-of-pocket for care, and in their larger chance of being employed within these sectors and thus lacking either salaries or health coverage to address their health care needs.

Women earn less than men in general, and minority women earn less than majority women. This results from the fact that even more than the rest of the workforce, employment opportunities available to many minority and poor women are marked by low wages, irregular hours and pay, job insecurity, and often institutional stratification by race and ethnicity.[5] The economic vulnerabilities that women, and especially minority women, face are the result of historical processes and current economic patterns that have restricted educational and occupational opportunities to women, African Americans, and Latinos in particular for generations, and which have placed glass ceilings of color at very low levels in the occupational hierarchy. As our study showed, the combined characteristics of low-wage work and the dependence on public assistance of all sorts undermines a woman's ability to enhance her human capital through education or job training.[6]

The disproportionately low wages that all women in the United States continue to receive relative to men reflect cultural beliefs and practices as well as labor market characteristics and public policies of more than a century of history.[7] Ideas about women's wages can be traced at least to nineteenth century British social structure in which the male breadwinner was viewed as the primary source of the welfare of his wife and children. The welfare of children, and the appropriate social order, required that women should not work outside the home and should devote themselves to domestic labor. Families were the basic production and consumption units and at most charitable religious and social services might assist with unexpected needs so that women need not work while they raised their children.[8]

Despite this primarily middle-class ideal of domesticity, women in the United States, particularly those of the poorer and working classes, have always worked outside the home to help support their families. More recently, mothers have been forced to work in the attempt to secure health care for themselves and their children.[9] Unfortunately, given the types of jobs that poorly educated and low-skill women can get the effort is often futile. The family model that includes a male breadwinner and in which women's salaries are secondary and their independent medical coverage superfluous, obscures the real life situations of many women and their families. Public policies that are based on this increasingly irrelevant male breadwinner model of family income and household employment help perpetuate the gender gap in salary and access to health care.[10] Today it would appear that a large fraction of children will spend at least some portion of their childhoods in a single-parent household headed by a woman with little earning capacity who is dependent on public health care coverage for her children.

Further, as noted, low-wage jobs, and increasingly higher-wage jobs as well, are marked by unstable employment and few benefits in the call for increasing "flexibility"

in the workforce.[11] Occupations in the service sector, including medical support staff, and retail industries in which women are overrepresented[12] are often structured around variable schedules, changes in number of hours worked, and a lack of benefits.[13]

MULTIPLE RESPONSIBILITIES

Compounding their difficulties with the feminized workforce is the fact that, although many women in the United States historically have been at least partially responsible for their household incomes, they also bore and continue to bear the major responsibility for child and elder care.[14] Women remain the primary child-care givers among married couples and are the more likely parent to retain responsibility for children in the event of divorce or separation. Traditional family arrangements have also placed the primary responsibility for aging and infirm parents on women. When older relatives need assistance because of poor health or for other reasons, women are the first to respond despite their other domestic and work responsibilities.

Poor women juggle these competing demands of work, family, and an increasingly punitive welfare system as best they can. Women of color, Mexican American women in particular,[15] are likely to experience periods with no health insurance coverage at a time when both employer-assisted programs and publicly funded health programs provide less coverage.[16] We now proceed to a case study to illustrate the ways in which the vulnerabilities we have identified work themselves out in the life of one family.

WELFARE REFORM AND CHILDREN: A THREE-CITY STUDY

Our example is from a study entitled "Welfare, Children, and Families: A Three-City Study," a large, multidisciplinary examination of all aspects of the lives of poor families in the period after the introduction of welfare reform in Boston, Chicago, and San Antonio. Approximately 2400 families were surveyed in three waves in 1999, 2000–2001, and 2004 (under analysis and not used for this chapter) in selected low-income neighborhoods in each city. Each household included at least one child younger than 4, or one child between the ages of 10–14.[17] The survey included a detailed study of child development among preschool children in the sample.

In addition to the survey and developmental assessment, the study included an ethnographic component in which approximately 60 low-income families were followed longitudinally in each city. The ethnography provided far deeper insights into the ways in which these families negotiated work, family, and welfare system demands in the neighborhood contexts in which they lived. Part of the ethnographic sample included a group of families in which at least one young child had a diagnosed disability.

Interviewers recruited welfare-eligible African American, Latin American, and European American families in each city. The ethnographic families were recruited between June 1999 and December 2000. About 40 percent of the families were

Latino, 40 percent African American, and 20 percent of European descent. Ethnographers met with the families monthly over an 18-month period and conducted 6-month and 12-month follow-ups. Most meetings occurred in families' homes, although ethnographers also accompanied family members to the grocery store, family celebrations, welfare offices, and on a number of other family errands and activities.

This chapter focuses on the city of San Antonio. San Antonio's economy is heavily reliant on tourism, light industry, and commerce. Unlike Chicago and Boston, which have historically had more developed industrial economies, San Antonio has less developed social service delivery, transportation, and employment opportunities. Since the introduction of welfare reform public aid has diminished in all three cities, at the same time considerable workforce growth has occurred in the service, freight, construction, and medical sectors. Jobs in these sectors are characterized by part-time work, low-wages, low-benefits, and often relatively unstable employment discussed in the introduction. As low-end wages stagnate and as benefit coverage deteriorates across the United States, all three cities face neighborhood and household changes. San Antonio is a useful example of a mid-sized city with an ethnic minority as the majority population and a core concentration of urban poverty.

The women we spoke to in each city made every effort to get and keep a combination of wages and welfare benefits necessary to support their households and to obtain health care for their children. In their struggle to do so, they often neglected their own health problems. Despite their best efforts, these women faced complex problems and irregularities in social service access that made it difficult to provide even their basic needs. Women with older children, or those with more than one child, found that finding and keeping a job, obtaining public supports, and maintaining health care coverage was often beyond their reach. Families in San Antonio faced particularly serious problems finding and keeping consistent health care.

Over the time we documented the "fits and starts" poorer mothers in San Antonio experienced with employment, child care, education, residency, and medical treatment. Throughout the study their difficulties seemed to multiply rather than diminish. Elsewhere we have presented a broader description of our findings and represented a number of the families interviewed.[15] Here, we concentrate on one household that exemplifies how problems for a woman with few resources and young children escalate over time and create barriers that keep her from dealing effectively with them.

"TERESA"

Teresa, as we will call her, was 33 with two daughters 10 and 12 years old and a 4-month-old son when we met her in July 1999. She and her children lived in a subsidized apartment in a housing development that sprawled across a formerly industrial section on the west side of San Antonio. Teresa participated in the study for over 3 years. She is of Mexican and African parentage and described herself as Hispanic, or simply "Mexican." Soon after the second daughter's birth, Teresa and the girls' father divorced, and in 1988 he was deported to Mexico. Teresa received no

support from him. She had severed ties to her son's father since he molested one of her daughters.

Through Teresa's example we will explore the ways in which health status and health care availability interact with the low wages, irregularity, and insecurity of gendered work. The study presents some difficulties faced by Teresa, since the family member's health and her work were intertwined with a host of other issues and problems including those related to the children's schooling, the family's housing, and their access to transportation. While this presentation focuses on the intersection of work and health, we also explore the ways in which both interact with these other problem areas. What was clear from the start was that the multiple responsibilities facing Teresa and her older daughter meant they were forced to sacrifice important elements of health care, as well as educational and work opportunities.[18]

Teresa's Health

When we met her, Teresa had been diagnosed with diabetes for 10 years. Her sister was also diabetic. Following her recent pregnancy, Teresa had experienced numbness in her legs, and by July 1999 had difficulty walking. Although she remained eligible for Medicaid coverage for a while after her last pregnancy, she still had difficulties with health care. Teresa was supposed to visit the physician every month and monitor her diabetes on a daily basis. However, she found it difficult to comply and often missed her scheduled visits because of family responsibilities, her children's health problems, her lack of transportation, or the fatigue and physical difficulties caused by her own worsening health. She also suffered from seasonal pollen allergies and during the study her diabetes-related conditions grew worse. Her vision deteriorated as she developed glaucoma. Her fingers, hands, legs, and feet all became symptomatic. She took three different prescriptions as well as insulin, but her diabetes was affecting her organs, and by May 2000 she learned that her kidneys were severely damaged.

Teresa's Work and Education

Teresa had a checkered educational and work history that was greatly affected by her health problems. She had dropped out of high school and was unable to complete her GED because of her poor health. She had worked as a nursing care assistant, and had been able to support her daughters without welfare in the early 1990s. By 1998, she was pregnant and increasingly diabetic, and had stopped working and applied for welfare but preferred to have stayed employed. She told us that she felt she would be "better off working," but also "would like to have insurance and hospital insurance for my kids" that were unavailable through her job. Her full-time position paid slightly above minimum wage and provided no benefits for her family.

In the summer of 1999, her son was a few months old, and Teresa was aware that she would be under renewed pressure to find a job and face sanctions from welfare if she failed to do so. However, she waited to look for work until she could get some treatment for her diabetes. In early December of 1999, Teresa and her children lived

in a shelter because she could not pay her rent, and her welfare funds were cut even further because her oldest child missed a week of school.

She continued to look for work even though she ran the risk of losing welfare and Medicaid if she were to find a job. Teresa worried that the physical demands of a nursing job would injure her health still further so she looked for other work. She found a job as a custodian at a sports arena but quit after 3 weeks. The wages were relatively low ($5.50/hour), the work hard, and the night hours difficult for arranging child care. A major precipitating factor was the hospitalization of her son for pneumonia and her need to stay home with him when he left the hospital. While the boy was sick, Teresa was exempted from the welfare-to-work requirements and regained TANF until her son was better. After that, she took another low-paying job.

Teresa returned to her nursing job in December 2000, and as a result lost her Medicaid and TANF. Unfortunately the job did not offer medical insurance. By February of 2002 her health had deteriorated further and she had difficulty standing or walking due to a pinched nerve in her back. She remained seated much of the day and used a cane to walk outside. As a result, she lost her job and had no way in which to pay for treatment or care. With no other option, Teresa again found herself dependent on welfare that she received for her son and older daughter, and on Medicaid, that the three of them received. Her middle child, who suffered from hyperactivity and attention deficit disorder among other problems, began receiving SSI (Supplemental Security Income) once Teresa was successful in obtaining that disability assistance for her.

Other People's Health

Both of Teresa's daughters suffered from health problems. Both girls were in what are called Special Education classes. Medicaid covered the younger girl's medicine, eyeglasses, and counseling, but Teresa struggled to pay for the nonprescription drugs that had been recommended for both her daughters and herself.

Teresa's son meanwhile continued to suffer from unspecified congenital problems. He was delayed in standing and experienced chronic asthma as well other acute ailments, including ear and eye infections and pneumonia. His health required a great deal of attention, but by his second birthday he was not only standing and walking, but beginning to dress himself. A year later he was toilet trained.

Meanwhile, Teresa's mother was hospitalized repeatedly with asthma and a liver problem, and occasionally stayed in Teresa's apartment when unable to care for herself. Teresa struggled to support the household for the period of her mother's illness with no income other than welfare (TANF) and Medicaid. At the hospital, Teresa and her siblings took turns attending their mother. Her mother died in early 2001.

Transportation

Teresa's ability to attend doctor visits, certification appointments for her Medicaid and other welfare services, and work was limited. Without a car, she had to walk

several city blocks to the nearest bus stop. Her physical condition often made this difficult. As a result, despite her impaired vision, Teresa bought a car in order to get to and from the jobs for which she had been told she must apply in order to receive any welfare coverage. Eventually, Teresa applied for a handicapped driver permit. When Teresa began receiving SSI because of her own poor health, she planned to have her elder daughter apply for an unrestricted driver's license in order that she become the family driver although the girl was not yet 16 years old.

Children's Schooling

As Teresa's health deteriorated, her elder daughter's assistance grew ever more essential in dealing with tasks ranging from caring for the baby to grocery shopping. On occasions, the daughter missed school in order to accompany Teresa to the welfare office. She supervised the younger children when Teresa had to rest, and cared for one when Teresa had to take the other to medical appointments or see the doctor herself.

The Fight for SSI

Teresa became increasingly disabled over time. She knew that SSI payments would be higher than what the family received from TANF and the income from that source would be more regular. Given her deteriorating health she did not think she could work much longer. After her younger daughter's ADD was diagnosed, Teresa applied for SSI for both herself and her daughter. Her younger daughter became eligible for SSI by February of 2000. Although the SSI allowance was more than TANF provided, her daughter also had new medical expenses but the family's total TANF cash benefits were lowered and their Food Stamps were cut because of the additional SSI income. Meanwhile, Teresa continued to be denied SSI for her own health problems.

By December 2000, Teresa's vision was deteriorating. She continued to drive her car to get to work, although her weak vision made this difficult. Without a workplace sick leave policy, she missed three doctor's appointments rather than lose her job. Finally, Teresa was approved for SSI in August of 2002, and automatically qualified for Medicare benefits. She gained access to new treatments and attended "diabetes classes" to learn about proper diet and exercise for diabetics. By the fall, Teresa was working to make her house wheelchair accessible and hoped that Medicare would pay for the chair.

Chronic Struggles

Teresa's story, although a single case, exemplifies the extensive and interrelated problems that mark the lives of most of the low-income single mothers that we interviewed. They struggled in low-wage and irregular jobs and had to deal with multiple complex responsibilities for children and older adults. Most had only transitory and

limited assistance from what, for many, was a deteriorating safety net. Using this narrative as a base, we now return to the general themes with which we introduced the chapter.

Low-Wage Jobs

Unlike many of the women interviewed in San Antonio, Teresa had the benefit of a skill set in which she had been trained and as a result could earn somewhat above minimum wages on those occasions when she could work. In that regard she may have been better off than many other single mothers. However, like many other mothers, for Teresa, the jobs she could get did not improve the family's economic situation. Working cost her a great deal financially since it involved multiple expenses for transportation, child care, and basic needs that welfare would not cover if she was working. This is a dilemma that has been described by other researchers as well.[19]

Further, in addition to their economic costs, the jobs Teresa could get took a physical toll on her. The physical demands required that she take time off from work for medical care or to recuperate and the illnesses generated additional health care costs. Financially, for Teresa, as for other single mothers, work was more of an economic loss than a means to economic self-sufficiency.

Irregular Jobs

Teresa, like many of the other mothers in the study, held jobs with irregular hours and hours outside the "normal" working day. Even these jobs were often hard to find and keep. Indeed, many of the mothers we spoke with worked at jobs in which their hours changed on a weekly or even daily basis. They worked different schedules each week, with changes in income depending on the number of hours assigned. This irregularity in employment had ramifications for a range of family functions from child care and homework supervision to transportation issues.

Multiple Responsibilities

Teresa faced a daunting and sometimes conflicting set of responsibilities. As a result of the new requirements that were part of welfare reform Teresa was required to look for a paid job in order to qualify for housing, for her children's medical care, and for cash assistance. In addition to these requirements, she was expected to find transportation, buy healthy food for the family on a limited budget, make and keep medical appointments for herself and her children, document all of these activities as part of the certification procedures for assistance, and somehow do it all without missing work. The result was that while she clearly provided for her children as best she could, she also depended on her children for essential services. Without her daughter's assistance it was clear that Teresa would simply have been overwhelmed.

The Unraveled Safety Net

The economic foundation upon which a poorer family's economic welfare depends is rarely firm. As for Teresa, their dependence on jobs that offer no benefits and the continuous uncertainty of their welfare benefits means that low-income mothers must engage in an ongoing search for necessary services for their families. Teresa's struggle was one that seemed to have no potential positive outcome. As her health deteriorated her capacity to work or to manage the complexities of her life did as well. She was engaged in a constant struggle to locate medical care and other services, while she also tried to find and keep jobs, none of which offered enough income or stability to improve the family's situation.

Even when Teresa was eligible for services, the application process could be difficult and lengthy. Many families in our study found the application process for social and medical services complicated. Maintaining their eligibility requires continual recertification and interactions with the bureaucracy. As a result, they often faced interrupted or delayed medical coverage. Many families lost coverage because they did not bring all necessary records to meetings with caseworkers. Missing required documentation is easy since so many are required, including original records of income, children's birth and health, and the father's capacity to support the child. If any of these documents are missing or lost in the application process itself, families may lose or face delays in their Medicaid coverage. Although SCHIP has been a great boon to a number of families, others find the application procedure confusing since they must document their ineligibility for Medicaid before they can apply for SCHIP.

Teresa, like many mothers, did not understand her own or her children's eligibility for transitional benefits after the loss of TANF. Although Teresa continued to apply for what she needed, many families were troubled by the stigma associated with public assistance, and in some cases they faced barriers resulting from the inability to speak English.[20] Families struggled to understand the different messages from caseworkers, physicians, educators, and the larger society about welfare eligibility and use.

As a result of the pressures of multiple responsibilities and limited resources mothers often experienced a cascade of negative consequences as difficulties in one domain fed into and exacerbated difficulties in another. Teresa's precarious health, as well as her children's health problems, made it difficult for her to keep a job or to keep her children in school or in child care, and for a time they were homeless. Her work, the overall condition of the family, and the family members' education all were undermined by poor health. Yet, when Teresa lost a job, health care remained unavailable.

Policy Responses

Without more regular jobs and assistance in meeting basic needs for medical and other services, it is hard to see how families like Teresa's and the others in our study could become stable. Even full-time minimum wage jobs can leave families with incomes below the poverty line. Jobs that offer irregular, part-time work almost assure

that a family will remain in poverty and that they will be worse off than on welfare. Low-wage jobs leave single mothers unable to support their households without ongoing assistance and they make frequent crises almost inevitable. For the families we studied, even if they were willing, fathers were unable to contribute enough to make a real difference in household finances. While the fathers of Teresa's children made no attempt to contribute to their children's support, many mothers reported receiving aid, however, it usually consisted of small and unpredictable donations from fathers whose jobs were as irregular and low-paid as those of the mothers. Without higher wages and more regular work, as well as the critical addition of subsidized health coverage, single mothers will be unlikely to support stable households.

Given the nature of the low-wage labor force, even mothers with regular, but low-paid employment required the assistance of public services. Even working mothers often need assistance with child care, medical care, Food Stamps and other problem areas to make ends meet. At the bottom of the income hierarchy even the most diligent budgeting and money management cannot make a limited income stretch as far as is needed to meet a family's needs. A brief analysis of our medical system as it relates to the needs of low-income families illustrates the problems associated with a means-tested approach to basic service needs. Indeed, there have been some important attempts to make these programs more accessible to working mothers. However, while mothers must meet eligibility requirements and seek recertification for services while juggling the demands of work and family on a poverty budget, they are unlikely to be able to stabilize their families.

Innovations in Medicaid and other programs can certainly help impoverished families but even with reforms such means-tested programs are unlikely to result in stability in health care access over the long term. In recent years the Medicaid application process has been simplified and the state-funded and federally matched SCHIP has been introduced to insure that children in families ineligible to receive Medicaid are covered. These reforms and programs extended coverage to a large number of children in families with incomes well above poverty. In the face of shrinking state revenues, expansion of SCHIP or Medicaid seems unlikely, and in Texas and some other states funding has been cut and many women and their children again find themselves without coverage.[21]

Although federal and state governments provide health care coverage for children in poor families, almost no programs provide similar coverage to their parents, unless they are pregnant or disabled.[22] As a result of economic stagnation, smaller state budgets, and rising health insurance costs both Medicaid and private health insurance coverage for children have diminished following welfare reform[23] in spite of increased federal spending on Medicaid.[24] Nearly 11 percent of all children (8.2 million) lacked health insurance coverage in 2002.[25] Yet nearly half of these children qualify for public care on the basis of family income.[26] This fact illustrates the impact of the barriers to accessing and maintaining coverage. The situation is unlikely to improve in the short term since states have instituted methods to cut their share of the Medicaid costs.[27] These strategies include limits on services, caps on enrollment, and restrictions on prescriptions covered.[28]

As this chapter goes to press, the federal budget cuts rather than maintains public health care coverage. Poorer and working-age families with children will be among the most seriously affected.[29] Established research, in addition to our study, documents the association between a lack of health insurance coverage, inadequate health care, and poor health outcomes.[30] That is, the diminished health care coverage will increase the probability of serious illnesses for children.[31] Lowered vitality and educational deficits resulting from poor health then increase the risk of intergenerational poverty.[32]

Elsewhere, we have presented a full argument in support of universal health coverage in the United States.[33] As part of the public debate over health care reform in the United States we must investigate avenues that move us toward a more egalitarian and universal medical care system that does not penalize specific segments of the population based on gender, marital status, race, ethnicity, and income. We must also address the serious problems associated with the decentralized and fragmented programs that provide other necessary services such as child care, public housing, and adult training and education if we are to truly stabilize impoverished families headed by workers in low-wage jobs. Finally, the problems of poor families cannot be addressed without critically assessing the liberalized low-wage labor market, what is called the feminized workforce, and its growing rather than diminishing gender gaps which provide inadequate income, irregularity, and no benefits to workers that undermine even the most diligent efforts to get ahead.

NOTES

1. Elsewhere we have discussed health coverage and care in the United States and other nations in a more comparative manner, in *Poor Families in America's Health Care Crisis*, ed. Ronald Angel, Laura Lein, and Jane Henrici (New York: Cambridge University Press, 2006).

2. Pamela Braboy Jackson and David R. Williams, "The Intersection of Race, Gender, and SES: Health Paradoxes," in *Gender, Race, Class, and Health: Intersectional Approaches*, ed. Amy J. Schulz and Leith Mullings (San Francisco: Jossey-Bass, 2006); Sara McLanahan, "Family, State, and Child Well-Being," *Annual Review of Sociology* 26 (2000): 703–706; Alice O'Connor, "Poverty Research and Policy for the Post-Welfare Era," *Annual Review of Sociology* 26 (2000): 547–562; Ruth E. Zambrana and Bonnie Thornton Dill, "Disparities in Latina Health: An Intersectional Analysis," in *Gender, Race, Class, and Health: Intersectional Approaches*, ed. Amy J. Schulz and Leith Mullings (San Francisco: Jossey-Bass, 2006).

3. We are grateful for both the funding support we received for this project, the help of multiple study team members, and the families and agency workers who so generously gave us their time and views. For more information about all of these please see www.jhu.edu/~welfare.

4. Elsewhere we have discussed health coverage and care in the United States and other nations in a more detailed and comparative manner, in *Poor Families in America's Health Care Crisis*, ed. Ronald Angel, Laura Lein, and Jane Henrici. (New York: Cambridge University Press, 2006).

5. Jackson and Williams, *Gender, Race, Class, and Health: Intersectional Approaches*; McLanahan, "Family, State, and Child Well-Being"; O'Connor, "Poverty Research and Policy

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6. Jane Henrici and Carol M. Miller, "Work First, Then What? Families and Job Training after Welfare Reform," in *Doing Without: Women and Work after Welfare Reform*, ed. Jane Henrici (Tucson, Arizona: University of Arizona Press, 2006).

7. Suzanne M. Bianchi and Daphne Spain, "Women, Work, and Family in America," *Population Bulletin* 51(3) (Washington, DC: Population Reference Bureau, Inc., December 1996).

8. Jane Lewis, "Gender and the Development of Welfare Regimes," in *Power Resources Theory and the Welfare State: A Critical Approach*, ed. Julia S. O'Connor and Gregg M. Olsen (Toronto: University of Toronto Press, 1998); apparently, there was one decade in U.S. history in which this elite British model was also the American average and that was, as popular culture leads us to expect, during the late 1940s through mid-1950s; however, according to research on this topic, there has never been a period in which the majority of American men were able to pay all household expenses with only their wages and without help from other sources (if not from women's incomes then, for example, from their parents).

9. That includes women receiving cash benefits, or welfare, as a number of researchers have shown: Kathryn Edin and Laura Lein, *Making Ends Meet: How Single Mothers Survive Welfare and Low-Wage Work* (New York: Russell Sage Foundation, 1997).

10. Bianchi and Spain, "Women, Work, and Family in America"; Lewis, *Power Resources Theory and the Welfare State*.

11. Holly Bell, "Putting Mothers to Work: Caseworkers' Perceptions of Low-Income Women's Roles in the Context of Welfare," in *Doing Without: Women and Work after Welfare Reform*, ed. Jane Henrici (Tucson, Arizona: University of Arizona Press, 2006); Laura Lein, Alan F. Benjamin, Monica McManus, and Kevin Roy, "Without a New, Without a Job: What's a Mother to Do?" in *Doing Without: Women and Work after Welfare Reform*, ed. Jane Henrici (Tucson, Arizona: University of Arizona Press, 2006).

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17. At the time of the interview, 40 percent of the survey families were receiving cash assistance and few had private health insurance.

18. Angel, Lein, and Henrici, *Poor Families in America's Health Care Crisis*.

19. Edin and Lein, *Making Ends Meet*.

20. Glenn Flores, M. Abreu, M.A. Olivar, and B. Kastner. "Access Barriers to Health Care for Latino Children," *Archives of Pediatric Adolescence Medicine* (1998): 1119–1125; Janet Perloff. "Insuring the Children: Obstacles and Opportunities," *Families in Society: The Journal of Contemporary Human Services* 80(1999): 516–530; Mae Thamer and Christian Richard. "Health Insurance Coverage Among Foreign-Born US Residents: The Impact of Race, Ethnicity, and Length of Residence," *American Journal of Public Health* 87(1997): 96–102.; Robin Weinick and Nancy Krauss. "Racial/Ethnic Differences in Children's Access to Care." *American Journal of Public Health* 90(2000): 1771–1774.

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CHAPTER 5

DISPERSING THE POOR: NEW DIRECTIONS IN PUBLIC HOUSING POLICY

Alexandra M. Curley

The 2000 census revealed that 2.3 million children in the United States live in extremely poor neighborhoods (poverty levels of 40% or more).[1] The growing field of "neighborhood effects" research suggests that neighborhood poverty, as opposed to just family poverty, can play an important role in child and family outcomes, such as employment, welfare participation, child development, and delinquency.[2] As a result, theorists and policymakers have argued that if concentrated poverty contributes to social problems and reduced life chances, then deconcentrating poverty should reverse this effect. This rationale has led to housing dispersal programs and mixed-income housing initiatives that intend to deconcentrate poverty, and consequently reduce the social problems attributed to the extreme poverty concentration in urban public housing developments.

This chapter reviews two large public housing initiatives that seek to deconcentrate poverty: Moving to Opportunity (MTO) and HOPE VI. These programs hope to improve the lives of poor families by changing the neighborhood environments in which they live through relocation to different communities and/or the redevelopment of public housing developments. The chapter reviews research on the effects of these two programs on low-income families and highlights key areas that could be strengthened in order to better help improve the lives of low-income families.

NEW DIRECTIONS IN PUBLIC HOUSING POLICY

In the 1930s and 1940s, public housing policy in the United States focused on constructing housing for working families. By the 1960s, the targeted recipients of public housing had shifted to those most in need of housing assistance. As tenant selection and rent calculation procedures changed, many working families moved

out of public housing.[3] These communities turned into blighted pockets of extreme isolation and disadvantage, and the physical and social conditions of the developments deteriorated. As a result, public housing policy has been criticized for contributing to the concentration of poverty, race, and social problems in urban communities across the nation.

Policymakers and scholars have realized that concentrating extremely poor households in large superblock public housing projects in low-income communities leads to further racial and economic segregation, as well as isolation from opportunities. One early policy response to this practice was the Section 8 program (recently renamed the Housing Choice Voucher Program), a housing assistance program created in 1974 that provides portable vouchers for people to rent in the private housing market. Rather than concentrating people in public housing developments, the vouchers allow low-income families to rent apartments throughout different communities. More than 1.4 million households currently receive housing vouchers.[4]

In response to the growing concentrations of low-income families of color in public housing, the Gautreaux program was established by the courts in 1976 to desegregate Chicago's public housing. Gautreaux provided vouchers to low-income black families living in high-poverty public housing communities to relocate to predominantly white higher-income suburbs. Research found that the children of the families who moved to the suburbs were more likely than those who remained in the city to graduate from high school, enroll in college, and obtain jobs with benefits.[5] However, there were no differences in adult wages or the percentage of families living in poverty. Yet, mothers who moved to the suburbs were more likely to be working.[6]

MOVING TO OPPORTUNITY (MTO) PROGRAM

Inspired by some of the positive results of the Gautreaux program, HUD's Moving To Opportunity (MTO) demonstration program was created in 1994 as an experimental initiative to assess the effects of relocating public housing residents from concentrated developments to low-poverty communities. The five-city program (Baltimore, Boston, Chicago, Los Angeles, New York) randomly assigned public housing residents to one of three groups: (1) an experimental group, which received housing counseling along with Section 8 vouchers that could only be used in low-poverty neighborhoods (poverty rates of less than 10 percent); (2) a Section 8 group that received traditional vouchers (not restricted to low-poverty communities); or (3) a control group that remained in public housing. The random assignment was used to improve researchers' ability to attribute measured differences to the intervention (relocation to low-poverty neighborhoods) and not to differences in family characteristics or motivation.[7] Yet, only about half of those who were offered the opportunity to relocate to low-poverty neighborhoods took up the offer, making strong conclusions difficult.[8] Still, much can be learned about the program's impact from research so far.

Early short-term impact studies were conducted by different groups of researchers in different MTO sites about 2 to 3 years following implementation. In addition to these site-specific studies, an interim evaluation was conducted to measure mid-term

impacts across all five MTO sites about 6 years following implementation. Research has focused on assessing whether moves to low-poverty neighborhoods resulted in positive neighborhood effects such as improvements in self-sufficiency, health, child development and achievement, and delinquency. Previous research suggests that neighborhoods can shape access to opportunity through factors such as neighborhood resources (schools, institutions, proximity to jobs), neighborhood characteristics (crime, disorder, violence), and social capital (social networks, middle-class role models, job contacts). Overall, MTO findings suggest that relocating low-income families from high-poverty public housing developments to low-poverty communities can lead to substantial improvements in housing quality, neighborhood safety, and mental and physical health.[9] Findings on self-sufficiency, child development, educational achievement, and delinquency are less encouraging.

Neighborhood and Housing Quality

Research indicates that the MTO program was successful in dramatically improving housing and neighborhood conditions for families in the experimental and Section 8 groups who relocated out of poverty concentrated public housing. Families in the experimental group moved to neighborhoods with lower rates of poverty, welfare receipt, female-headed households, higher rates of employment and education, higher percentages of professionals, two-parent families, and homeowners.[10] Families in the Section 8 group who moved also made gains in these neighborhood traits, but only about half as large as the gains experienced by the experimental group families.[11] The findings demonstrate that portable vouchers enable families to move to better neighborhoods, and that those who receive counseling and vouchers restricted to low-poverty areas make greater gains in neighborhood quality.[12] It should be noted, however, that although families in the experimental group moved to low-poverty communities, these new neighborhoods were not affluent communities.[13] In addition, the MTO program had only a small impact on neighborhood segregation. For families in the experimental group, relocation reduced the concentration of minority residents in their new neighborhoods by less than 10 percent.[14] Nearly two-thirds of the experimental group families relocated to neighborhoods where 80 percent or more of the residents are minority.[15]

Families who moved out of public housing through the MTO program also experienced improvements in neighborhood safety, exposure to violence, and reduced victimization. For example, 40 percent of families in Boston reported feeling unsafe in their communities prior to moving. After relocation, 24 percent of families in the experimental group reported feeling unsafe, compared to 39 percent of those in the control group.[16] Families in the experimental group were also more likely to move to neighborhoods with higher levels of social organization and social control.[17] Movers in both the experimental and Section 8 groups reported large reductions in neighborhood problems such as litter, trash, graffiti, abandoned buildings, public drinking, and people hanging around. Movers also felt safer in and around their homes, had less difficulty getting police to respond to calls, and reported more satisfaction with

their current housing and neighborhoods than families in the control group. These improvements were consistently about 10 percentage points greater for families in the experimental group compared to those in the Section 8 group.[18] In addition, mothers in the experimental group were also much less likely than those in the Section 8 and control groups to report problems with crime, violence, disrespectful neighbors, and widespread idleness (i.e., lots of people who cannot find work).[19]

Findings also suggest that families in the experimental group were more likely to move to neighborhoods with greater collective efficacy. Collective efficacy refers to the social cohesion and shared expectations among residents and is believed to be important for reinforcing community norms and social order.[20] MTO research has found that mothers who moved to low-poverty neighborhoods reported that their new neighbors were more likely to share information about children's misbehavior than their old neighbors.[21] In addition, significantly more mothers in the experimental group reported that their new neighborhoods were good places for their families to live and that if there were problems in their new communities their neighbors could help solve them.

Self-Sufficiency

It was expected that moving families from high-poverty public housing developments to low-poverty neighborhoods might improve employment prospects and decrease welfare use by increasing families' proximity to jobs, middle-class role models, and community norms that are more supportive of employment than welfare. Yet, moving also means disruptions in the supportive social networks that many low-income people rely on for emotional support, job referrals, child care, and small loans, suggesting that relocation could lead to short-term setbacks.

Findings on outcomes related to self-sufficiency, such as employment, welfare use, and income, have not been consistent across sites.[22] Some earlier studies found small positive effects on the welfare receipt of families that moved.[23] Yet, the more recent interim impact study indicates that MTO participation across all sites had no positive impact on welfare participation, income, or food security.[24] In fact, the cross-site interim evaluation actually found a slight reduction in the employment rate for adults in the experimental group 2 years after the program was implemented.[25]

Social Capital

In addition to economic outcomes, it was also expected that MTO relocation might have an impact on residents' social capital. William Julius Wilson's (1987) social isolation theory suggests that people living in communities of concentrated poverty are isolated from middle-class people and working role models.[26] This isolation limits their access to important job networks and mainstream norms pertaining to work, family, and community. In contrast to this perspective, others argue that residents of poor communities often have well-functioning social networks that provide an important safety net and help residents cope with the hardships of poverty.[27] Through

extensive support networks, families access needed social and instrumental support. Thus, one perspective suggests that the relocation of poor residents from their communities may decrease social isolation and enhance social capital, and another perspective suggests that relocation may disrupt support systems and lead to further instability.

Of the few studies that have included social capital measures, findings are mixed. One study found little significant evidence that movers experienced changes in social capital relative to nonmovers.[28] Yet, there is some evidence that moving to low-poverty areas could improve people's job networks in the long run. Moving to a low-poverty neighborhood increased the chances that adults would have friends who graduated college or earned more than $30,000 a year.[29] These better-educated and steadily employed neighbors could turn into useful job contacts in the future. However, only 8 percent of the participants in the same study said they had found a job through someone living in their neighborhood, and there were no differences across the three groups.

Adult Health

Research suggests that relocation to low-poverty neighborhoods can lead to improvements in both physical and emotional well-being. Individuals in the experimental and Section 8 groups in one site were more likely to report "good or better" overall health than the control group.[30] Findings from another site were similar, and the improvements in the overall health of parents in the experimental group were linked to dramatic improvements in emotional well-being.[31] The more recent cross-site study found a large and statistically significant effect of relocation on only one measure of physical health: obesity. There was a large reduction in the incidence of obesity among experimental and Section 8 adults, but no significant effects on hypertension, asthma, or self-reported overall health. The authors suggest that the effect on obesity could be related to reduced psychological distress and increases in exercise and nutrition observed for the Section 8 and experimental groups.[32] In addition, although there was no significant impact of relocation on overall physical health for the entire adult population, there was a significant positive impact on physical health for the younger adults. The authors suggest this could be indicative of younger people being more responsive to changes in habits and behaviors due to a change in neighborhood environment.

Both the short-term and interim studies found positive impacts on the mental health of adults in the experimental group, and sometimes for those in the Section 8 group. Adults in the experimental group experienced a reduction in psychological distress, a reduction in depression, and an increase in feelings of peacefulness and calmness.[33] Researchers believe that the reduction in stress experienced by families who moved away from dangerous public housing communities is likely a key factor contributing to the improvements in mental health.[34]

Educational Achievement

Although it was anticipated that the quality of schools would improve for children who moved to low-poverty neighborhoods, evidence indicates that gains in school

quality were modest. The children who relocated with vouchers were attending schools that performed only slightly better on state exams than their old schools.[35] In fact, nearly three-quarters of the children in the experimental group who moved were attending schools in the same school district. Many remained in the same large urban school districts, and some did not change schools at all due to school choice options and/or families not moving very far away. In addition, the MTO program had no significant effect on teacher-to-pupil ratios.

Early research revealed that the MTO program was having a mix of positive and negative effects on children's educational outcomes.[36] On the one hand, elementary and middle school students in the experimental and Section 8 groups were more likely to improve their math and reading scores compared to those in the control group (gains were more pronounced among the experimental group). Yet, evidence from the same study revealed *increases* in grade retention, suspension, and expulsion for teenagers in the experimental group and increases in grade retention for teens in the Section 8 group. Higher rates of disciplinary problems and grade retention could reflect an increase in academic or behavioral problems, or they could be due to stricter academic and behavioral standards in their new schools, or discrimination by teachers or administrators.[37]

Other short-term findings suggested that children who moved out of public housing developments were less involved with their schools and neighbors. For example, in one city, children in the Section 8 group were less likely to participate in student–government groups than those in the control group. In another city, girls who moved to middle-class neighborhoods participated in fewer after school activities.[38] In addition, girls in the Section 8 group were less likely to have a friend in the neighborhood compared to girls in the control group. While earlier short-term impact studies found a mix of positive and negative results for educational outcomes, the 6-year interim evaluation revealed no significant effects on any measures of educational performance for children who moved to low-poverty neighborhoods across all MTO sites.[39]

Delinquency and Problem Behavior

It is thought that youth behavior can be shaped by neighborhoods in a number of ways: through neighborhood resources such as schools, after school programs and jobs, as well as peers, adult role models, and exposure to crime and violence.[40] Research has found significant differences in a number of outcomes for children who moved out of public housing developments through the MTO program, though not always in the direction expected. One early study found that although delinquency did not significantly decline for youth in the MTO program 3 years after implementation, youth in the Section 8 group had the lowest rates of delinquency, and youth in the experimental group were least likely to trespass, steal, or spray-paint graffiti.[41] However, the youth in the experimental group were more likely to hit someone or destroy property than youth in the other groups. Early research on the Boston site found a decline in problem behavior among boys aged 8–14 in the experimental

group.[42] A study of the MTO Baltimore site found a decline in violent crime arrest among teenagers in the experimental group, but an increase in property crime arrests. Greater law-enforcement in low-poverty communities could explain some of the increase in property crimes.[43]

While short-term research suggested a mix of positive and negative impacts on problem behavior, the interim impact evaluation revealed negative impacts for boys and positive impacts for girls. The study found significant increases in behavior problems among boys aged 12–19 in both the experimental and Section 8 groups. There were large significant increases in the proportion of boys in the experimental group that were ever arrested and in the frequency of property crime arrests. In addition, there were significant increases in smoking among experimental and Section 8 group boys. However, for girls aged 15–19 in the experimental group, there were reductions in marijuana use and smoking; and for girls in the Section 8 group, there were large reductions in the proportion who had been arrested for violent crimes.[44]

Child Health

Studies suggest that children in the families who moved through the MTO program are experiencing positive effects on their health. Data from the Boston site indicate that children who moved to lower-poverty neighborhoods experienced a decrease in nonsports-related injuries (injuries from falls, fights, or dangers such as glass and needles). In fact, injuries among the experimental group declined 74 percent compared to the control group.[45] In addition, asthma attacks that required medical attention declined 65 percent among youth in the experimental group compared to the control group. Data from the New York site similarly found improved mental and physical health outcomes among children in the experimental group.

While these early findings are encouraging, the interim impact evaluation indicates that health outcomes may differ for male and female youth. In their cross-site analysis of over 4,000 households, researchers found large positive effects for female youth in the experimental and Section 8 groups on mental health and risky behavior; and small positive effects on physical health.[46] There was a very large reduction in the incidence of generalized anxiety disorder among girls in both the experimental and Section 8 groups, a moderately large reduction in psychological distress for girls in the experimental group, and a substantial decrease in the incidence of depression among girls in the Section 8 group.[47] While relocating out of high-poverty public housing communities had positive effects for female youth, relocation appears to have had adverse effects for male youth. Male youth in the experimental and Section 8 groups were more likely to have an *increase* in nonsports-related accidents or injuries and behavioral problems than youth in the control group. However, the adverse effects for males did not manifest right after the initial relocation, but after several years.[48] This is interesting since it was expected that the effects of relocation on youth might be negative in the short-term due to the disruption of moving and the difficulty of adjusting to new communities and schools, and more positive in the longer-term as they become more adjusted.

Evidence indicates that the MTO program may have profoundly different effects on male youth compared to female youth. Clearly, male and female youth may respond and interact differently to changes in their neighborhood environments. Researchers suggest possible mechanisms that could explain the gender differences. For example, girls may have been more at risk for particular negative outcomes in their old neighborhoods, and relocation may have reduced these risks. Girls may disproportionately suffer from domestic violence and sexual abuse, and therefore MTO relocation may have reduced their exposure to such risks, resulting in benefits particularly relevant for girls. In addition, female youth were more likely to have more adult role models to whom they talked about their problems, which could explain some of the gender differences in education, behavior, and mental health outcomes. Girls may be more likely to respond positively to new higher-income communities and peer groups, whereas boys may be more likely to respond by withdrawing or rebelling. Other possibilities include that boys may visit their old neighborhoods more often and therefore may be exposed to negative influences through their old neighborhood and old peers. New neighborhoods may also lack the institutions that provide support for at-risk boys that might have been present in their old neighborhoods.[49]

Summary of MTO Findings

Findings indicate that the MTO program is showing short to mid-term successes in improving neighborhood and housing conditions, adult mental health, girls' mental health, and girls' behavior for those who relocated out of public housing developments with housing vouchers. These interim successes show promise for long-term improvements in child and family outcomes. The lack of dramatic improvements to date in other child outcomes (educational performance, delinquency) and adult outcomes (employment, welfare use, income) are disappointing, but do not mean that improvements in neighborhood will not lead to long-term improvements in individual life chances. The small program impacts (positive and negative) on some of the child outcomes may reflect the fact that relocation did not lead to substantial benefits for parents (in terms of employment, welfare use, income, parenting practices, and involvement with schools).[50] In addition, relocation did not lead children to attend high-performing schools.

Potential long-term impacts of living in safer, lower-poverty neighborhoods include further improvements to adult and youth mental health, parent and child physical health, child development and behavior, and adult self-sufficiency. It is certainly possible that program impacts may be greatest for both parents and children in the long-term. Reducing exposure to violence and danger could improve child development, and perhaps, allow adults more freedom to pursue employment and education.[51] The positive impact on the mental health of mothers and female youth is promising. Sustained improvements in mental health could certainly lead to other improvements for families and children down the road.

THE HOPE VI PROGRAM

The HOPE VI program is another housing policy that seeks to deconcentrate poverty in public housing and improve the lives of low-income tenants. Passed by Congress in 1993, the HOPE VI program differs from dispersal initiatives like MTO because rather than strictly dispersing residents into different communities, it attempts to revitalize the public housing community itself. The HOPE VI program is aimed at redeveloping the "most severely distressed" housing projects throughout the country. These include developments that suffer not only from physical deterioration, but also from isolation, inadequate services, crime, chronic unemployment, welfare dependency, and high concentrations of extremely poor families of color.[52] Recognizing the negative effects of the isolation and poverty concentration in older distressed projects, the HOPE VI policy focuses on mixing public and private funding to build sustainable mixed-income communities, deconcentrating poverty, and encouraging resident self-sufficiency.

In addition to transforming the physical structure of buildings, HOPE VI transforms the social and economic structure of public housing by bringing in new residents—those of higher incomes—to offset the concentration of poverty. The goal is to create mixed-income communities where low-income public housing residents live among higher-income families who pay market-rate rents. It is expected that attracting and retaining higher-income residents will require better quality management and maintenance and bring better services to the area. HOPE VI redevelopment entails the demolition of decaying housing developments and the construction of new housing that blends in with the larger community. HUD has allocated $5.6 billion in HOPE VI grants to redevelop 231 sites around the nation.[53]

HOPE VI reflects a shift away from past public housing programs because in some ways it considers more than just peoples' housing needs. Many of the problems associated with public housing developments have been attributed to a severe lack of social infrastructure; and HOPE VI seeks to fill this void by providing funds for social services. Services provided include a range of programs designed to help residents move toward self-sufficiency, such as case management, education, job training, and child care.[54] While the available funds may not be enough to realistically help residents achieve self-sufficiency, the program has been admired for the fact that social service money is built into a public housing policy, representing a shift toward a more comprehensive housing program.

HOPE VI has received praise for recognizing the negative effects of concentrating extremely poor residents in disadvantaged housing developments and for bringing a more innovative approach to public housing. However, the program has received much criticism for its major drawbacks, including that it dislocates many families and reduces the nation's public housing stock. Because HOPE VI demolishes more units than it rebuilds and reserves a proportion of the rebuilt units for higher-income families, many public housing units are lost. The program entails the construction of 95,100 replacement units, only 48,800 of which will be public housing units.[55] Thus, in order to deconcentrate poverty and make room for

higher-income residents, HOPE VI displaces a substantial number of low-income families.

Policymakers suggest that HOPE VI can decrease social isolation and increase the social mobility of public housing residents by altering the social and economic composition of their communities. It is assumed that higher-income families will be good role models for the poor, and that low-income families will benefit from having close contact with working families (i.e., by diversifying their social networks). However, since not all original residents can return to the redeveloped sites, these proposed benefits would likely only reach a segment of the community.

Overall, research and evaluation of the program has been challenging due to the lack of consistent data across HOPE VI redevelopment sites.[56] This is, in part, because HUD did not require evaluations of HOPE VI programs until the year 2000; and there are no strict guidelines for current evaluations. Further, the program has been evolving and changing since it began and looks different from site to site due to the flexibility given to housing authorities. HUD initiated "baseline" and "interim" assessments,[57] but these were case studies focused more on the physical redevelopment of the sites, rather than the outcomes of original residents. Still, there are several informative longitudinal studies of small samples of HOPE VI sites as well as single-site studies that provide a sense of how families are affected by the program.

Due to the extended time it takes to redevelop sites, most research to date focuses on how families fare during the initial relocation period. Whereas residents in the MTO program have the option to relocate (for those assigned to the Section 8 and experimental groups), residents in the HOPE VI program must move whether or not they wish to do so. Residents who have to relocate for HOPE VI typically relocate to other public housing developments or move to the private market with Section 8 vouchers. Although relocation trends vary site to site, the *HOPE VI Resident Tracking Study*, a retrospective study of residents from eight sites, found that 19 percent were living in redeveloped HOPE VI communities, 29 percent were relocated to other public housing developments, 33 percent relocated with vouchers, and 18 percent had left public housing.[58]

Although many HOPE VI residents relocate temporarily (usually for a few years until redevelopment is complete), others must relocate permanently since there are never enough units for all original residents to return to the rebuilt communities. Many families relocate not knowing whether they will return to the redeveloped community. One study that assessed the relocation choices of residents at four HOPE VI sites found that residents made relocation choices "based on significant misinformation about Section 8 procedures, HOPE VI move-back criteria, and availability of relocation services."[59] Others indicate that relocation assistance is significantly lacking, especially for hard-to-house families, such as those with many children, chronic health problems, disabilities, problems with domestic violence, gang affiliation, or substance abuse.[60] It is feared that these residents may face increased housing instability and even homelessness since they are unlikely to be successful finding suitable

units in the private market with vouchers, and they are unlikely to return to the rebuilt communities due to the restrictions in the number of units, the size of units, and the new eligibility criteria.[61]

In addition to the expected benefits for families who return to the rebuilt mixed-income communities, there is also the potential for positive impacts on families who relocate to lower-poverty neighborhoods with vouchers. Yet, studies have found that HOPE VI residents often have a difficult time finding replacement housing with vouchers because the availability of affordable housing is severely limited in many regions, many landlords are reluctant to accept vouchers, most residents are inexperienced with using vouchers, and discrimination against minorities and public housing residents continues to be a problem.[62]

Neighborhood and Housing Quality

Despite these problems, studies show that similar to MTO relocation, HOPE VI relocation is improving the neighborhood conditions in which many residents live. For example, a study of five HOPE VI sites found that the average neighborhood poverty rate decreased from 40 percent to 28 percent.[63] For voucher holders, the average neighborhood poverty rate dropped from 60 percent to 27 percent.[64] However, about 40 percent of residents still reside in neighborhoods of concentrated poverty (over 30 %), and the majority still live in neighborhoods marked by extreme racial segregation.[65] In fact, 76 percent of relocated residents live in neighborhoods where 80 percent or more of the population is minority.[66] The families who end up relocating to other public housing developments or to other extremely poor, distressed, and racially segregated communities with or without vouchers are the families likely to fare the worst.

Many residents who relocated reported improvements in neighborhood safety, especially those who relocated with Section 8 vouchers. For example, while 67 percent of residents reported significant problems with shootings and violence in their old developments, only 20 percent had these problems in their new communities.[67] Many residents also experienced improvements in housing quality, with voucher holders experiencing the greatest gains. Although 75 percent said their units were better than the ones they left, the housing quality of all HOPE VI movers was still lower than other poor people nationwide.[68]

Reoccupancy by original residents varies from site to site and in many sites only a small portion of the original residents returned.[69] Overall, about 46 percent of original residents are expected to return to the newly redeveloped sites.[70] Many residents do not return to the redeveloped sites because stricter move-back criteria, such as employment requirements or criminal background checks, make them ineligible. Others may be eligible but decide not to return because they are comfortable in their new communities or do not want to move their families again. The fact that many original residents do not return to redeveloped HOPE VI communities is not necessarily a bad outcome if these families made informed decisions to relocate to better housing in better neighborhoods.

Self-Sufficiency

The combination of social services and increased proximity to higher income people (i.e., better job networks) is intended to help residents move toward self-sufficiency. Although self-sufficiency is a key goal of HOPE VI, baseline data suggest this may be a difficult goal to achieve.[71] Less than half of HOPE VI residents were employed, and the vast majority were living far below the poverty level.[72] The *HOPE VI Panel Study* found that employment rates did not change from baseline to follow up (a 2-year period) at five HOPE VI sites.[73] Many residents cycled in and out of employment, and significant barriers to getting or keeping a job included poor health, having young children, and a lack of jobs in the neighborhood.[74] There was a slight increase in incomes for working residents and a decrease in income for those not working. Welfare participation also declined, particularly for employed residents. There was an increase in the proportion of employed respondents who had been at their jobs for three or more years (45% versus 31% at baseline), and those who lived within a mile of their original public housing development were more likely to have been at their job three or more years. Only 1 percent of respondents reported that they had found a job through the HOPE VI program, compared to 16 percent at baseline. People continued to primarily use family and friends for job information, although social networks were more dispersed due to relocation. Others have found that residents are no more likely to find employment due to living in mixed income communities.[75] At one HOPE VI site, residents were using an array of new social services, but utilization was not related to employment, a key program outcome.[76] Overall, research does not show that the program is successful in preparing residents for or connecting them to the job market.

Although theory and policy suggest Section 8 movers may have the most to gain from relocation to lower-poverty neighborhoods, research indicates that relocation can sometimes have a negative impact on voucher users' financial stability. Studies have found that HOPE VI residents who relocated with Section 8 vouchers often experienced additional financial hardships due to the new responsibility of paying utility bills (families were not responsible for such bills as tenants of public housing).[77] The *HOPE VI Resident Tracking Study* found that residents who moved to private market housing with or without vouchers faced new challenges with economic stability.[78] About 50 percent said they were having difficulty affording enough food for their households, and 59 percent were having problems paying rent and utilities. One study of a Boston HOPE VI site found that Section 8 movers experienced more financial setbacks than others, and many continued to struggle paying their utility bills 2 years after relocation. The Section 8 movers were also much more likely to incur additional debt, obtain more credit cards, and have their telephone service and/or heat shut off for nonpayment during this same period.[79] The fact that many Section 8 movers were struggling to pay their utility bills 2 years following relocation raises questions about their likelihood of achieving long-term economic stability through this program.

Along with the increase in economic problems due to utility bills, studies have found that housing vouchers do not always bring housing stability, as some HOPE VI

families make multiple moves with their vouchers.[80] Reasons for moving may include seeking a better quality unit, a unit in a different neighborhood, having problems with the landlord, or having a landlord who decides to sell the home or no longer accept the vouchers. In addition to the financial and housing instability multiple moves can cause, they also weaken the potential for positive "neighborhood effects." Relocating multiple times decreases the likelihood of families connecting with their neighbors and local social institutions and successfully adjusting to their new communities.

Health

Evidence indicates that the physical and mental health of residents residing in HOPE VI developments is substantially worse than other low-income Americans.[81] For example, 41 percent of HOPE VI residents reported being in fair or poor health, which is three times the national average. HOPE VI residents have alarmingly high rates of chronic health problems, including obesity, hypertension, diabetes, asthma, and arthritis. Mental health problems are also a significant problem, with 17 percent suffering a major depressive episode in the last year (nearly three times the national average). Rates of poor health are also significantly higher for HOPE VI children, with 25 percent suffering from asthma. Research indicates that many HOPE VI households are coping with multiple health problems while they are dealing with relocation.[82]

Many hope that relocation and redevelopment will lead to substantial improvements in both mental and physical health. Yet, chronic physical and mental health problems are unlikely to dissipate quickly and are likely to continue affecting residents' ability to become gainfully employed and successfully adjust in the new communities.[83] Research to date has not found changes in physical health for HOPE VI residents. One study found that Chicago residents who relocated for HOPE VI redevelopment experienced improvements in mental health, which researchers believe could have positive effects on employment and self-sufficiency in the long run.[84] Another study found that Section 8 movers were more likely to attribute improvements in emotional well-being to relocation than other movers. They cited better living conditions, more privacy, a new sense of dignity, and enhanced feelings of peacefulness from their new living situations.[85]

Social Capital

Another key issue explored by researchers is the impact of HOPE VI on residents' social networks and social interaction. While several previous studies and theoretical perspectives[86] suggested that programs like HOPE VI might help improve low-income residents' opportunities for social mobility by improving access to social capital and diversifying their social networks, HOPE VI research to date does not support this notion. In fact, the research supports previous work[87] that suggested that relocation might actually impose additional barriers to mobility by severing residents' strong social networks and weakening social capital building opportunities. HOPE VI researchers have found that relocation often breaks up strong social networks and

results in a reduction in social support, which they suggest could lead to negative outcomes for families and communities.[88]

Although supportive social networks may be broken due to relocation, residents may rebuild networks in new neighborhoods. In addition, it is thought that residents who relocate to lower-poverty areas and to the rebuilt HOPE VI communities may be more likely to build ties to neighbors who are steadily employed and well-educated. Building these sorts of leveraging social ties may lead to improved opportunities for mobility.[89] Yet, research to date shows low levels of interaction among neighbors in redeveloped HOPE VI communities.[90] In addition, studies suggest that residents who relocate with vouchers also have little meaningful contact with their neighbors.[91]

Children

By improving distressed public housing communities and moving families to better neighborhoods, the HOPE VI program has the potential to improve children's life chances. About 39 percent of HOPE VI children changed schools due to relocation, and research indicates that relocated children are attending schools that are less poor, but still nearly all minority.[92] Voucher holders experienced the most improvements in school quality.[93] Parents who relocated with vouchers were less likely to report problems with school quality and more likely to perceive their children's schools as safe.[94] Children of voucher holders were also significantly less likely to be held back a grade than those still living in public housing (even those who changed schools).

Some parents also reported changes in children's behavioral problems after relocation. Parents who relocated with Section 8 vouchers were more likely to report improvements in behavioral problems, while public housing movers reported *increases* in behavioral problems among boys.[95] Clearly, relocation to other public housing developments means moving to other poor and often dangerous communities. Findings suggest that boys, in particular, may face more challenges in these new communities than those who relocate out of public housing with vouchers.

Although research found differences in child outcomes by relocation group, evidence indicates that certain parental characteristics play a key role. Parents who were more engaged with their children's education (attending meetings and after-school activities) and those who graduated high school or had a GED, were less likely to report behavioral problems or that their child was held back a grade and more likely to report that their child was very engaged in school.[96] On the other hand, parent suffering from depression were more likely to report child behavior problems. These parental affects hold true for children in all relocation groups, suggesting the importance of programs aimed at reducing parental stress and helping parents become more involved with their children's education.

Summary of HOPE VI research

In summary, the HOPE VI program has the potential to have major effects on the lives of low-income families. While some residents may benefit from better housing

and better communities, others relocate to housing and communities similar to those they were forced to leave. Thus, HOPE VI deconcentrates poverty at the original public housing sites as intended, but reconcentrates poverty in other public housing developments and other poor communities to which many residents relocate. As for its intended economic and social effects, evidence to date does not suggest that HOPE VI is successful in helping families achieve social and economic mobility through the creation of economically integrated developments or through relocation to other communities. It is certainly plausible that the intended benefits of income mixing and relocation will take more time to generate. The gains in neighborhood and housing quality for some relocated residents may lead to longer-term benefits such as improved physical and emotional well-being and better job networks. Longitudinal studies examining impacted families before, during, and after HOPE VI relocation (including those who do not return to the redeveloped site) are still very much needed.[97]

CONCLUSION

MTO and HOPE VI research provide important insights into the short- and mid-term program impacts on low-income families. Research evidence indicates that people are not always affected by deconcentration and housing mobility programs as expected. For example, it was expected that children who relocated from high-poverty to low-poverty neighborhoods would show improvements in educational achievement, behavior, and delinquency. Yet research reveals that other factors including age, gender, parental characteristics, and school quality also play an important mediating role in determining outcomes. Likewise, it was expected that adults too would benefit from such moves by increasing employment opportunities and decreasing welfare participation. Yet, findings show minimal impacts, at least in the short to mid-term. It was also assumed that relocation to lower-poverty areas would lead to increases in resident engagement with higher-income neighbors, but research indicates this is not happening.

Both the MTO and HOPE VI programs appear to be producing both positive and negative effects on families. The most successful outcome of the MTO program appears to be the dramatic improvement in neighborhood quality for families who relocated with vouchers, but especially for those who relocated to low-poverty neighborhoods. Research indicates that relocating low-income families from high-poverty public housing developments to safer communities with greater social organization can lead to improvements in adults' and girls' mental health as well as girls' behavior. On the other hand, MTO relocation had little impact on the racial segregation of the neighborhoods in which families live. Further, these moves did not result in substantial gains in employment, earnings, welfare participation, or children's educational achievement. In addition, relocation from these communities appeared to have negative impacts on the behavior and health of boys.

Evidence from the HOPE VI program similarly suggests that relocation can improve housing and neighborhood quality, as well as adult mental health. Similar to the MTO findings, HOPE VI appears to have had very little impact on moving families to less segregated communities. HOPE VI research also found few positive economic

or social effects. There is some evidence that relocating public housing residents to Section 8 housing may increase economic and housing instability. In addition, HOPE VI relocation often breaks up supportive social networks, which could thwart any positive effects from relocation.

Research evidence highlights key areas where the MTO and HOPE VI programs should be strengthened in order to achieve their full potential and improve the lives of low-income families.[98] First, while both programs show that providing vouchers to families living in distressed public housing enables families to relocate to better quality housing in better quality neighborhoods, the MTO program shows that providing people extra housing counseling and search assistance, as well as vouchers restricted to low-poverty areas, substantially improves outcomes. Based on the positive results from the MTO program, the HOPE VI program should provide more intensive counseling and assistance to families relocating through the program. Helping families consider the benefits and drawbacks of different neighborhoods and helping them assess where they will access services their families depend on (childcare, transportation, medical care) in new communities could lead to better outcomes and future housing and economic stability. In addition, both programs should encourage families to move to low-poverty and less-segregated communities. Housing authorities should work with landlords in a variety of neighborhoods to improve the selection of units and neighborhoods for residents using vouchers.

Intensive housing counseling and search assistance may be necessary to improve not only housing and neighborhood outcomes for families, but also their successful adjustment and integration into their new communities. More in-depth counseling could help minimize losses in social support and help movers rebuild social ties and access support and leverage in their new communities. In both programs, vulnerable families are moved from their communities and familiar support systems. The findings from the HOPE VI program, in particular, suggest a need for ongoing supportive services to help families access local services and successfully adjust to their new living arrangements. More extensive support could help reduce the stress of making an involuntary move, especially for those whose physical or mental health problems may be exacerbated by relocation. High rates of depression and chronic health problems, coupled with the challenges involved in making an involuntary move, warrant sustained support to help families successfully transition to their new communities.[99] Services targeted to youth, particularly male youth, could help decrease negative impacts and lead to future positive impacts.

Evidence suggests that further financial support is needed to help Section 8 movers cope with additional utility bills. Providing these movers supplemental support during the initial relocation years may improve families' long-term housing and economic stability. Finally, due to the severe lack of affordable housing and the growing need for subsidized housing around the nation, the HOPE VI program (and future housing programs) should do more to ensure public housing units are not lost due to redevelopment. This may entail rebuilding lower-density mixed-income communities at the original public housing sites, as well as building or acquiring units at other sites to make up for those lost. The benefits of relocating families with vouchers and building

higher quality mixed-income communities should not mask the costs of reducing the nation's public housing stock (units with deep, long-term federal funding) for the lowest income families.[100] Lastly, the children of relocated families may ultimately be the ones most affected by housing mobility programs. Future MTO and HOPE VI research is needed to assess whether the negative interim impacts last over time and whether the positive interim impacts lead to greater long-term impacts. Understanding the long-term effects of housing programs like MTO and HOPE VI is critical to building an urban housing policy that helps improve the lives of low-income families.

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62. Finkel, A.E., Lennon, K.A., & Eisenstadt, E.R. (2000). HOPE VI: A Promising Vintage?" *Policy Studies Review*, 17, 104–119.

63. Buron, *An Improved Living Environment*?

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65. Buron, *An Improved Living Environment?*; Buron et al., *The HOPE VI Resident Tracking Study*.

66. Buron, *An Improved Living Environment?*

67. Buron, *An Improved Living Environment?*

68. Jennifer Comey. *An Improved Living Environment*? *Housing Quality Outcomes for HOPE VI Relocatees*. (Washington DC: Urban Institute, 2004).

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72. And 35% reported incomes less than $5,000. Levy and Kaye, "How are HOPE VI Families Faring? Income and Employment."

73. Levy and Kaye, "How are HOPE VI Families Faring? Income and Employment."

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75. Rosenbaum, Stroh, and Flynn, "Lake Parc Place."

76. Mary Collins, Alexandra Curley, Cassandra Clay, and Rita Lara, "Evaluation of Social Services in a Mixed Income Housing Development." *Evaluation and Program Planning*, 28 (1), (2004): 47–59.

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82. For example, 45% have at least one household member (adult or child) in fair or poor health. Harris and Kaye, *How Are HOPE VI Families Faring? Health*.

83. 28% of 18- to 44-year-olds who were not employed reported health barriers to employment; 59% of 45- to 64-year-olds reported health barriers to employment. Harris and Kaye, *How Are HOPE VI Families Faring? Health*, p. 5.

84. Susan Popkin and Mary Cunningham, *CHA Relocation Counseling Assessment: Final Report*. (Washington DC: Urban Institute, 2002).

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87. For example, see Edin and Lein, *Making Ends Meet*; Robert Putnam. *Bowling alone* (New York: Simon & Schuster, 2000); Stack *All Our Kin*; Vale, *Reclaiming Public Housing*.

88. Susan Saegert and Gary Winkel, "Social Capital and the Revitalization of New York City's Distressed Inner-City Housing." *Housing Policy Debate*, 9(1), (1998): 17–60; Susan Greenbaum, "Social Capital and Deconcentration: Theoretical and Policy Paradoxes of the HOPE VI Program." Paper presented at the Conference on Social Justice, Windsor, Canada. May 5, 2002; Popkin et al., "The HOPE VI Program: What About the Residents?"; Susan Clampet-Lundquist, "HOPE VI Relocation: Moving to New Neighborhoods and Building New Ties." *Housing Policy Debate*, 15(2), (2004): 415–447; Curley, "Hope and Housing."; Edward Goetz, *Clearing the Way: Deconcentrating the Poor in Urban America* (Washington, DC: Urban Institute Press, 2003).

89. See Xavier de Souza Briggs, "Brown Kids in White Suburbs: Housing Mobility and the Many Faces of Social Capital."; Tama Leventhal and Jeanne Brooks-Gunn "Moving to Better Neighborhoods Improves Health and Family Life Among New York Families." *Poverty Research News.* Jan.–Feb. 2001.

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92. Susan Popkin, Michael Eiseman, and Elizabeth Cove, *How are HOPE VI Families Faring? Children.* (Washington, DC: Urban Institute, 2004).

93. For instance, an average of 68% of students qualify for free school lunch in their new schools, compared to 85% in their old schools. Popkin, Eiseman, and Cove, *How are HOPE VI Families Faring? Children*.

94. Voucher holders reported fewer problems with violence in schools than families still living in public housing (20% vs. 30%). In addition, only 21% of voucher holders reported school quality as a problem compared with more than 50% at baseline. See Popkin, Eiseman, and Cove, *How are HOPE VI Families Faring? Children*.

95. At baseline about two-thirds of children had one or more behavioral problems and about half had two or more. Boys who relocated with vouchers were more likely to have two or more behavioral problems at baseline compared to all boys (67% vs. 61%). But their behavior improved at follow-up and they were no more likely to have two or more behavioral problems than other boys. In contrast, boys who moved to other public housing developments were less likely to have behavioral problems at baseline (43%) but more likely to have behavior problems after relocation two years later (62%). Popkin, Eiseman, and Cove, *How are HOPE VI Families Faring? Children*.

96. Popkin, Eiseman, and Cove, *How are HOPE VI Families Faring? Children*.

97. Popkin et al., *HOPE VI Panel Study*.

98. For example, see Popkin et al., *A Decade of HOPE VI*.

99. Harris and Kaye, *How Are HOPE VI Families Faring? Health*.

100 Popkin et al., *A Decade of HOPE VI*.

CHAPTER 6

Providing Educational Opportunities for Children Living in Poverty

Hassan Tajalli

The history of public education policies in the United States is the history of shifting goals and orientations. The challenge of providing educational opportunities for poor children is shaped by a multitude of players with varying degrees of power and a bundle of ideological issues. Parents, living environment, schools, local school districts, state government, the federal government, and increasingly the courts directly affect the educational opportunities of poor children. There is also ongoing debate over the appropriate division of power and responsibility of schools, parents, and the various levels of government. But at the heart of the challenge lies fundamental ideological issues that the United States has been facing since its inception. The competing values of market competition and social justice, in particular, have shaped the vacillating educational policies toward disadvantaged children. The paramount values of the former are individualism, competition, and liberty. A market free of government interference is expected to create a self-regulating, self-correcting social system that promotes prosperity. To the advocates of the free market, education, like any other commodity, is an individual good that should be subject to the forces of the market. On the other hand, there are those who view the market to be irrational and self-destructive. If left unrestrained, they argue, market competition will not only undermine prosperity but will also lead to social injustice and an immense inequality of wealth and power that stifle liberty. To these advocates, education is a public good that can benefit both individuals as well as the entire society. Public education, therefore, should be protected from the inequalities that market promotes.

The purpose of this chapter is to show how these competing views and values have shaped the educational policies of the United States toward poor children. We will start our discussion by looking at the devastating impact of poverty on the educational

performance of students and the current demographic distribution of these students in the United States. The ideological roots of education policies and the role that race and poverty have played in shaping these policies are examined. Inequality in public education, to a large degree, is related to the way public schools are financed in the United States. We will examine this issue to show how property-based public school financing has undermined educational opportunities of the poor. It is also argued that the current shift to performance-based education has failed to solve the educational problems of the disadvantaged students. Suggestions for improving educational opportunities of disadvantaged students are offered in the concluding section.

PROBLEMS OF POVERTY FOR STUDENTS

For most of its history, public education in the United States has not provided disadvantaged children a real chance to break out of the cycle of poverty. Currently, over 40 percent of school children in the United States lack the type of educational opportunities that are available to other children. This means that what they are taught is inadequate, their access to higher levels of education is limited, and the educational system does not equip them with the means to improve their chances in life. The problem is caused not only by the schools themselves and the educational policies of the various levels of government and the courts, but more importantly, by the physical, emotional, and behavioral scars that poor children bring to school everyday. The public educational system has been largely unable to compensate for these liabilities of poverty while at the same time narrowing opportunity gaps for these children.

The burden of poverty, weighs on the shoulders of poor children before, during, and after their school day. What children bring to school with them has a profound impact on how they perform at school. There is a large body of research on the antecedents of low academic performance by poor children. The search for the root causes of the problem has taken researchers as far back as the mother's prenatal care, care after birth,[1–3] and preschool education[4] of the children. The findings show that poor students suffer from every form of childhood deficiency, ranging from gross malnutrition, recurrent and untreated health problems, emotional and physical stress, to child abuse, and learning disabilities.[5] The physical and emotional scars that children of poor families bring with them to school impede their cognitive development. There is also widespread consensus that children enter school with a range of prior knowledge, skills, beliefs, and concepts that significantly influence what they notice about the environment and how they organize and interpret it.[6] Poor children enter schools with abilities and a mindset that places them at a competitive disadvantage. It is then no surprise that the academic achievement of poor students is not up to par with that of other students, even when they are placed in the same school environment as nonpoor children.

Poor children have persistently shown lower levels of performance on every indicator of educational achievement. The test scores, graduation rates, and college

entrance/completion rates of low-income students have been significantly lower than those of their nonpoor peers. High school students living in low-income families are six times as likely as their peers from high-income families to drop out of high school.[7] Non-Hispanic whites between the ages of 25–29 in 2003 were more likely to have earned at least a bachelor's degree (32%) than their black (18%) and Hispanic (12%) peers who are predominantly low-income.[8]

These achievement gaps between poor and nonpoor are present in every kind of school district.[9] If fact, the disparity can be traced to preschools. For example, in a thorough investigation of educational gaps between white and black kindergartners, Lee and Burkam[10] found that black kindergartners are 34 percentile points below the levels of white kindergartners—roughly the same gap that exist in elementary and secondary schools.

Why has this problem persisted for so long, even in the face of many educational reforms and even when students are placed in similar educational conditions as the nonpoor? At times, the blame has been placed on the children themselves, their parents, or their ethnic community. Others have blamed the skills and expectations of schoolteachers and administrators. Still others have placed the blame on inadequate school funding.

The liabilities of poverty adversely affect the functioning and learning abilities of children. Schools, however, have powerful opportunities to compensate for these liabilities.[11] School management and accountability, financial resources and teachers can all positively influence students who are handicapped by their circumstances. However, an argument can be made that even schools and teachers who cater to poor children are directly and indirectly victimized by poverty. These schools lack resources, qualified teaching staffs, and administrations accountable to the parents of poor students. The teachers and administrators of these schools also have low standards and expectations of student performance. In fact, poor children who need the most help to catch up with their peers are the least attended to by the educational system. In an extensive survey of the literature, Paul Barton[12] found 14 factors associated with educational attainments that differentiate the performance of low-income and minority students from that of their nonpoor peers. The findings clearly show that educational achievement is associated with home, school, and societal factors. Almost all of these factors are determined by the underlying socioeconomic status of parents. In short, the ultimate solution for enhancing the educational opportunities of disadvantaged children lies in the enhancement of wide ranging educational policies and combating poverty in society.

WHO ARE THE POOR STUDENTS?

The burden of poverty on the academic achievement of disadvantaged children is well documented. But who are the poor children of the United States? What are the demographic characteristics of these children? How large is their population? These types of questions and their answers will ultimately shape our understanding of the problem and how to solve it.

Nationwide, about 40 percent of children in the United States live in low-income families, while about 18 percent live in families whose income falls below the federal poverty line. With over 60 percent of black and Hispanic students living in low-income families, poverty and race have become two sides of the same coin in the lexicon of educational reforms. The 2004 statistics show that 55 percent of low-income children live in families with at least one parent working full-time, year-round. Low-income children are mostly black or Hispanic and come from single-parent families with low levels of education. About 61 percent of black children and 63 percent of the Hispanic children are low-income. Nearly 51 percent of the children who live in a single-parent family live in low-income conditions, while 84 percent of the children whose parental education is less than high school live in the same conditions. Low-income children are mostly concentrated in urban (52%) and rural (47%) areas. The South (43%) and West (42%) have the highest concentration of low-income children. The Northeast has the lowest concentration of low-income children (33%).[13]

THE IDEOLOGICAL ROOTS OF PUBLIC EDUCATION

For nearly 200 years, the hallmark of American politics has been a struggle to balance individual liberty and social justice. However, there has been a sharp disagreement on what exactly these terms mean, how to bring into balance these competing values, how best to achieve them, and who should be the recipients of these values. The disagreements are best represented by two ideologies that share the two fundamental values of liberty and social justice. They are conservatism and welfare liberalism. For the most part, early Americans defined social justice in terms of liberty. They perceived liberty as the greater of the two values. However, their narrow conception of liberty served the privileged segment of society. Liberty to most early Americans was nothing more than the absence of restraint from government. They viewed government as an impediment to the free growth and development of the individual. Individuals could be free only when the tentacles of government left them alone. Unrestricted market competition was believed to be the best means of achieving freedom. Whatever resulted from free market competition was perceived to be just and fair. Early Americans, as a result, treated education like any other commodity that was available only to those who could pay for it. Poor children, for the most part, did not receive formal education; if they did, it was either an act of charity or an attempt to convert the slaves to Christianity. The Southern states opposed the education of blacks altogether. It was not until after President Abraham Lincoln issued the Emancipation Proclamation in 1863 that blacks were given the opportunity to receive education.

Some early pioneers, however, did not view education as another commodity that should be subject to market forces. Notable among them were Thomas Jefferson and George Washington who advocated the creation of a public school system for all American children, regardless of their socioeconomic background. They viewed free universal public education not only as morally right but also as socially beneficial for

the new country. The progressive idea of free universal education, however, could not materialize in the wake of the enormous political, social, and economic issues facing the new nation.

By the mid-1800s, a new understanding of liberty and the role of government began to emerge in England. The new generation of liberals, known as welfare liberals, expanded our understanding of liberty, social justice, and equality. They argued that in the face of ignorance, poverty, illness, and prejudice, freedom and opportunity could not be realized without the active participation of government. A child born and trapped in poverty has no true chance of becoming free to grow and develop to the full extent of his or her abilities. Welfare liberals argued that the absence of government interference would not provide an opportunity for the poor to enhance their chances in life. The chains of ignorance and poverty are more insidious than any other hindrance to liberty and opportunity. The poor and the disadvantaged need to be empowered to be free. It is, therefore, the moral responsibility of the state to use its power to empower people—not only to fulfill the promises of liberty for all, but also for the common good of society. The power of the state, it was argued, needs to be used to overcome the obstacles to freedom and opportunity. The common good is served when society, acting through government, establishes, among other things, free public schools for the children of the needy.

The welfare liberal ideas that began in England in the mid-1800s soon found their way to the new world. Until the 1840s, the education system in America primarily served the children of white middle-class and wealthy families. Pioneer reformers such as Horace Mann of Massachusetts and Henry Barnard of Connecticut campaigned tirelessly to promote the new welfare liberal ideas on education. Mann started the publication of the Common School Journal. In his journal, Mann continuously argued that free common schooling is a public good that has social, political, and economic benefits for all. It was to promote good citizenship, unite society, and prevent crime and poverty. By the end of the nineteenth century many states were convinced by the argument and had adopted free education for all children, including the poor. In 1852, Massachusetts was the first state to pass such a law, followed by New York in 1853. By 1920, the remaining states had joined to mandate free compulsory elementary education for all children. Soon after, most states enacted legislation extending compulsory education to age 16.

The United States federal government did not play any noticeable role in public education until the onset of the Depression in the early 1930s. The Depression marked the ascendancy of welfare liberal ideology over the individualistic laissez-faire ideology of the past. The Depression convinced many Americans that poverty is not necessarily caused by laziness or character flaws, but rather by structural problems beyond the control of any individual. They were convinced that economic recovery was possible only through the active participation of government. Keynesian economics and its success in overcoming the Depression was a further proof to many that government policies can cure social problems such as poverty. For two generations since then, Americans came to believe that government could play a positive role in building a more decent and just society. Both Democratic and Republican administrations in

this period were convinced that they could use the power of the federal government for achieving the common good. This belief in the positive power of government was the foundation of the New Deal, the Fair Deal, the New Frontier, and the Great Society programs, spanning presidents from Franklin Roosevelt to Lyndon Johnson. The same belief permeated many of the domestic policies of the Nixon, Ford, and Carter administrations.[14]

Massive federal government involvement in public education began in the 1960s under the most activist administration and Congress in the history of the United States. The major focus of federal reforms was the problem of equity for minority citizens. The new educational programs were aimed at schools with high concentration of poor children. As part of his "War on Poverty," President Lyndon Johnson launched a series of educational policies including the preschool program of Head Start, health programs, and massive federal aid known as Title I. Other federal acts that addressed educational issues were the National Defense Education Act of 1958, the Vocational Education Act of 1963, the Manpower Development and Training Act of 1963, and the Elementary and Secondary Education Act of 1965. All these programs sought to enhance the opportunities of economically and socially disadvantaged children.

Although federal spending on the education of needy students was only about 10 percent of total public school spending, the government used its regulatory power and enforced desegregation mandates to achieve its goal of equity for low-income students. Enforcement of civil rights as well as the antipoverty policies of this era tremendously enhanced the lot of poor students. Collectively, these programs resulted in "major increases of high school completion and college access, particularly for blacks. Southern blacks made the largest educational achievement gains, and the racial gaps in completion and achievement scores narrowed significantly."[15]

Historically, individual states, rather than the federal government, have had primary authority over public education. Individual states, in turn, have delegated most of their responsibilities to local school districts to collect taxes and run the day-to-day operation of their campuses. Public schools are heavily subsidized by local property taxes that are controlled by school districts. As a result, public schools in the United States have become a microcosm of their socioeconomic environment where wealthy communities have rich school districts that have both the financial resources to buy whatever money can buy and an environment that is conducive to learning. Poor school districts, on the other hand, are handicapped by all the misfortunes that poverty can bring.

Concerned with the gross inequalities among school districts, states have, since the 1930s, tried to narrow the gap between the haves and the have-not school districts. In the hope of narrowing the gap, states have consolidated many school districts into larger units and have begun spending more money on public education. In 1940, for example, there were over 117,000 school districts in the United States, but by 2004 the number had dropped to 14,383. Similarly, in 1940 local property taxes financed 68 percent of public school expenses. This number had decreased to about 43 percent in 2002.[16]

RACE AND INEQUALITY

In the United States, there has always been a racial and ethnic bias in the distribution of wealth. The wealth of a school district is often determined by the racial composition of its residents. Wealthier districts tend to be populated mostly by white non-Hispanic residents while African Americans and Hispanics mainly populate the poorer districts. Until the early 1950s, blacks were segregated from whites and the system was sanctioned by the Supreme Court of the United States in *Plessy v. Ferguson* (1896). Segregation created an inferior level of education for blacks. In 1940, for example, public spending per pupil in southern black schools was only 45 percent of what was spent on white pupils. The black schools had overcrowded and dilapidated facilities, staffed by less qualified teachers who were not paid adequately and students had to walk miles to and from school. In short, the issue of segregation in the United States is of the outmost importance because it is so strongly linked to poverty. Poverty matters because it denies individuals equal opportunities in life. The lack of equal opportunities, in turn, undermines the foundations of liberalism and democracy.

Since the early 1950s, the courts have played an important role in addressing the interrelated issues of race, poverty, equality, and freedom. Depending on the ideological mood of the nation and the composition of the Supreme Court, the decisions of the Court have favored either race and equality, or freedom of choice. For nearly 20 years since 1954, the Court's decisions favored desegregation, the rights of previously oppressed racial/ethnic groups, and the reduction of inequality for poor schoolchildren. Since a 1974 Supreme Court case, however, the tide of welfare liberalism has shifted back in favor of conservatives. Since then, the Court has shown less concern with racial segregation and educational opportunities for poor students.

A landmark Supreme Court decision that broke with the conservative tradition that had been set by the Plessy court was *Brown v. Board of Education of Topeka (*1954). The Brown court overruled the Plessy decision and declared that racial segregation in public schools was unconstitutional. The Brown ruling stated, "in the field of public education the doctrine of 'separate but equal' has no place. Separate educational facilities are inherently unequal." In line with the prevailing welfare liberal ideas, the Court stressed the fundamental importance of equal opportunities and the rights of individuals. It declared that "education is . . . the very foundation of good citizenship. . . . it is a right which must be made available to all on equal terms (*Brown v. Board of Education 1954*)."

Three successive rulings expanded the mandates of the Brown decision. In *Cooper v. Aaron* (1958) the court prevented state governments from blocking desegregation on the claim that it would produce violence. In 1971 the Court ruled that the existence of all-white or all-black schools must be shown not to result from segregation policies and that busing could be used in efforts to correct racial imbalances (*Swann v. Charlotte-Mecklenberg Board of Education 1971*). In *Keyes v. Denver School District* (1973) the Court held school districts responsible for their racial policies. More importantly, it recognized Latinos' right to desegregation, as well as that of African Americans.

Under pressure from the federal government and the courts, reluctant Southern states gradually agreed to desegregate their public schools. Brown succeeded in dismantling legal segregation. For the two decades of the 1960s and 1970s, the Southern states made slow but significant progress in desegregating their public schools despite the massive exodus of the white population to suburban areas. Various Supreme Court decisions in the early 1970s, however, heralded a new era in the history of public education in the United States—an era that rejected the ideological underpinnings of the previous 50 years. This ideological shift was a reflection of profound changes that were taking place in society. By the early-1970s, a whole litany of political, social, and economic problems arose causing disillusionment of Americans with their government and its social and economic policies. While the Vietnam War undermined the legitimacy of government, double-digit inflation and high unemployment brought into question the wisdom of an activist government. American people came to believe that the past social policies were costly and counterproductive and that the antipoverty programs of the past not only were ineffective in reducing poverty but trapped the poor and their children in a cycle of welfare dependency.

The shift of attitude in the general public cast its shadow over the composition and the decisions of the Supreme Court. Beginning with the Milliken decision in 1974, the Supreme Court's support for desegregation began to fade as the national mood shifted back to the conservative ideas of the past and the Court lost its liberal majority. The Milliken decision effectively blocked interdistrict and city-suburban desegregation plans (*Milliken v. Bradley 1974*). The decision turned down the interdistrict busing that could remove the de facto segregation that existed between urban and suburban areas. It protected and exacerbated white flight to suburbia by confining integration to specified areas within cities. The ruling was encouraged by Richard Nixon and others who wanted an end to desegregation.[17,18] The tide of desegregation was reversed in the Supreme Court case of *Board of Education of Oklahoma v. Dowell* in 1991 when the Court ruled in favor of dismantling desegregation plans. As a result, many school districts ended their desegregation plans. Subsequent decisions allowed piecemeal termination of school desegregation (*Freeman v. Pitts 1992*) and the termination of court supervision of desegregation cases (*Missouri v. Jenkins 1995*). The Dowell case, in particular, encouraged the resegregation of public schools. Since then, there has been a significant reversal toward segregation in most of the states that were highly desegregated before. Segregation is now present in a severe form in central cities of large metropolitan areas, smaller central cities and suburban rings of large metropolitan areas. Except in the South and Southwest, most white students have little contact with minority students. By the late 1990s, the segregation of black students surpassed that of the 1960s.[19]

Sadly, the process of racial resegregation has intensified the segregation of poor and wealthy schools. Segregated minority schools are often poverty-stricken schools that cannot provide equal educational opportunities for their students. Today black and Hispanic students in public schools are not segregated by law but by wealth. Government statistics show that as the proportion of black and Hispanic students increase, so does the proportion of students in the schools eligible for the school lunch

program. In 2003, for example, about 71 percent of black and 73 percent of Hispanic fourth graders were in high-poverty schools (schools with more than 50% of students eligible for the school lunch program) compared to 21 percent of white students. The concentration of poor black and Hispanic students is even more severe in central cities. In 2003, within central city schools, 61 percent of black and 64 percent of Hispanic fourth graders were concentrated in the highest-poverty schools (schools with more than 75% of students eligible for the school lunch program) compared to 12 percent of white students.[20] In other words, black and Hispanic students are more likely than white students to attend schools with a majority of students from poor families.

PUBLIC SCHOOL FINANCE AND INEQUALITY

For many reformers who have not abandoned the welfare liberal ideals of equal opportunity, the de-facto segregation of public schools is unacceptable. Since the early 1970s, these reformers have turned their attention toward the unequal distribution of resources between poor and wealthy school districts. The underlying assumption, however, has always been that minority students will be the primary beneficiaries of the equitable distribution of resources. By shifting the focus of equity on the difference between poor and wealthy school districts, reformers significantly enhanced their chance of mobilizing support and success.

For most states, school finances are linked to their local real property taxes. Differences in real property values have created a significant disparity in educational opportunities for students who attend wealthy school districts and for those students who live in poor districts. While wealthy school districts can generate more money with less tax effort, poor school districts tax their residents at a higher rate and still generate less income for their school districts. During the 1985–1986 school year, for example, the wealthiest school district in Texas had $14 million in taxable property per student while the poorest district had $20,000 in taxable property per student. The white Independent School District in the Texas Panhandle taxed its property owners at 30 cents per $100 of value and spent $9,646 per student. Neighboring Morton I.S.D., on the other hand, taxed its property owners at 96 cents per $100 of value but was able to spend only $3,959 per student.[21]

Such discrepancies in school spending have been the basis of much litigation throughout the country. But the highest national court has become less activist since the Brown case.

In *Milliken v. Bradley* (1974), the Supreme Court showed its lack of enthusiasm for desegregation when it did not support interdistrict and city-suburban desegregation. In effect, the Milliken court exempted white suburban school districts from participating in real desegregation programs. This ruling was not unexpected given its milestone decision in the previous year. In a landmark decision in 1973, the U.S. Supreme Court took a step back in protecting disadvantaged school districts. In *San Antonio School District v. Rodriguez*, the court ruled that education is not a fundamental right protected by the U.S. Constitution and consequently gross inequalities

in school finances are not necessarily unconstitutional. This ruling tossed the issue into the state court systems. For more than three decades, lawsuits to equalize school funding have been finding their way through the courts in 44 states. So far, the plaintiffs have scored victories in about half the states, forcing legislatures to increase funding for poor schools. The supreme courts of states such as Kentucky, Texas, Vermont, and New Hampshire have forced policymakers to accept some degree of wealth equalization among their school districts. The core argument of the litigants has been that inequality in the distribution of educational resources denies equal educational opportunities to students of poor school districts. They blame the lower academic performance of poor students on inequitable distribution of educational resources. They point out that had there been a more equitable distribution of school resources, poor students would not have been seven times less likely to earn a college degree than well-to do students.[22]

FROM EQUITY TO PERFORMANCE

The economic and political turmoil of the 1970s brought into question the tenets of welfare liberal ideology. The public's disillusionment with government and its polices culminated in the election of President Ronald Reagan—a man who completely rejected the ideological tenets of welfare liberalism. Since the presidency of Reagan, public education in the United States, for the most part, has been operating under the ideological principles of neoconservativism. Contrary to the earlier ideology of welfare liberalism that was directed toward social justice and equality, the neoconservative ideology embraces principles of the market and individual liberty as paramount social values. What results from market competition is thought to be necessarily good and able to resolve many of the present social ills such as poverty. For the free market to operate properly, the new ideology holds, individuals need to be free from the tentacles of government and take responsibility for their own destiny. The sharp edge of this ideology is directed toward the government's antipoverty programs. Overcoming poverty is not considered the responsibility of government but of the poor themselves. The focus is more on individual responsibility and freedom than the type of social justice and equality that were promoted by welfare liberals.

Beginning with the presidency of Reagan and extending through the Clinton and George W. Bush administrations, the focus of public education has shifted from being an instrument of opportunity to the "quality" of education. The Reagan administration's 1983 report on *A Nation at Risk* crystallized the necessity of this shift. The paramount educational values are no longer rights and equality but rather the market mechanisms of performance appraisal, competition, and rewards and punishment. Neoconservatives believe that solutions to educational problems cannot be found in poverty, inequality, and segregation but rather within the confinements of schools. Teachers and school administrators are responsible for the failure of poor students rather than inadequate school funding or the socioeconomic status of the parents. It is believed that a performance-based-educational system can resolve many of the existing educational problems of disadvantaged children. Under this system,

measurable performance standards need to be set, students need to be regularly tested, and schools need to be held responsible for achieving the standards. Schools that fail to achieve the standards should be punished and those who achieve them should be rewarded. More testing, more course work, and rewards and punishment are, therefore, the tools of choice for improving the quality of education among disadvantaged children and preparing the next generation of workers for the coming global market competition.

The emphasis on performance, however, is predicated on questionable assumptions. First, the heightened concerns about the relatively low-average scores of American students on international tests ignore the fact that wealthy American schools do not have this problem. The problem of low performance is the problem of poverty in America. The main culprits for low-average score on international tests are not the rich schools that are populated by white students, but rather the poor schools catering to black and Hispanic students. The second questionable assumption is that low performance is the result of the laziness of students, teachers, and administrators and it can be improved if students and schools are held accountable. Test scores are to be considered impartial measures of student and school performance. There is virtually no discussion of the 800-pound gorilla of poverty in the middle of the room. No attention is paid to 40 years of research findings showing that test scores are strongly linked to nonschool forces in the lives of students. Since the publication of the groundbreaking Coleman[23] report in 1966, research has repeatedly shown that the socioeconomic background of parents, more than anything else, determines the academic performance of students. The new emphasis on performance, therefore, has brought into question whether it is a ploy to redirect attention from the real problem—namely inequality of resources and the wider problem of poverty.

The questionable assumptions of performance-based educational policies have produced questionable outcomes. Thirty years of data do not support the educational claims of neoconservatives. To evaluate the soundness of performance-based educational policy, it is important to compare the achievement gains of the current period with the reforms of the 1960s and the early 1970s. The comparison of the achievement results should humble the supporters of the current reforms. When the focus of U.S. educational policies was centered on the issues of desegregation and equal opportunity, in the 1960s and part of the 1970s, disadvantaged children achieved major academic gains as measured by increased high school graduation rates, college enrollment, and lowering gaps in academic achievement between the races. Black students made the largest educational achievement gains, particularly in the states that had traditionally excluded them.[24]

On the other hand, reviews of U.S. Department of Education's statistics reveal disappointing results in the educational gains of students since the end of the equity-driven educational reforms of the 1960s and early 1970s. Apart from some gains in mathematics achievement between 1973 and 1999, other indicators of achievement are unacceptable. There was no measurable difference in the reading proficiency scores of 17-year-olds in 1999 compared to 1971. Overall, grade 11 writing performance declined between 1984 and 1996. The biggest decline has been in the area of science.

The average science scores of 17-year-olds in 1999 remained 10 points lower than in 1969.[25] So long as the underlying problem of poverty among children is not addressed, one cannot expect any better results than what we have seen within the last 3 decades.

The latest educational reform of the neoconservatives is called 'No Child Left Behind' (NCLB). NCLB is a prime example of how a performance-based educational system of neoconservatives has exacerbated rather than alleviated the problems of public education in the United States. President George W. Bush signed the NCLB into a law in early 2002. The aim of the program, as was declared by President Bush, is to end "the soft bigotry of low performance." Under this program, federal educational funds are distributed not on the basis of need but successful results. The program measures success in terms of annual test scores of students. A strict system of reward and punishment is tied to the outcomes of test scores in order to enforce accountability among school officials. Low-performing schools are threatened with the loss of funds and, ultimately, closure. Like earlier performance-based educational approaches, NCLB ignores the fact that academic performance in the United States is ultimately attributed to the demographics of students. In fact, the system of reward and punishment that is built into the NCLB inadvertently exacerbates the problems of inequality, dropout, and achievement gaps for those children who need the most help.

Historically, failing schools have been racially segregated and poor. Successful schools, on the other hand, are the wealthy schools that serve primarily white students. Student test scores, more than anything else, reflect the differences in student background. Withholding funds from failing schools and funneling the funds to successful schools is tantamount to punishing poor students for being poor and rewarding rich students for having wealthy parents. The system ignores the fact that poverty and its by-product of inadequate school financial resources are the main causes of poor performance. Withholding more financial resources from these schools will not solve the problem of low performance. The system of reward and punishment that is promoted by the NCLB only widens and perpetuates the pervasive inequalities that exist in the American public education system.

The performance-based "No Child Left Behind" has had another perverse impact on the educational opportunities of disadvantaged students. The system encourages low-performing poor minority students to drop out of school or at best encourages them to pursue a GED outside formal public schooling. A joint research by Harvard University and The Urban Institute concluded that, "[t]he overwhelming focus of many states and school districts aiming to avoid test-driven accountability sanctions has led to increased reports across the nation of schools that "push out" low achieving students . . . in order to help raise their overall test scores."[26] The report indicates that racial and ethnic minority students are more likely to be pressured to leave the educational system. Dropout rates have also increased because of change in teaching methods. Public schools, particularly poor schools, feel increased pressure to narrow their curriculum and teach to the test. These changes discourage poor students who cannot see any value in the limited courses that are offered and the drilling methods

that are used. All of these problems will exacerbate the cruel realities of inequality that are already present in the educational system.

In short, the neoconservative market-oriented approach to public education not only has exacerbated the twin problems of de facto segregation and inequality of educational opportunities, it has failed to improve the quality of education to any noticeable degree. The laissez faire market-oriented approach to public education has entrapped poor students in segregated and inferior school districts while protecting rich districts from opening up to students from less fortunate districts. The over emphasis of neoconservatives on individual liberty and responsibility, and their lack of attention to issues of social justice, has denied 40 percent of public school children equality of educational opportunity. The neoconservatives concern over the quality of education in the United States is also misguided. The problem of low educational performance is the problem of poverty. Research for the last several decades has repeatedly reminded us that the socioeconomic status of parents is the primary determinant of students' performance. As a result, a solution to low educational performance should go beyond schools and teachers accountability.

CONCLUSION

A market-based educational system ignores the root cause of the problems facing public education. Quality of education, equitable educational opportunities and real life opportunities for disadvantaged students can be greatly improved if the following are recognized. First, it should be recognized that the core problem of public education in the United States stems from poverty. Rich school districts, for example, are not facing the problems of poor quality of education, low student performance, excessive dropouts, and low college admission of their students. Nor are the graduates of these schools denied life opportunities. School districts populated with low-income students are the ones facing all of these problems.

Second, the focus of public education should shift to the needs of low-income students. A need-oriented public education system can greatly benefit the poor without lowering the quality of education for others. Under this system, resources would be distributed based on the needs of students and schools. The scars of poverty and the lack of preparedness of poor students place them in a competitive disadvantage when they enter the public schools. The physical, psychological, and cognitive needs of these students demand more attention and resources for preparing them for the challenges of schoolwork. More resources are also needed for recruiting skilled teachers and administrators, maintaining decent and acceptable school facilities and equipment. A need-based distribution of resources will not resolve problems such as parental involvement and the cues these students will receive from the environment that they live in, but it will alleviate some of the gross inequalities that exist under the current market-oriented system.

Third, it should be remembered that the root causes of the educational problems are outside of schools. More school resources, while crucial, will not necessarily rescue poor students from school failure or the vicious cycle of poverty. A real positive

impact on educational achievements of poor students demands social policies that go beyond the school life of students. To begin with, the current market-driven social and economic policies that are in place and have entrapped the poor, need to be revised. Decent minimum wages, universal health insurance, restructuring of tax codes, and work incentives, are only a few public policies that can alleviate the problem of poverty. There must also be a recognition that the students' educational achievement is affected by many factors that occurred before they enter public schools. To improve the educational achievements of poor students, a number of protective policies such as prenatal care, early childcare, and preschool care and education need to be in place. Without these early protective policies, the chances of disadvantaged students to succeed in their educational career are greatly diminished.

Finally, improving the quality of education of low-income students will not necessarily enhance their life opportunities. As Reimers[27] has aptly pointed out, improving the educational achievements and capabilities of the poor will not necessarily change their status in life. Educational achievements, capabilities, and income of the poor may be improved without changing their relative standing in society because the nonpoor also would have increased their education. A narrow focus on enhancing the educational quality for the poor, in absolute terms, disregards the existing social distance between the poor and the nonpoor. Educational policies not only need to improve the capabilities of the poor but most importantly must be geared also toward closing the social and economic distance that eliminate the positive effects of more and better schooling. Reducing the social distance demands a change of attitude from market-oriented to social justice-oriented public policies. The promises of liberty and equality, the two bedrocks of a liberal democracy, cannot be realized if 40 percent of students in a society have no real chance of changing their social station to a higher ground.

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CHAPTER 7

How Education Policy Continues to Leave Poor Children Behind

Roseanne L. Flores

> "Not everything that counts can be counted, and not everything that can be counted counts."
>
> —*Albert Einstein*

As we moved into the twenty-first century the gap between families living in poverty and those with adequate means to support themselves has widened. This trend began in 2000 and continues to rise.[1] According to the National Center for Children in Poverty many poor families face incredible hardships, such as the lack of affordable housing, inadequate food supplies, and lack of health insurance.[2] For many families these hardships imply that they are not living in safe and secure communities, that are supplied with adequate schools, libraries, or businesses, that in theory could provide them with secure gainful employment, or their children with a sufficient education. And on the off chance that poor families happen to live in more affluent communities that have ample resources, more often than not because of their economic status they will not have access to these resources. For example, poor families living in middle-class communities often do not have access to the same quality of health care as their middle-class peers. This lack of access to cultural and social capital prevents the majority of poor families from acquiring upward mobility, which is the American dream.

So why should we care about the impact of poverty on families? One very important reason is that poverty has the most deleterious effect on our youngest citizens, children, who are the future of America. If we don't invest positively in them today, we will invest negatively in them tomorrow.

According to the National Center for Children in Poverty, "Poverty is associated with negative outcomes for children. It can impede children's cognitive development and their ability to learn. It can contribute to behavioral, social and emotional

problems. And poverty can lead to poor health among children." So what can be done? One of the most important solutions that has been put forth to address this social issue has been providing parents with adequate employment opportunities, and their children with better educational opportunities in order to break the cycle of poverty. Although parental employment has an indirect impact on children's development, that is, it can lead to a better home environment and better schools, this chapter will focus on the education of children.[3]

Since the birth of the nation it has been argued that education should function as the great equalizer, lifting people out of the burdens of their ignorance and circumstances.[4] If this notion was true over 200 years ago, it therefore stands to reason that in the twenty-first century education should also be able to provide children with the foundation needed to lead productive lives within American society. However this assertion will only hold true if all children receive an equal education; but what if they do not? The lack of access to equal educational opportunities has plagued America over the last several centuries and continues to plague us today. However not until recently has the federal government actually implemented a plan that would systematically change how America's children, attending public school would be educated. Given the introduction of this new educational reform at the federal level the question that arises is whether this it is actually working.

In 2001, in an attempt to address the inequalities within public education President Bush signed into law the No Child Left Behind Act. In his opening address to the nation, the president stated that a commitment had to be made that would ensure every child academic success, by guaranteeing that all American children would be able to read by the end of third grade. In order to ensure that this policy would succeed states and local school districts had to provide a licensed teacher for every classroom, schools needed to provide a rigorous curriculum based on scientific evidence, and children's skills needed to be assessed to make certain that they had mastered pertinent classroom information at grade level. To date, however, although the federal government boasts of success, (citing as evidence an increase in children's tests scores.) this commitment has not been fulfilled, due in part to inadequate funding and lack of support from local, state, and federal agencies. Once again the children who would have benefited most from the successful implementation of this program, America's poor children, the one's most at risk for under achievement and school failure, have been left behind. Given the enthusiastic tenets put forth by the No Child Left Behind Act (NCLB Act) how did this educational reform manage to leave poor children behind again?

This chapter begins by examining the history of American public education and its relationship to children reared in poverty. The second section examines public education in the current climate with the passing of the No Child left Behind Act. In this section I discuss the tenets of the No Child Left Behind and what they were meant to achieve. The final section focuses on how the No Child Left Behind policy has failed to be adequately implemented, and how this failure has led to the increased marginalization of poor children.

HISTORICAL OVERVIEW OF PUBLIC EDUCATION

Since the birth of the nation, education has been portrayed as one of the essential components necessary to build the strong foundation needed by children in order to succeed, and to ensure that as a country we continue to prosper and grow strong. As early as 1779, Thomas Jefferson proposed a plan that would provide free education for Virginia's children for 3 years to be supported by taxes.[5] Although his plan was never enacted, it prepared the groundwork for future discussions concerning the education of American's children. The American school system, as we now know it, originated with the Common School movement in the 1830s led by Horace Mann and Henry Bernard from New England, and the Jacksonian democrats and the Workingman's Association.[6] While both groups held opposing views, the purpose of the movement remained the same: to provide schools that could be attended by everyone, and that would be supported by public funds.[7] The overarching philosophy behind this movement was that education was the great equalizer among people, and therefore should be used to eradicate the majority of social ills, such as poverty and crime, while at the same time producing a common bond between diverse groups of people.[8] It was felt that by educating America's children the nation would continue to produce productive individuals while at the same time keeping the nation moving in a forward direction.

Given this vision, by the end of the nineteenth century, free public elementary education had become available to all children; however, because of the newness of the concept it was limited in scope and only addressed the needs of younger children. By the beginning of the twentieth century, America created the high school due, in part, to the fact that a large number of adolescents had voiced a desire to continue their education.[9] The goal of this new school was to provide a safe place where adolescents could continue to develop intellectually, obtain the skills necessary to acquire a job, and in some cases continue to further their education. In addition, the new high school also provided a place where those recently arriving to the nation could socialize and assimilate into mainstream society.[10]

Nevertheless, in spite of the original goals of the public education system, some groups of Americans were marginalized and left behind. In order to address these social inequalities the government enacted policies to ensure that equitable schools would be created for all Americans. However, because segregation existed in several communities, even this goal was thwarted.[11] In 1954 the federal government intervened and the Supreme Court ruled in the monumental case of *Brown v. the Board of Education* that segregation by race was illegal and "separate but equal" schooling was non-existent.[12] This ruling by the Supreme Court began the systematic integration of schools. It should be noted, however, that although the *Brown v. Board of Education* ruling led to the desegregation of schools and did much to make public education inclusive, the intent of the ruling was never fully recognized and discrimination continued to rear itself.

In 1965 Lyndon B. Johnson signed into law the Elementary and Secondary Education Act (ESEA) as part of his "War on Poverty." This act provided federal

funds to help public schools meet the needs of "educationally deprived" low-income children.[13] In order to keep the federal government from usurping the responsibilities of the local governments and school districts, schools were given the flexibility to meet the educational needs of low-income children. While the goal of this legislation was laudatory, and some programs like Head Start were implemented that have supported and sustained educational change to this day, many interventions failed due to the lack of vision and consistency within the programs.[14]

In the 1980s the National Commission on Excellence in Education was charged by the Secretary of Education with the mission of evaluating America's educational system. As part of this evaluation the committee was mandated to examine the curricula, standards, and expectations of American schools across the nation, and to compare them to those of other advanced nations. As a follow-up, the members of this commission produced the now famous document "A Nation at Risk." In this report the commission outlined several limitations of the American educational system, some of which are described below. In general, they found that overall the curriculum was not rigorous, and did not measure up to that of other nations; that teachers were not prepared to teach math and science and many were ill-prepared to teach within their content areas; that children did not spend enough time engaged in educational activities; and finally, children lacked the technological skills necessary to keep pace with the ever-changing society. In response to these findings the commission recommended that changes be made to the content children were exposed to, with more of the curriculum covering core knowledge; that schools adapt higher academic and conduct standards; that more time be devoted to teaching the new core curriculum by using classroom time more efficiently, lengthening the school day, and the academic year; that teachers be prepared to meet the new goals through training, incentives, and career development; and, finally, that the local, state, and the federal government support these efforts with adequate leadership and funding. Although the report provided the framework for changing the underperforming American educational system, little was done to bring these reforms to fruition and, once again, the children who would have benefited most from these changes were left behind.

In 1994 Bill Clinton signed into law the *Improving America's Schools Act*. This was a reauthorization of the 1965 ESEA legislation. The goals of the reauthorization were (1) to ensure that each classroom met and maintained high standards; (2) to improve the quality of teachers and principles; (3) to provide flexibility to the states and school districts as to how they used federal funding, with the provision that schools, districts, and states would provide annual report cards; and (4) to ensure that children were provided with a safe and drug-free learning environment. Although this law pushed states and schools to regroup and provide all children, particularly disadvantaged children, with a better education it did not go far enough, with some states making more progress than others.

In 2001 George W. Bush introduced the No Child Left Behind Act that was signed into law in January of 2002. This legislation replaced the Elementary and Secondary Education Act of 1965. The purpose of the No Child Left Behind legislation was (1) to hold schools and local and state governments accountable for the performance of

their students; (2) to give parents more flexibility in choosing where their children could attend school, if the schools were failing; (3) to have highly qualified teachers in every classroom; and (4) to ensure that children were reading by third grade. This law was a noble attempt on the part of the federal government to finally make happen what had been endorsed by many officials in the 1980s and 1990s.

TENETS OF THE NO CHILD LEFT BEHIND ACT

As part of the No Child Left Behind Act the federal government proposed several tenets that it felt needed to be met in order for the American education system to truly work and benefit all children. The policy called for no child in America to be left behind by (1) closing the achievement gap between disadvantaged children who were comprised primarily of low-income, minority, and immigrant children and their middle-class peers; (2) improving literacy; (3) expanding flexibility for states, local governments, and schools in terms of spending; (4) rewarding success and punishing failure; (5) providing parents with more choices; (6) improving the quality of teachers; and (7) making schools safe for the twenty-first century.

Equal Opportunity for All Children through High Standards and Increased Accountability

In order to close the achievement gap between disadvantaged children and their middle-class peers the No Child Left Behind policy proposed that states, local districts, and schools be held accountable for ensuring that all students achieved high academic standards. Moreover, it called for children to be assessed in math and reading to ensure that the academic achievement standards were met. The purpose of these assessments were (1) to provide the federal government with information concerning whether or not states, local governments, and schools were meeting the educational needs of the children, and (2) to provide parents with information concerning the satisfactory or unsatisfactory progress of their children's schools. Finally, a proposal was made to penalize schools if they failed to satisfactorily educate their disadvantaged students. For example, if schools continually failed to meet their Annual Yearly Progress (AYP), after 3 consecutive years, students could choose to leave the failing school with Title 1 funds used to make this move possible.

Improving Literacy

In order to improve literacy the No Child Left Behind policy proposed that schools focus on reading in the early grades, using reading curriculums based on scientific evidence for kindergarten through third grade. For states that adhered to this model, funding could be applied for under the Reading First Initiative. Moreover, for those states that participated in the Reading First Initiative funding would be made available from the Early Reading first program.

Greater Flexibility for States, School Districts, and Schools

Another goal of the No Child Left Behind Act was to reduce the duplication of spending across educational initiatives within the states. Given this provision, state and local governments were enabled to combine Title 1 funds with other local and state funds so as to benefit entire school programs. Under this provision, funds for technology and overlapping grants were allowed to be consolidated and sent to state, local, and school districts.

The Consequences of Success and Failure

Like most things in life, with greater freedom comes greater responsibility, and so along with the greater flexibility in controlling funding by the states, came greater accountability. Under the No Child Left Behind Act states that performed well in narrowing the achievement gap between low- and high-performing students were to be rewarded, and receive a one-time bonus based on their meeting the accountability criteria, with individual schools receiving bonuses for helping to improve disadvantaged children's performance. On the other hand, those states and schools that failed to meet the criteria would receive a reduction in their federal funding.

Greater Parental Choice and Involvement

Under the No Child Left Behind Act parents were to be given access to school reports so that they could make informed choices. If parents found that their child's school was on the list of failing schools they would be given the option to petition to their school district to have their child moved to a nonfailing public school, or to receive vouchers in order to pay for private school.

Enhancement of Quality Teachers

One of the major tenets of the No Child Left Behind Act was to ensure that there would be a qualified teacher in every classroom. How this was to come about was left to each state, but according to federal regulations each state would be held accountable for making it happen. In addition, states, local governments and school districts were to be held accountable for ensuring that professional development would be based on scientific research, and best classroom practices. Moreover, states were expected to strengthen their K-12 math and science programs by working closely with higher education institutions.

Safe and Drug Free Schools

Under the No Child Left Behind Act teachers were to be empowered to remove students from their classroom who posed a threat to themselves or others. Funds were to be made available for drug prevention and after-school programs. Children

who were victims of school violence were to be removed and placed in a state school, with parents and the public being provided information concerning the safety of the school. And finally, schools were to be given additional funds to provide students with character education.

MOVING FROM THEORY TO PRACTICE: LIMITATIONS TO THE TENETS OF THE NO CHILD LEFT BEHIND ACT

Equal Opportunity for All Children through High Standards and Increased Accountability

Although the first tenet of the NCLB act has called for schools to provide lower achieving children with an education equal to that of their middle-class peers, in fact the opposite has occurred due to the stringent criteria imposed for meeting Annual Yearly Progress. According to the tenets put forth under the *NCLB* Act children were to be exposed to high academic standards in reading and math with all states mandated to create a set of standards and assessments to measure progress in these subject areas.[15] In general, this tenet is not new and therefore should not have been problematic. So why then has this tenet been difficult to achieve? If examined carefully, the problem is not in the actual tenet, but rather in the consensus concerning how standards for reading and math should be achieved, and ultimately assessed. Furthermore, not only is there a lack of consensus around the issue of standards and assessment but also a problem exists around the frequency with which the children should be tested. Under the current version of the No Child Left Behind Act states have been required to test children's skills every year as opposed to every 3 years, thus creating an additional burden for states and school districts.

So what will happen if this tenet is not met, and what have states and school districts done to avoid failure? The implications for not meeting this tenet are as follows: if a school fails to meet the criteria set by the state for passing a subject, they could be labeled as a failing school and be required to come up with a plan for improvement over the course of the following year, while simultaneously going on the list of schools which require improvement.[16] If, after 2 years, the school continues to fail, students could request a transfer to another school using the Title I funds allocated to the failing school to make the move possible.[17,18] Thus, in order to ensure that schools have not lost funds, states, schools, and teachers have felt increased pressure to make sure children perform adequately on tests, with this new focus on test performance having led to the watering down of the teaching of academic content.

While on the surface holding states and school districts accountable for their students' success appears to be a reasonable request, when one goes below the surface here is what in effect happens. According to the theory behind the NCLB Act, the curriculum and practices for disseminating the content of the curriculum are supposed to be based on scientific evidence and best classroom practices.[19] The problem is that the scientific evidence and best classroom practices tell us that testing is only one way to assess whether or not children have acquired knowledge. Moreover, previous work in the

field of child development has demonstrated that true learning is not based on drill and practice, but rather on the ability to critically reason about the material disseminated in the classroom.[20] If children truly understand the conceptual material to which they are exposed, they will be able to take any test and pass it. Furthermore, the higher reasoning skills, which are required in upper mathematics and science courses, are based on the ability to reason abstractly and use the formulas. Scientists don't become scientists because they can produce a number of formulas in a specified amount of time, but rather because they are creative and can use those formulas to solve a problem—involving the ability to understand and analyze material beyond the surface level.

With the advent of the NCLB Act the focus on testing has caused schools to create an environment that has stifled learning. With the pressure for schools to perform and to meet AYP, teachers have begun to incorporate aspects of high-stakes tests into their curriculum spending more time on giving practices tests, rather than teaching the subject matter.[21] Although this has led to an improvement of AYP for some schools, it has also led to a narrower education for disadvantaged children, thus increasing the gap between these children and their middle-income peers.[22]

In addition, because states have been given the flexibility to set the standards for academic achievement, some states have created harder standards than others, making educational goals inconsistent across the nation. This imbalance across standards has led some states to have more failing schools than others and, as a result, states like Michigan, that once had a stringent passing rate on its English examination for high school students, has lowered it's criterion for passing.[23]

In short, given the number of problems that have surfaced due to the inconsistency in implementation of the NCLB Act across the states, it appears that the legislation in its present form is not working and is failing to provide an equal educational opportunity for all children.

Improving Literacy

Another major goal of the NCLB act was to put reading first. This initiative was based on the findings from the National Reading Panel which asserted that in order for reading instruction to be useful, it was necessary for children to have an understanding of phonemic awareness, phonics, and comprehension. In addition, the panel proposed that children should practice reading out loud and be given guided feedback.[24]

Again, in theory, the goal of this tenet is a laudable one, but, in reality, it has not been successfully implemented. In order to meet this initiative, schools needed to put in place reading programs that would allow children to become successful readers. For the most part, school districts have chosen what has been referred to as "off-the-shelf" programs because they are easier to implement, particularly when schools are lacking in expertise. But how effective are they?[25] In order to examine the effectiveness of different reading models on low-income children's reading ability, Tivnan and Hemphill examined the change in literacy skills of first grade children attending disadvantaged schools.[26] These authors found that, for the most part, in spite of their differing philosophical approaches, the programs adopted by the school districts

had a similar effect on first grade children's reading ability, with children performing better on word reading and phonemic segmentation. However, although there was an increase in vocabulary, the children in this study still lagged behind the first grade reading norms on vocabulary and reading comprehension. In addition, this study found that programs that trained teachers to conduct reading groups, had students who were closer to grade level on reading comprehension at the end of the school year.

In general, many schools across the nation have adopted similar types of reading programs to meet the requirements of the NCLB Act. However, as the results of Tivnan and Hemphill study have demonstrated, children are not becoming effective readers, they are only learning a modicum of vocabulary and some word attack skills. According to previous research, vocabulary is one of the best predictors of reading achievement, which is usually acquired through the reading of text.[27] If the vast majority of reading programs are not exposing children to meaningful and challenging text, but only focusing on basic level reading skills, then they are failing poor children. Furthermore, if schools are not taking into account the beginning reading skills of their students when they are entering schools, as well as the expertise of their teachers, then they are also not providing the best environment for the success of their students. Because schools are required to assess the reading skills of their children at the end of the school year, teachers have taken to teaching to the test, rather than teaching reading. If this remains the model of choice, low-income children will be doomed to being poor readers, and the cycle will continue.

Greater Flexibility for States, Local Government and School Districts

Under the NCLB act states, local governments and school districts were given greater flexibility in the use of funding. According to this tenet, funds that were previously allocated for use by disadvantaged schools and students, could technically be transferred to a high-performing school and used to enhance the school overall. Again, given the principle of AYP and the removal of Title 1 funds from failing schools, the burden has fallen on impoverished, disadvantaged schools that disproportionately make up failing schools.[28,29] Given the mandates of the NCLB Act, when a student transfers from a low-performing school to a high-performing school, part of the Title 1 funds transfer with them, with disadvantaged schools falling further behind. This transfer of funds hurts the low-performing school by leaving the students who remain in the school to suffer from the further draining of resources from an already impoverished base.[30] If the students who remain in the school that has been stripped of funding cannot find an alternative placement, they will be doomed to a fate bleaker than that of their peers who were able to transfer. Thus, the law that was to provide equal educational opportunities to poor and disadvantaged children is again failing them.

The Consequences of Success and Failure

Under the NCLB act, while some states and school districts have experienced success, many have not. Some failures have included schools that were once considered

blue ribbon schools being designated as needing improvement, because of the failure of their special education students on math proficiency tests.[31] Other failures have occurred due to the labeling of teachers and schools as inadequate. Although school failures based on the loss of status due to the failing of a few students is troubling, even more disturbing are the devastating consequences the NCLB Act has had on the human psyche.

Ambrosio describes, in his article, one of the most severe consequences that the NCLB Act had on the teachers and students at the Roosevelt High School in Oregon, a school that served poor students of color.[32] According to the NCLB Act, there must be a qualified teacher in every classroom. A high-quality teacher is one who has certification, is proficient in an area, or has a bachelor's degree. The teachers at Roosevelt High School did not have any of these requirements and, therefore, were labeled as not being qualified. Because of their status, the teachers were asked to notify, by letter, their students and their students' parents, informing them that the school "needed improvement" and that their children could transfer to other schools if they wanted. Having the teachers participate in this process was demeaning, and not only demoralized the teachers, but made the students and parents feel terrible about the education the children were receiving. It was felt by everyone involved that this type of punitive action was not constructive. It did nothing to improve the school, but rather only caused humiliation for the teachers, students, and parents.

In addition to not being constructive, having teachers inform parents and students about their inadequacies was also in direct contradiction to one of the defining principles of the NCLB Act which was to provide children with character education. According to standard leadership and character building principles one of the major features of building a strong character is to have respect for self and others. If the goal of the NCLB Act is to create a learning environment where students want to succeed and value their education, then creating environments that provide win-win solutions rather than win-lose ones would be the objective. However, if students learn to view teachers as inadequate and incompetent, then it is doubtful that they will treat them with respect, which in some cases could lead to an increase of behavioral problems already rampart in some schools. Thus, given the previous example and under the current circumstances, the NCLB Act, in it's current form, can only lead to win-lose outcomes for everyone involved.

Greater Parental Choice and Involvement

According to the Merriam-Webster's Collegiate Dictionary the definition of the word "*choice*" implies having an option, and "*option*" implies a power to choose something that is specifically granted or guaranteed.[33] Under the tenets of the NCLB Act, parents were given the right to choose a better educational environment for their children. The question that arises, however, is what are the choices, and are the choices viable options?

According to the research reported by the Civil Rights project at Harvard University the options that parents have for their children who are attending low-performing

schools are quite limited. In this research, the authors report that choices are limited, in part, because of the actual lack of options for transferring between schools. For example, in certain areas the schools available for students to transfer to are also low-performing schools, therefore making the *choice* nonexistent. In addition, the lack of funding necessary to support the No Child Left Behind Act also makes the option to choose less than optimal.[34] Moreover, although the tenets of the No Child Left Behind policy has called for all children to receive a "high quality" education, the policy does not explicitly define what features a high-quality education must have in order to be considered "high quality," making the definition somewhat relative.[35] So what constitutes a high-quality education? In order to address this question, one would have to examine the education of middle-class and affluent children. For the most part, children who are the recipients of a high-quality education not only have high-quality teachers, but are also exposed to many other cultural events and experiences that society deems necessary in order for a person to be considered educated. For example, children attending high-quality schools are exposed to foreign languages, have courses in math, reading, science, and social studies (that are challenging), receive music and art and have the opportunity to engage in several after-school activities, such as athletics, social clubs, theatre, and chorus to name but a few activities. Moreover, the parents of the children attending such schools expect that their children *will* learn, and when there is a problem, expect there to be a reasonable solution. Furthermore, the parents of children attending high-quality schools expect their children to have every advantage and opportunity so as to ensure their success not only in the present, but also in the future.

So where are these schools located and why aren't they viable *choices* for children attending low-performing schools? For the most part, the schools described above are located in middle-income and affluent suburban communities, with a few in urban environments that have been specially zoned so as to accommodate affluent children. However, according to the research most of these schools do not lie within the districts in which poor children live, making them not an option for poor families. Furthermore, because the No Child Left Behind Act does not provide incentives for wealthier districts to take students from low-performing schools, but instead often creates potential barriers, wealthier schools have become wary of reaching out and embracing this population. For example, if a number of students were admitted to a school in an affluent neighborhood and the students fail to adequately perform, the scores of the school could, in theory, drop the school from being a high-performing school to a low performing one. Then the school could easily be dropped from being a blue ribbon school because of a few scores. The fact that such an outcome is possible has caused most districts to abstain from actively pursuing low-performing children.[36]

So what about using the voucher system? According to the Center for Policy Alternatives vouchers do not adequately cover the cost of private school education, that often involves hidden costs, such as uniforms, transportation, payment for after-school care and the like.[37] And furthermore, because most private institutions will not take the face value of the voucher in lieu of the full tuition payment, parents would be forced to pay the out of pocket expenses on their own, that, for most parents, in

this situation is not an option. Thus, once again, making the *alternative choice* is a less than optimal solution to the problem.

In addition to the lack of access to schools, lack of funding has also been cited as an impediment to local school districts adequately implementing the No Child Left Behind Act.[38] For example, states and school districts have reported feeling overburdened by the additional costs of administering tests, providing additional staff development in order to meet the mandates of the NCLB, (managing the data) all of which are not covered by the federal budget.[39] For some schools, these added stressors have led to low staff morale and anger on the part of parents, teachers, and students.

Enhancement of Quality Teachers

The No Child Left Behind Act states that there must be a qualified teacher in every classroom. According to the tenets of the law, qualified teachers must have at least a bachelor's degree, a full-state certification, and be competent in their subject area.[40] The problem lies not in the idea, but rather in the leeway that the federal government has given to defining what constitutes a high-quality teacher. For example, because of the flexibility in the standards, some states have chosen to follow the philosophy that anyone can be a teacher, with the requirements to become a teacher consisting of knowledge of the subject area and the completion of a few workshops on how to manage children. However, this philosophy flies in the face of educational research that argues qualified teachers need to know a great deal about child development in order to impart information to children in a developmentally appropriate manner. Understanding how children think, speak, and act is essential to providing them with a solid educational foundation and requires more than a 2-week training session. Having said this, when states introduce such lenient qualifications for individuals to become teachers it begs the question—would we allow a doctor to perform surgery after a few weeks of training dissecting rat pups? Or would we allow someone to build a bridge with a 2-week certification in engineering, arguing that the remainder of the skills could be learned on the job? If both of these examples appear to be ludicrous, how much more incredulous is it for us to believe that the skills required to help children not just pass tests—they can take a course focused on raising their test scores—but rather to be able to critically think and create new knowledge can be taught by just anyone after a few weeks of training and the passing of a multiple choice test? Why is such a proposal even entertained? One could only believe that the proposed model would be acceptable if we believed that the students attending low-performing schools need not aspire to becoming doctors, lawyers, philosophers or mathematicians, but rather that they be prepared to take on low-paying jobs that do not require many skills. If this is our a belief, then the model fits well. If not, then allowing states to set the bar so low for teacher qualifications (so that they can meet the requirements put forth under the No Child Left Behind Act), we are setting children up to fail. We are not providing them with the necessary skills that would allow them to eventually improve their economic plight, and to survive in our

ever-changing global economy, therefore, we are just perpetuating the cycle of poverty for low-income children and future generations to come.

Safe and Drug-Free Schools

The final tenet that remains to be addressed in this chapter focuses on the safety of American schools. Are our schools safe? According to the NCLB law, children attending schools that are not safe have the right to transfer to a safer environment.[41] Again, the law allows flexibility in how the states define what is meant by "safety." Does safety only involve physical safety, or does it also involve sexual harassment, bullying, ridicule, and the like?[42]

Like the previous tenets, identifying schools as being unsafe, places schools in a somewhat precarious position because once listed, students and parents have the right to request a transfer. If this happens, schools run the risk of losing money and other resources. Thus, again, the fear of being penalized often leads teachers and administrators to underreport violent incidents.[43] Rather than creating safe and welcoming environments in which students learn, schools are engaging largely in record keeping so as to minimize the penalties imposed by the NCLB law and endangering the well-being of the nations children. So where do we go from here?

FUTURE DIRECTIONS FOR THE NO CHILD LEFT BEHIND ACT

America is currently the wealthiest nation in the world, yet so many of our children are not receiving an education that will allow them to succeed in the twenty-first century. In order for America to remain at the forefront in technology, science, math, and education, the nation must ensure that all of our youngest citizens receive the education that they need to compete in our ever-changing global economy. In an attempt to address this need, the federal government has instituted the No Child Left Behind Act. While at first glance the Act appeared as if it would help to eliminate the disparities that had been created between low-and high-performing schools over the last 30 years, in reality, it has widened the gap by not providing a mechanism that would allow the tenets of the law to be adequately implemented. States, local school districts, teachers, parents, and students have suffered. Schools have become more segregated, much needed resources have been taken from low-performing schools leaving the students who have remained behind worse off than they were initially, teachers have become disillusioned about their professions, states and school districts have looked for ways to meet the letter of the law, rather than the spirit of the law, and most importantly, poor students have been left behind.

Although children have learned in some cases to take tests, for the most part they have not learned to critically think which is the ultimate goal of education. If children are to become successful learners, then the NCLB Act needs to be overhauled. Research has shown that children learn in a variety of ways, and under a variety of conditions. If the goal is to produce educated children, then all of these circumstances need to be taken into account when designing methods to instruct children. Moreover, the

goals, objectives, and time frame for how and when children are to progress through a curriculum in a developmentally appropriate manner need to be clearly specified, if we are to be able to assess whether or not children are mastering information. Once the goals and objectives are clear and have been implemented, then they can be systematically evaluated, retaining what works and revising or discarding what does not work. If the NCLB Act is patterning itself on the scientific method, then the authors of this Act must understand how science works, noting that the primary purpose of science is to confirm or reject theories based on hard evidence and replication. Given what we know to date concerning how states and local school districts have created and assessed standards, and based on the evidence obtained in support of the success of NCLB Act (that is, children's tests scores in reading, writing, and mathematics), one could argue that the children's tests scores, at best, provide inconclusive evidence concerning America's children's proficiency in reading, writing, and mathematics.

So what should be the goal of a valid education for America's children? The goal of a valid education should be to provide children with the skills necessary for learning. According to Piagetian theory learning occurs in two ways: "learning in the narrow sense" and "leaning in the broad sense."[44] For Piaget, when children learn in the narrow sense, they are learning a set of facts, for example, all of the capitals of the states. While this information is important and children need to learn it, it is also culturally specific, with children living in America learning information relevant to American culture and Canadian children learning information relevant to Canadian society.[45] On the other hand, learning in the broad sense requires that children develop ways of thinking that can be applied to many situations.[46] Again, this type of learning cannot be taught through direct instruction, but develops through active interaction with the environment.[47]

If learning in the broad sense cannot be acquired through instruction, why discuss it? According to Piaget, learning in the broad sense of development is a necessary precursor to learning in the narrow sense. If the cognitive structures do not develop and are not in place, then children will not benefit from instruction. Interaction with the environment leads to two types of knowledge: physical/observable knowledge and logicomathematical knowledge, which is essential for abstract reasoning. In the case of reasoning, if the child's experiences are limited, then the interactions will be somewhat impoverished and, therefore, the reasoning will be limited. These interactions can be impoverished either physically or socially.

Understanding child development and the theories of child development have a direct impact on how we view education, how children learn in general, and on No Child Left Behind Act specifically. First, at a very basic level, understanding how children learn and develop is crucial to educating them, and not to have this knowledge is irresponsible. To try and *make* people into teachers by giving them a few weeks of training is not only to devalue the profession, but also demeaning and unethical. Second, if it is understood that learning takes place on multiple levels and that standardize tests measure "learning in the narrow sense," but not necessarily "learning in the broader sense," then we must also acknowledge that when we use tests as the only measure of what children "know," we are sampling a very shallow

level of knowledge. While standardized tests provide us with some information, they do not tap into the vast amount of knowledge that children may have, and, thus, to hold a child back, or fail a school based solely on one measure, is again inaccurate, and, at best, weak evidence for what children know and are learning. Finally, if we are really serious about educating children to think, then we must provide them with the physical and social environments that are conducive to such learning and development. Teachers must be free to allow their students to explore and question. They must not feel pressured to teach to a test, but rather to be empowered to provide children with experiences that will allow them to think. If teachers are not empowered to do this, then America's children may become the best multiple choice test takers in the world, but they certainly will not be the leaders of tomorrow in the sciences, arts, or humanities because either they will not have been exposed to them, or if they have, will not be able to think analytically about them.

In ending this chapter, I will leave you with one last thought. I wonder how Albert Einstein would have faired under the NCLB Act if he lived today. As a child he was slow to speak, abhorred high school because his success depended on him memorizing a list of facts, and failed his entrance examination for the Swiss Federal Institute of Technology.[48] Thank goodness the world will never know!

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CHAPTER 8

The Education of Black Children Living in Poverty: A Systemic Analysis

Garrett Albert Duncan and Gail E. Wolfe

The sociologist Loïc Wacquant surmises that we cannot understand mass incarceration in contemporary United States society without understanding the North American institution of slavery, both as an historic and an historical starting point and as a functional analogue. In fact, Wacquant argues that U.S. slavery, Jim Crow, urbanization, and imprisonment are all linked by their historical and contemporary *race making* functions. By this he means that these institutions did or do not simply reinforce color-coded social divisions but either produced, or coproduced with other systems, racial divisions anew out of inherited, received demarcations of group power.[1]

Following Wacquant, we suggest that public schools have also served a race making function in America, particularly from the Reconstruction period through contemporary post-civil rights society. Like prisons, public schools help to redefine what it means to be a citizen though constructing its corollary: a racialized superfluous population of urban—and rural and suburban—students that exists outside the social or economic mainstream. During the first several decades of the twentieth century, the race making function of schools was linked to preparing black youth for what James Anderson called "Negro jobs." Negro jobs, as Anderson explained, were by default those jobs that remained after full white employment.[2] We posit that post-civil rights schools are still in the race making business of preparing students for "Negro jobs" and that this function takes on new meanings in contemporary post-industrial society, especially for black children and youth living in poverty.

In this chapter, we conduct a systemic analysis that examines the disparate forces that have shaped and continue to shape the education of black children and the other societal systems that play powerful roles in organizing their lives. We do this by analyzing the structures, organization, and practices of various social systems to

understand how their different parts create educational outcomes that chronically place black children living in poverty at a disadvantage in contemporary schools and society. Specifically, the systemic analysis provided in this chapter explicates the aforementioned mechanisms to inform educational policy and practice toward positioning black children living in poverty as change agents to eventually transform their communities in their best interests and in the better interests of the larger society.

THE POST-CIVIL RIGHTS EDUCATION OF BLACK CHILDREN LIVING IN POVERTY

Post-civil rights conventional wisdom is perhaps the greatest obstacle to systemic change from the ground up insofar that it holds that community and self-imposed factors mostly contribute to the academic underperformance of black children living in poverty. *Post-civil rights* refers to the era that began with the 1954 landmark *Brown* v. *Board of Education* ruling that abolished legal segregation in public institutions, such as education, housing, and the workplace. Prior to *Brown*, or the pre-civil rights era, schooling inequalities were explained as the outcomes of segregation and discrimination. However, *Brown* purportedly eradicated institutional obstructions to opportunity and, nowadays, the storyline that blames black people for their disadvantages in society has tremendous currency in popular explanations for contemporary racial inequalities in schools.

Contemporary educational inequalities, captured in the catch phrase "achievement gap," are evident in academic disparities between black and white students, where the latter group outperforms the former on various measures of academic attainment. Two of the more popular views hold that anti-intellectualism is prevalent in black communities[3] and that parents place little value on education, which accounts for why their children underachieve in schools.[4] Another common explanation is that black children have oppositional identities[5] and reject academic achievement for fears of "acting white."[6] Some scholars speculate that high-performing black students who identify with education succumb to pressures from their black peers to underachieve[7] or who, in integrated schools, become so caught up in how they believe others view them that their academic performance suffers as a consequence.[8]

Certainly, disparities in measures of academic attainment between black and white students continue to exist. Gaps began to narrow in the 1970s and 1980s but widened in the 1990s. The National Center for Education Statistics' 2002 National Assessment of Educational Progress, or the "nation's report card," shows contemporary racial disparities in academic performance (Table 8.1).

While we acknowledge the significance of racial disparities in shaping the life chances of black children living in poverty, we believe that widely accepted causes for them are dangerously misguided. In our view, contemporary explanations for racial disparities that blame children exclusively for their educational outcomes fail to account for the tug-of-war that has characterized the schooling of Americans of African descent for nearly 400 years.[9]

Table 8.1
NAEP National Reading Results for Grade 12—Public School Percentages of Students at Each Achievement Level by Demographic Characteristics, 2002

	Achievement Level			
Demographic Characteristics	**Advanced**	**Proficient**	**Basic**	**Below Basic**
All Students	4%	30%	38%	28%
National School Lunch Program Eligible	1%	19%	38%	41%
National School Lunch Program Not Eligible	5%	33%	38%	24%
White	5%	35%	38%	22%
Black	1%	14%	37%	48%
Hispanic	1%	19%	39%	41%
Asian American/Pacific Islander	4%	29%	39%	28%
American Indian	(Reporting Standards Not Met)			

Source: National Center for Education Statistics, National Assessment of Educational Progress (NAEP), 2002 Reading Assessment.

On one end of the ideological and programmatic spectrum that has shaped education in struggling black communities has been the advocacy of an education to extend the practice of freedom and democracy to its residents. The quest for black liberation here has been realized through a two-pronged approach to education from its very inception in the universal system of schooling in the south. For example, upon emancipation, according to Anderson, "the short-range purpose of black schooling was to provide the masses of ex-slaves with basic literacy skills plus the rudiments of citizenship training for participation in a democratic society. The long-range purpose was the intellectual and moral development of a responsible leadership class that would organize the masses and lead them to freedom and equality."[10]

On the other end of the ideological and programmatic spectrum was the advocacy of an education for black students to ensure the maintenance of white supremacy in U.S. society. Such was especially true during the post-Reconstruction era when local and federal agencies intervened to take control over the education provided children in poor black communities. An observation made by W. E. B. Du Bois, reported in a 1918 issue of *The Crisis*, is typical of the second-class education provided to black students during this period. Here, Du Bois decried the material disparities he found in the education of black and white students in Butte, Montana public schools:

> What, now, is the real difference between these two schemes [white and black] of education? The difference is that in the Butte schools for white pupils, a chance is held open for the pupil to go through high school and college and to advance at the rate which the modern curriculum demands; that in the colored, a program is being made out that will land the boy at the time he becomes self-conscious and aware of his own possibilities in an educational *impasse*. He cannot go on in the public schools even if he should move to a place where there are good public schools because he is too old. Even if he has done the elementary work in twice the time that a student is supposed to, it has been work of a kind that will not admit him to a northern high school. No matter, then, how gifted the

> boy may be, he is absolutely estopped from a higher education. This is not only unfair to the boy but it is grossly unfair to the Negro race.[11]

As we've suggested, black communities have long advocated for themselves an education for liberation, that is, one that promotes their full participation in the civic and economic life of the broader society or, when thwarted in this primary goal, that provides the means for self-sufficiency. Yet, as suggested by Du Bois' observation, the goals of black communities notwithstanding, white power interests have historically used the material and political resources at their disposal to exercise tremendous control over the direction of the education of black children and youth.

For the most part, the educational goals of black communities continue to be thwarted, even despite the *Brown* ruling.[12] Certainly, *Brown* contributed to unprecedented improvements in the education of black children and youth, especially for those living in poverty. However, the legal ruling did not and could not completely resolve the centuries-long struggle of black communities to obtain quality schooling in America. For instance, as a federal legal intervention into the education of black students, *Brown* never fully equalized the resources that they received, especially in terms of per student funding. In addition, the landmark court ruling contributed to the mass displacement of black educators who have played an historical role of advancing the intellectual and moral objectives of black communities. Reduced resources and the dearth of black educators that serve black children in poverty in contemporary schools contribute to disparities between these students and their peers, placing them further at risk in a society where the skills required of full citizenship have been dramatically redefined in our post-industrial, global society.

These factors aid post-civil rights era schools in their race making function by creating a superfluous population in whom society invests more on incarceration than on education.[13] In addition, the 2001 No Child Left Behind Act, arguably the greatest federal intervention into schooling since the *Brown* decision, has actually contributed to the educational problems that black children encounter in schools as opposed to ameliorating them, as intended by the law. In what follows, we discuss each of these matters in turn before turning to a discussion of the work of educators who meet the contemporary challenge of educating black children living in poverty as an unremarkable feature of their practice.

Funding Disparities in New Century Schools

Huge racial disparities in academic outcomes persist in public schools largely as a result of the ways they are funded in the United States. Most local funding typically derives from property taxes, where it follows that in wealthier white districts, property values and, hence, property taxes are much higher than those in less affluent and poor districts where black students are concentrated. In the 1990s this resulted in funding disparities in which New York State, for example, spent $38,572 per student in its richest school district, a sum which was seven times more than that of its poorest district, $5,423; the disparity was even greater in Texas where the wealthiest schools

Table 8.2
Average Funding Gaps between High-Minority and Low-Minority Districts, 2003

State	Low Minority Districts	High Minority Districts	Funding Gap
California	$6,682	$5,998	– $684
Florida	$6,008	$5,908	– $100
Missouri	$6,344	$6,764	$419
New York	$10,197	$7,778	– $2,419
Texas	$7,626	$6,018	– $1,608

Source: Education Trust 2005.

spent as much as ten times more on its students at $42,000 per pupil than those in its poorest district spent on its students at $3,098 per pupil.[14]

In the first decade of the twenty-first century, funding inequalities still persist between poor and wealthier districts and between schools with predominantly black student populations and those with mostly white student populations. Oftentimes, poverty and race overlap to further impact on the schooling opportunities of black children living in poverty. The significance here is that disadvantaged student populations require greater resources to account for dilapidated physical plants, underresourced facilities, and higher concentrations of special needs programs to equalize their life chances with those of their peers in wealthier districts. Most analyses of school funding apply a formula that indicates that students living in poverty require on average 40 percent more than their wealthier peers to level the field of resources and, hence, their future opportunities.[15]

However, with few exceptions, states spend approximately $900 less on districts with high concentrations of students living in poverty than they do on those with low concentrations of students living in poverty and $614 less on districts with large student of color populations than they do on those with predominantly white student populations. With the 40 percent adjustment, class-based disparities increase from $907 to $1,436 per student and race-based disparities increase from $614 to $964. Although, nationally, class-based inequalities are greater than race-based inequalities, more states (30) invest less in students of color compared to white students than states (27) that invest less in poor students compared to wealthier ones.[16] Table 8.2 provides 40 percent adjusted data that demonstrate the funding disparities in school districts in representative states with large concentrations of black children living in poverty.

We should point out that in 2003 the Missouri public K-12 school population was mostly white at 79 percent; black students, on the other hand, comprised only 17 percent of the pupil population, with Asian American, Latino, and Native American students together totaling 3 percent.[17] Significantly, in Missouri the majority of black students attend public schools with other black students in either St. Louis or Kansas City. Thus, the data reported above on the state's general investment in its public education system obscure how segregation contributes to the unequal distribution of educational resources as well as to disparate educational outcomes along racial lines. The quality of education in both cities is directly related to the effects

Table 8.3
Percentage of Secondary-Level Classes Taught by Teachers Lacking a Subject-Area Major or Minor, 1999–2000

	US	CA	FL	MO	NY	TX
Average	24%	27%	28%	24%	18%	30%
Low-poverty schools	19%	23%	14%	14%	18%	23%
High-poverty schools	34%	27%	47%	37%	15%	36%
Low-minority schools	21%	28%	18%	22%	16%	24%
High-minority schools	29%	26%	31%	39%	21%	30%

Note: "Low" denotes less than 15%; "high" denotes greater than 50%.
Source: Education Trust, *Education Watch—key education facts and figures* (the nation, CA, FL, MO, NY, and TX) 2004.

of white flight, restrictive covenants, and redlining in the region.[18] It should also be noted that students that attend St. Louis public schools are further isolated along the lines of race and class as a sizeable number of school-age students in the city, especially those from middle-class families, attend private schools.

Along with fewer material resources, black children living in poverty will most likely be taught by teachers who are less qualified than those who teach their white peers in more affluent schools. Table 8.3 shows the percentages of teachers who lack subject area college degrees in the middle and high school classes they teach.

Similarly, in our own research, we have found evidence that implicates teacher quality in the educational outcomes of the students at the urban schools we studied.[19] In one school, teachers typically subjected their students to dated curriculum and instruction, despite the availability of up-to-date resources. For example, from 1996 through 2000, students in a classroom at an elementary school in our study used model 186 and 286 personal computers, despite the fact that new, Internet-ready computers were available throughout the school, including in the room next door to where the older computers were housed. Some of these computers went unused over a span of 3 years. During this period the school was under scrutiny and was subsequently placed on the district's "school of opportunity" list, a designation that effectively placed the school on academic probation and at risk for being closed—which is precisely what happened to it in the summer of 2004.

At the same time, access to modern technologies, such as computers, does not mean that students will be allowed to use them in ways to promote the acquisition of the skills needed to succeed in the worlds of higher education and work in our high-tech society. These technologies are rarely exploited for their potential to promote academic achievement of black students but instead are typically used for drill and practice. For example, in 1998 more teachers reported using computers primarily for drill and practice with their black eighth grade students (42%) than they did with their white (35%), Asian American (35%), or Latino (35%) eighth graders. In contrast, fewer of these teachers reported simulations and applications or learning games as their primary computer use with black students (14

and 48 percent, respectively) than they did with their white (31 and 57%), Asian American (43 and 57%), and Latino (25 and 56%) students.[20] These findings reflect a timeworn pattern in which teachers routinely employ qualitatively different curricular and instructional strategies with their students in ways that sustain the race making function of schools in post-civil rights America. Such practices specifically place black students at a disadvantage in higher education and the workplace in a high-tech, digital socioeconomic order that requires of its participants innovation, creativity, intellectual dexterity, and initiative.

Culture and Power in Post-Civil Rights Schools

In the preceding section, we focused on the unequal distribution and use of resources, with the premise being that access to resources is a prerequisite to creating equitable outcomes for disadvantaged students. However, access to resources alone will not bring about changes in the education and the life chances of black children living in poverty. Matters related to decision making and the social division of power in schools also shape the education of these students. Along these lines, the absence of black educators in teaching and administrative positions in K-12 public schools also characterizes the post-civil rights education of black children,[21] leaving them having often to fend for themselves in hostile educational environments.

In the absence of black school leaders, black students often encounter second-generation discrimination and other challenges to obtain quality education.[22] Second-generation discrimination refers to unjust educational practices, such as the resegregation of students in previously desegregated schools and the disproportionate punishment of black students. These forms of injustice often stem from the failure of teachers and administrators to recognize or respect the self-determination of their black students; indeed, incidents of second-generation discrimination decrease in schools with black leadership.[23]

With respect to the first practice, resegregation in integrated schools counselors with the assistance and approval of teachers typically sort students into homogeneous subsets by ability groupings. This generally results in the concentration of white students in honors and gifted classes and of black and Latino students in lower tracks, remedial courses, and special education programs. Racial inequality is indicated by the statistically disproportionate distribution of students enrolled in the respective programs. Researchers apply a plus/minus 10 percent formula to determine if there is a disproportional placement of racial groups within a certain category of programs.[24] Table 8.4 indicates how students are distributed nationally across gifted and talented and remedial programs.

A proportional number of black students in any of the categories indicated in Table 8.4 relative to their school population would fall within the range of plus and minus 10 percent of 17 (i.e., 1.7) or roughly between 15 and 19 percent in any given program. Percentages that fall outside of this range are an indication that either too many or too few black students are represented in a program relative to their proportion within the broader student population.

Table 8.4
National Student Placement in Public School Programs by Race/Ethnicity, 2000

Race/Ethnicity	Public K-12 Enroll.	Gift. & Talent.	Remedial	Suspension
White	61%	74%	60%	48%
Black	17%	8%	22%	34%
Hispanic	16%	10%	15%	15%
Asian American/ Pacific Islander	4%	7%	2%	2%
American Indian	1%	1%	1%	1%
Total	47,018,606	2,926,034	3,908,226	3,053,449

Source: Education Trust, *Education Watch: The nation—key education facts and figures* 2004.

Table 8.4 also indicates a second feature of second-generation discrimination, that is, the racial disparities in the way that discipline is meted out in post-civil rights schools. These gaps increased in the late-1990s and the early 2000s as a result of the adoption by districts of "zero-tolerance" policies to curb real and imagined violence in American schools.[25] Widespread reports and highly publicized incidents of the expulsion of black students in the late 1990s refueled concerns in communities of color about educational justice and prompted the civil rights leader, the Reverend Jesse Jackson, to observe that, with increasing frequency, "school districts [are choosing] penal remedies over educational remedies when it comes to disciplining students."[26]

While, in general, poorer students are more likely to be suspended than wealthier students, researchers have found that black students from the wealthiest families were suspended at almost the same rate as white students from the poorest families.[27] Interestingly, a 2005 Yale study found that, nationally, prekindergarten students are expelled at three times the rate as are students in K-12 settings and, predictably, that black prekindergarten students are twice as likely to be expelled as are their white and Latino preschool classmates.[28]

The warehousing of black students in remedial programs as well as their exclusion from school is in many ways a form of racial profiling that delimits their opportunities in life. Racial profiling is a systemic feature of life for black children and youth in society and occurs systematically at various levels of the educational system, where policymakers, researchers, and educators often conflate "black" and "urban." For example, in his study of city schools, Pedro Noguera describes how policymakers and society talk about and respond to things designated as urban in ways that suggest that the appellation refers neither to geographical locations nor to spatial configurations. Rather, Noguera argues that urban is typically employed "as a social or cultural construct used to describe certain people and places."[29] This view of urban (re: black) schools results in policy decisions that pose difficulties for black students from impoverished areas to change their circumstances, either by entering into higher education[30] or into the workforce.[31]

With respect to the racial profiling in higher education admissions, two city students whom the first author recommended for admission to his university were placed on a

waiting list. After he contacted the admissions office on their behalf, he received the following response from the officer in charge of their application:

> I want to thank you for your words of support for both Aaron and Margaret. I am SO sorry to inform you that we have all but finished with our waitlist for this year's class, so I see very little hope of them coming to [the university] as freshmen.
>
> Though not the ideal arrangement, if they REALLY want to be here, transferring is always an option. We work with many students each year to make this happen. If you think that this may be an option for either of them, please let me know, and I will do what I can to help. They both sound like exceptional individuals and people who would both contribute to and benefit from the [university] community. It is frustrating not to be able to give you better news. I do hope, though, that as you continue to meet students you believe to be good candidates, you bring them to the attention of our office. It is often because of information such as what you've provided here a student comes to our attention in ways he or she may not have otherwise.
>
> It is challenging to find and capture talented students from the [city] schools, so I am especially sad at not being able to be more helpful with Aaron and Margaret. So often, students who have their sights set on [the university] coming from the [city] have not been adequately academically prepared. Those who are well prepared/top students are often looking to go somewhere other than [here]—away from home—and do. . . . In any case, PLEASE keep those names of qualified students we should be looking at carefully coming![32]

The admissions officer's contradictory response suggests that the university viewed these students and the urban city district in which they were educated with sweeping generalizations indicative of profiling, despite the fact that the school from which they graduated consistently ranked first in the state on a broad array of academic indicators.[33] Similarly, in urban classrooms profiling inheres in what Ann Arnett Ferguson calls the adultification of black boys in the school that she studied. Adultification occurs as the behaviors of boys as young as eleven and twelve foreclose their futures in the eyes of adults who often identify them as headed for jail.[34] Similarly, in his study of school violence, Ronnie Casella found that urban school officials were prone to "punishing dangerousness"—punishing not the specific violent behavior of youth but the *possibility* of their violent behavior somewhere off in the future.[35]

With respect to the prospects of black youth entering the workforce, as government jobs are eliminated due to federal downsizing and automation, employers in private industries are loathe to hire black workers, especially younger ones.[36] Employers cite a variety of reasons, but two predominate: (1) young black women and men lack the prerequisite technical and social, or "hard," skills, and (2) skills notwithstanding, they lack the appropriate "cultural capital" (e.g., attitude, demeanor) and are a liability in a market that relies heavily on image, presentation, and perception. The first concern of employers is connected to the quality of education, mainly in urban schools, that prospective employees receive while the second concern is associated with yet another pedagogical institution, the media that disseminate stereotypical imagery of them. To be clear, the larger point that we are making here is that the concomitant

effects of various institutions contribute to poor prospects for black children who will one day seek to enter the U.S. economy and larger American society as productive citizens.

The Resegregation of Public Schools in New Century America

Despite integration gains in the 1970s and 1980s, public schools have become more segregated in the 1990s and the early years of the twenty-first century, making it easier for them to sustain race making functions. Jonathan Kozol, a prominent critic of educational inequality, observed that schools were more segregated in 2006 than they were anytime since 1968.[37] Urban and fringe city school districts, for instance, are being populated by increasingly multicultural populations of students of color from working-class, poor, and immigrant families and more affluent suburban schools were being populated by homogeneous bodies of white students from middle-class families.[38]

The reversal of school integration is attributable both to failed attempts to integrate schools at the local level as well as to significant Supreme Court rulings such as *Milliken* v. *Bradley* (1974) that removed federal courts' powers to impose interdistrict remedies between cities and surrounding suburbs to desegregate city schools. In addition, the resegregation of schools in the 1990s and 2000s occurs within the broader political and economic context of changing public investments where states are increasingly spending more on criminal justice than they are on public education.[39] Indeed, during the opening years of the twenty-first century, states on average spent three times more on criminal justice than they did on education[40] and the same amount that they did on Temporary Assistance to Needy Families (TANF) and food stamps combined.[41] Such public policy decisions have resulted in what Kozol has called the "savage inequalities" that plague urban and rural schools, leaving them in the new millennium to provide their largely black student populations with what Robert Moses has called a "sharecropper's education."[42]

Moses' observation augurs poorly for black children living in poverty in contemporary society where access to and the manipulation of symbols and information define the economy, skills that require the support of much more than what a sharecropper's education can provide. Jeremy Rifkin brings the implications of a sharecropper's education in contemporary U.S. economy for the future of black children into bold relief: "Automation ha[s] made large numbers of black workers obsolete. The economic constraints that had traditionally kept black Americans 'in line' and passively dependent on the white power structure for their livelihoods, disappeared."[43] Along these lines, the Bureau of Labor Statistics anticipates that between 1998 and 2008, most of the 2.1 million jobs to be created in the United States will be related to information and service.[44] More recent projections indicate that the vast majority of jobs that will be created between 2002 and 2012 in the service-oriented, high-tech economy will require workers who have a firm grasp of mathematical, scientific, and computer skills,[45] the very skills that are compromised by a "sharecropper's" education.

No Child Left Behind and the Education of Black Children in Poverty

Amid growing concerns over schooling inequalities, the 2001 No Child Left Behind (NCLB) Act, the cornerstone of President George W. Bush's domestic policy during his first term, was passed with bipartisan support, marking the broadest expansion of the federal government into K-12 schooling since *Brown*. Although met with skepticism by those who saw the measure more as a political maneuver to position the President and his party in a positive light, NCLB includes remarkably explicit language to eliminate academic inequalities and to reduce educational disparities among children from different racial and economic backgrounds. Not since *Brown* had federal policy taken such strong measures to compel school districts across the nation to seriously educate all children.

No Child Left Behind's egalitarian rhetoric, however, has been betrayed by federal budget cuts that have severely undermined the capacity of public school officials to comply with the law's mandate. For example, federal cuts for the 2005 fiscal year eliminated more than $9 billion of promised funds from the NCLB budget. In addition, the government cut more than $7 billion from monies intended for Title I programs, the very programs directed at student populations especially at risk for failing in school, a population that is comprised largely of black children living in poverty (seeTable 8.5 for selected school districts).

As Table 8.5 indicates, such cuts tremendously impact school districts with high concentrations of poor students as well as those with large black student populations. In Missouri alone, where we live and work, Kansas City and St. Louis city schools lost nearly $35 million, or 41 percent of their respective budgets, of promised Title I funds during the 2005 fiscal year. Larger public school districts lost even more. For instance, federal cuts eliminated nearly $300 million from the budgets of Title I programs in Los Angeles public schools, as indicated in Table 8.5, and downsized the budgets of those in the schools in the five New York City boroughs by 38 percent to the tune of $650 million.[46] These cuts resulted in a severe strain on teachers, resources, and educational programs that are necessary to ensure that no child is left behind in America's schools.

The budget cuts also exacerbate other conditions that place black children living in poverty at risk in school and society. For instance, although NCLB's sweeping provisions allow for multiple ways to assess learning, underfunding contributes to the over-reliance by schools on standardized testing to measure student achievement. The extensive use of testing has also resulted in promoting the very sort of curriculum and instruction in schools that further marginalize—academically and socially—those who are at the greatest disadvantage in society.

Further, the general abuse of testing occurs at a time when students complain that schools neither challenge them nor prepare them for the worlds of work and higher education. Similarly, employers and college and university administrators complain that high school graduates often come to them without the basic skills that they expect young people to gain in school. Whether entering the workforce or enrolling in college, young people need to be highly skilled to survive and flourish in our

Table 8.5
Bush Administration's Proposed Fiscal Year 2005 Budget for Title I versus Title I Funding Promised by No Child Left Behind

School District	Administration Proposed Title I Budget	Title I Funding Promised under NCLB (Estimate)	Difference ($)	Difference (%)
Los Angeles Unified	$452,705,000	$747,310,200	–$294,605,200	–39.42%
Dade County (Miami)	$138,857,300	$225,414,000	–$86,556,700	–38.40%
Kansas City (MO)	$16,836,500	$28,338,800	–$11,502,300	–40.59%
St. Louis City	$30,288,300	$53,341,100	–$23,052,800	–43.22%
Bronx County (NYC)	$252,754,800	$406,375,000	–$153,620,200	–37.80%
Dallas Independent	$79,963,600	$135,281,300	–$55,317,700	–40.89%
Houston Independent	$108,036,600	$186,107,200	–$78,070,600	–41.95%

Source: Children's Defense Fund 2005.

contemporary postindustrial society. Both colleges and universities require of the students they admit the same skills and knowledge base that employers demand of high school graduates they employ: innovation, creativity, intellectual dexterity, and initiative. These are the very skills that are compromised in the unbridled pursuit of increasing test scores and that prepare black children living in poverty for the "Negro jobs" that no longer exist in postindustrial society. To be certain, neither NCLB nor standardized testing can be blamed for creating all the problems that exist in our schools but federal budget cuts can be rightly criticized for having exacerbated them.

THE EDUCATION OF BLACK CHILDREN LIVING IN POVERTY IN NEW MILLENNIUM AMERICA: LESSONS FROM THE "GAP CLOSERS"

Echoing a view expressed by W. E. B. Du Bois at the beginning of the twentieth century, the eminent American historian John Hope Franklin noted that the problem of the color line also promises to be part of the legacy and burden of the twenty-first century.[47] What we've described thus far in this chapter would seem to give credence to Franklin's words. For sure, contemporary public schools appear to sustain their historical race-making function in society by providing black children and youth a sharecropper's education, or one that effectively prepares students for "Negro jobs" in post-civil rights society. Such an education has devastating implications for children living in poverty in a postindustrial society that is absent a full-employment economy: It implicates schools in the untenable role of contributing to the creation of a superfluous population, one for whom society is prone to invest more on incarceration than it does on education.[48]

However, we are optimists by moral necessity as well as by lived experience and are emboldened by the frontline educators across the nation who are responsible for realizing the promise of *Brown* some 50 years after its rendering. These educators routinely lay bear the institutional lie that we cannot educate black children living in poverty as to do so is normal, those educators whom Asa Hilliard calls *gap closers*.[49] Gap closers are teachers, principals, and programs that normally promote academic excellence among typically low-achieving black students. As Hilliard notes, gap closers are generally unacknowledged in debates on school reform and rarely influence the direction of teacher education and school leadership programs that prepare teachers and administrators to work in schools with low-achieving black students. Instead the vast majority of researchers, educators, and policymakers operate from the assumption that failure is inevitable when it comes to educating most black students and that the most we can hope to do is to assist these students in meeting minimum competency standards.

These beliefs prevail despite the presence of gap closers and gap-closing schools in diverse settings in every part of the country. For example, black children living in poverty have a long tradition of academic excellence at the high-powered, African-centered Marcus Garvey School in Los Angeles. They also fare extremely well in the public Central Park East Elementary and Secondary Schools of New York. These latter schools feature a fairly traditional but nonetheless rigorous curriculum with high-performance standards. In addition, an untold number of parochial schools

and military academies also have had considerable success promoting high-academic achievement among black students. Despite their different ideological commitments, educators at these schools abide by the belief that, regardless of their backgrounds, all students can meet high standards. More importantly, though, these educators go about the business of educating black students as though such expectations are nothing out of the ordinary.

These seemingly disparate settings have in common certain philosophical principles when it comes to educating black children living in poverty. Theresa Perry captures these tenets in the following statement:

> African-American students will achieve in school environments that have a leveling culture, a culture of achievement that extends to all of its members and a strong sense of group membership, where the expectation that everyone achieve is explicit and is regularly communicated in public and group settings. African-American students will achieve in these environments, irrespective of class background, the cultural responsiveness of the setting or the prior level of preparation.[50]

In the above statement, Perry calls into question the common reasons that many educators and policymakers use to explain black student underachievement: Poverty, cultural difference, and educational history. In many ways, Perry suggests that when we are present with students and begin teaching where they are, as opposed to where they have been or should be, we can promote academic excellence. Similarly, Antonia Darder writes that the extent to which we embrace our students as integral beings is directly linked to our "willingness and ability to be fully present and in possession of the capacity to enter into dialogical relationships of solidarity with students, parents, and colleagues."[51]

Gap closers across America are largely comprised of educators who have entered into relationships of solidarity with students, parents, and colleagues and have made remarkable changes in previously struggling schools with large populations of children living in poverty. For example, in Texas, Jim Scheurich examined highly successful and loving, public elementary schools populated mainly by low-socioeconomic status children of color. In his research, Scheurich describes what the leaders of these schools have come to call the HiPass model of school reform; HiPass is an acronym for High Performance All Student Success Schools. As Scheurich explains, this model "did not come from the reform literature or from the leadership or organizational literatures."[52] In fact, as he reports, "those who developed the model were not self-consciously developing a model; in their view, they were just developing schools that were successful" for traditionally underserved working class and poor students of color, students whom they called "their children."[53] In addition to being academically engaged and civic minded, students at these schools typically achieve scores on high-stakes standardized tests that either match or exceed those of their peers at more affluent area suburban schools.

The schools in Scheurich's study are characterized by five core beliefs: (1) all children can achieve at high academic levels—no exceptions allowed; (2) work must

be refocused on the needs of the child rather than on the demands of the bureaucracy; (3) all children must be treated with love, appreciation, care, and respect—no exceptions allowed; (4) the racial culture, including the first language of the child is always valued—no exceptions allowed; and (5) the school exists for and serves the community—there is little separation. These schools go further than affirming the Constitutional rights reasserted in the *Brown* ruling and support those critical rights affirmed by the Universal Declaration of Human Rights that are imperative to promoting the civic purpose of public schooling in multiracial, multicultural societies.

The organizational cultures of these schools are characterized by seven interwoven, mutually reinforced features, or "shared meanings," that are readily observable by anyone upon entering a site: (1) a strong, shared vision; (2) loving, caring environments for children and adults; (3) collaborative, family-like environments; (4) innovation, experimentation, and openness to new ideas; (5) hardworking but not burning out; (6) an appropriate conduct that is built into the organizational culture; and (7) a sense of shared responsibility in which the school staff as a whole hold themselves accountable for the success of all children.

Most remarkable about these schools in Scheurich's study is the fact that they had previous histories of chronic underachievement and were typically transformed in 3–5 years under the leadership of newly assigned principals. These principals guided the transformation of their schools from low-performing to high-achieving educational centers while keeping 80 to 90 percent of the teachers and without changing the general socioeconomic demographics of their student populations.

Research conducted on the urban secondary schools in New York report similar findings.[54] Guided by values and supported by organizational cultures similar to those found among the elementary schools in Texas, the schools in New York also demonstrate remarkable support for their largely black and student of color populations from working class and poor backgrounds. These schools promote among poor students of color the sort of capital by which they come to see themselves as responsible change agents in their school and in their communities. Like their younger peers in the Texas elementary schools, students in the New York high schools report that their teachers are academically and socially responsive. Also, these students' perceived sense of belonging in school contributes to a sense of academic press in which they are likely to feel more challenged and prepared for college than do their black peers in suburban settings.

These schools also defy academic prescriptions and popular conventions that overpredict the impact of poverty and parental education or family educational status on student aspirations, engagement, motivation, and achievement. In other words, in these schools, "parental education was not correlated with student level of engagement or aspirations for college."[55] These findings are consistent with research on schools that promote black student success in diverse settings around the country. Despite their different ideological commitments and programmatic features, educators at these schools abide by the belief that, regardless of their backgrounds, all students can meet high-performance standards. More importantly, though, these educators

go about the business of educating black students as though such expectations are nothing out of the ordinary.

In our work in St. Louis, we have also encountered dedicated students and skilled gap closers from racially, economically, and linguistically diverse backgrounds in elementary and secondary schools throughout the city. These educators embrace radically humanistic values in the tradition of Jean-Jacques Rousseau, John Dewey, Septima Clark, and Paulo Freire and, most importantly, foster cultures of achievement in their schools or classrooms. These, like other gap closers around the nation, resist the idea that failure is inevitable when it comes to educating black students or poor students or immigrant students, or that the most we can hope to do is to assist these students in meeting minimum competency standards. They, like their gap-closing peers, know that the real achievement gap is the disparity between the widely reported underperformance of black students and the capacity of these students for excellence as opposed to differences in test scores between black and white students.[56] Most importantly, however, the values that these educators translate into school policy and classroom practices are theoretically and ethically consonant with the educational values that have inspired black children, youth, and adults of all backgrounds to invest themselves in schools, even when their goals and aspirations have been hijacked, either by judicial decree, state and federal mandates, coalition politics, or the decisions of those who are elected and charged to serve them.

CONCLUSION

As we conclude, we are mindful that, as the noted social theorist Anthony Giddens explains, the world in which we now live is much more complicated than the ones of the past. This is due to the proliferation of media and other forms of communicative technologies that allow for the unchecked dissemination of information, images, and symbols. This is a "runaway world," Giddens notes—one that is associated with drastic social and economic changes in both the United States and the broader international society.[57] These changes, attendant to postindustrialism and globalization, present individuals with a vast array of social, cultural, and economic opportunities.

At the same time, opportunities have not been available to all and, so far, both postindustrialism and globalization have reinforced patterns of racial dominance, both in the United States and abroad. As indicated previously, jobs in the United States for the foreseeable future will be divided between disproportionately high numbers of opportunities in low-paying, low-status, unstable positions and small numbers of high-paying, high-status, more secure ones. Poor black children and youth are generally destined to fill the former category as adults later in life and increasingly are being left out of both.

Thus, basic shifts in the U.S. economy in the past 20 or so years have altered both the technical function of public schools as institutions that develop socially recognizable skills among students and the moral imperatives of these places as sites that promote citizenship and social justice. To be clear, however, no one approach,

philosophy, program, or political posture represents the magic formula to guarantee underserved children and youth educational settings that affirm human dignity, promote intellectual development, and foster a deepened sense of community. Yet, as history and the efforts of the gap closers discussed in the previous section have shown, black communities are the primary and most enduring resources in the education of their children and youth; any effort to promote educational excellence among underserved students must honor the voices that originate in these communities—both in and on their terms.

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CHAPTER 9

RESETTLING REFUGEE CHILDREN

Qingwen Xu and Denise Pearson

The United States is by far the largest of the 10 traditional resettlement countries, in that it has historically accepted more refugees for resettlement than all other countries combined. Every year, refugee men, women, and children enter the United States with hopes of finding a life better than the one they left. They come with the expectation to integrate into American society, in employment, education, community, and social settings. From 2001 to 2004, America resettled about 160 thousand refugees.[1] Among them, a substantial number are children. Worldwide, school-age children (age 5–17) represented about 49 percent of refugees received in 2002, according to the United Nations High Commissioner for Refugees (the UNHCR).[2] In the United States, from 1989 to 2001, there were approximately 400 thousand refugee children (age <19 years), accounting for 30 percent of refugees.[3] Refugee children are normally exposed to numerous risk factors resulting from settlement, including lack of formal education, exposure to violence, forced displacement, and multiple losses. In addition, refugee children frequently live in families that are financially poorer, have less educated parents (without English proficiency) than their counterparts in the host country, and endure substandard health and mental health conditions. Meanwhile, refugee children and their families are resettled in a society of which they know little; some of this knowledge, such as the knowledge of educational, social, and legal systems, is critical to successful resettlement and adjustment. Consequently, the lack of knowledge frequently sets refugee children apart from the mainstream community and causes further concerns for their overall development.

Unfortunately, researchers have not paid adequate attention to the plight of refugee children, in particular to their resettlement in the United States. Refugee children's special circumstances ask for appropriate response from both policymakers and social service practitioners. This chapter first examines systematic barriers to refugee

children's successful resettlement, and the role of the U.S. child welfare system in the resettlement process. Then it introduces a Parenting Empowerment Program offered by a voluntary resettlement agency in Colorado. Last, based on the review of U.S. resettlement policies and service programs and empirical data from the Parenting Empowerment Program, this chapter offers recommendations for policy changes and for more effective practices in order to better address refugee children's needs so as to secure their future well-being.

REFUGEE CHILDREN AND THEIR JOURNEY TO THE UNITED STATES

Refugee Children and Their Special Journeys

Refugee children come to the United States via diverse journeys, and gain their legal status and rights to stay in the United States in diverse ways. The majority of children come to the United States under the protection of the UNHCR and in accordance with international arrangements, such as the Somali refugee program. Because of wars and armed conflicts, these children are classified by the UNHCR as refugees. They flee en masse, often by foot, from their home country into neighboring countries, and normally live in refugee camps operated by governmental entities. As one of the UNHCR's "durable solutions," rather than returning to their home country, some refugee children and their families are permanently transferred from refugee camps to the United States, where they can begin a new life. Because the UNHCR's ultimate goal is family reunification, refugee children are usually resettled in the United States together with their parents and/or extended families. A smaller number of children gain their refugee status and are eligible for resettlement as a result of reunification with their refugee families who are already in the United States. Between 1997 and 2002, approximately 93 percent of refugee children arrived in the United States in the company of biological or legally adoptive parents; others traveled to the United States to reunite with caregivers, or to join a relative who had been newly designated as their caregiver.[4] Normally, refugee children and their families receive a series of resettlement services before their departure, during travel to the host country, and after their arrival.

A special category of refugee children is "unaccompanied minors," who come to the United States without a parent or legal guardian. These children travel alone either voluntarily in hope of eventually joining their parents and relatives, or by force, fraud, and coercion. Children in this category are either identified by the Department of State (DOS) before their arrival, reclassified after arrival, or granted asylum. Over the last several years, the plight of unaccompanied children in federal custody pending immigration hearings has gained significant attention from the media, Congress, the legal community, and the public.[5] In November 2002, Congress acted to redress the plight in the Homeland Security Act by transferring basic care, custody, and placement functions from the Immigration and Neutralization Service (INS) to the Department of Health and Human Services (DHHS). DHHS thereafter retains the exclusive

authority to place refugee children in state juvenile dependency proceedings and foster care, and provide services through its Unaccompanied Refugee Minor Program (URM), which was developed in the 1980s to address the needs of thousands of children from Southeast Asia without a parent or guardian to care for them. Since 1980, almost 12,000 minors have entered the URM program, according to the Administration for Children and Families (ACF).

Risk Factors to Refugee Children

Regardless of their different journeys to the United States, refugee children are exposed to multiple risk factors that can negatively affect their development. Economic, political, and social factors can affect refugee children's development as they resettle in a new country. Such factors are important in predicting their adjustment to their new circumstances as well as their physical and psychological well-being. The effects of war and trauma on children have been documented since World War II.[6] Subjected to the horror of war, dependent children's developing coping skills put them at risk for mental health disorders.[7] Researchers found that while children's physical health could recover rather quickly, children's social behavior was slower to improve, and some refugee children have persistent developmental issues.[8] Within the last decade there has been research examining refugee children's mental health. Indeed, a group of studies published in 1995 found that serious psychiatric disorders were present in 40–50 percent of refugee children.[9]

In addition to the effects of war and trauma, the literature also suggests that refugee children have experienced extra difficulties in the process of resettling in a new society and adjusting to a new social system. Refugee children and their families enter a new country; the process of gaining refugee status is not only complex and difficult but also emotionally draining. Most refugee children have lived in a condition of continual stress caused by uncertainty about their future, which compounds the trauma experienced in their home country. They are likely to live in temporary housing and attend substandard schools.[10] Once settled in a local community, however, refugee children's mental health does not improve much, because they face new challenges of achieving acceptance at school, developing a personal identity in a new society, and acting as "cultural brokers" for their parents at home.[11] Researchers have found that Indochinese refugee children who resettled in the United States reported significant mood disturbances and psychological distress within the first 2 years of resettlement.[12] Furthermore, living in a Western society as ethnic minorities, refugee children have experienced discrimination at schools and in the community, which creates high levels of stress and psychological distress.[13] Researchers have indicated that new life circumstances in their host communities, such as peer relationships and exposure to bullying, are of equal or even greater importance than previous exposure to war and violence, which affect refugee children's social adjustment and self-worth assessment.[14]

Unfortunately, unlike most other children, refugee children frequently lack the support and help from their parents and families to cope with the stress and psychological

distress during their resettlement and adjustment. While it has been recognized that the family is the natural environment for the growth and well-being of children (as stated in the 1989 Hague Convention on the Rights of the Child), refugee children often lack such a healthy family environment; their parents and families are often suffering from high rates of depression and psychological distress as a result of adjustment.[15] Researchers have identified that stress in the family and exposure to war and violence are two equally weighted determinants of refugee children's poor mental health.[16] Certain aspects of the home environment highly correlate with children's cognitive development, including the manner in which the mother responds emotionally and verbally to the child, the mother's emotional well-being, the mothers' ability to cope with the stress of displacement, and the organization of the child's physical and temporal environment.[17] Also, because refugee children in the United States usually learn English and customs faster than their parents, they may find themselves mediating between their parents and the outside community[18] rather than receiving support from their parents.

In order to assess refugee children's needs and better support their development, researchers recommend services that facilitate the successful adaptation of refugee children, help refugee children and their families heal from their experiences, and begin integrating into the host society. Therefore, whether current resettlement services can meet these challenges and objectives, and what is the best practice to resettle refugee children become critical. This chapter, then, systematically evaluates present refugee children's resettlement programs and services in the United States, also the administrative structure, funding sources, and roles of social service institutions in the process of resettling refugee children.

SOCIAL SERVICES FOR REFUGEE CHILDREN IN THE UNITED STATES

Resettlement Program and Structure

Social services provided to refugee children and their families in the United States generally include two stages. For the first stage, services are provided mainly to assist in immediate resettlement efforts, that is, for the first 6 months upon refugee's arrival. The second stage includes long-term resettlement and integration programs and other mainstream social services such as Medicaid and Food Stamps. The initial resettlement service is administrated by the U.S. Refugee Resettlement Program and funded by the Department of State (DOS) Bureau of Population, Refugees and Migration (PRM). In fiscal year 2004, the DOS designated $132 million for refugee admissions and resettlement programs. The UNHCR is a designated partner in the U.S. refugee resettlement program, and is involved in the process of determining processing priorities, setting the annual cap for admission, and facilitating the refugee migration. The DOS distributed funds to a network of over 400 voluntary agencies (Volags) throughout the United States through what is called the Reception and Placement (R&P) grant. The DOS contracts with Volags to provide

refugees with food, housing, employment, medical care, counseling, and other services to help refugees make a rapid transition to economic self-sufficiency. While the R&P grants are supposed to fund services to resettle refugees during their first 30 days in the United States, recipients of R&P grants are expected to augment funds with private cash and in-kind contributions, and provide services to refugees, including sponsorship, prearrival resettlement planning, reception upon arrival, basic needs support for at least 30 days, and case management and tracking for 90 to 180 days.

Domestic long-term refugee resettlement and integration programs are closely coordinated by the PRM but funded through the DHHS's Office of Refugee and Resettlement (ORR). Ongoing benefits for the newly arrived refugees include transitional cash assistance, health benefits, and a wide variety of other services. The primary focus is job placement, cultural orientation, English language acquisition, and health care access. Most services at this stage are provided up to the first 8 months after arrival; refugees are expected to become employed and self-sufficient by that time. Refugee Cash Assistance and Refugee Medical Assistance are only available for the first 8 months. After this period, unemployed and low-income single people and childless couples are not eligible for any cash assistance. Families with children (<18 years of age) then have to turn to mainstream welfare programs, such as the Temporary Assistance for Needy Families program, which assists poor families for 2 years, and Medicaid, which provides health benefits for unemployed and low-income families. Under the DHHS umbrella, additional services are offered, such as family strengthening programs, youth and elderly services, adjustment counseling and mental health services, aimed to further assist refugee families adjust to their new lives in the United States. However, social services provided through the refugee resettlement system, such as employability services under the State Formula Grant Programs, are available only for the first 5 years after arrival in the United States; the services, in reality, are structured to promote employment and self-sufficiency for much earlier than 5 years. Unfortunately, refugee children's needs and needs assessment are not specifically identified in the refugee resettlement program, as described above. Services are primarily designed for parents and families in hopes that a resettled family with at least one family member employed will assure refugee children's well-being and provide for their needs.

The program, in particular for refugee children, is for unaccompanied refugee minors who have not joined with parents and/or do not have a legal guardian. The URM program, under the direct administration of ACF, provides a comprehensive range of services for unaccompanied refugee minors and places them in culturally appropriate places. Currently, the URM program offers special foster care for these children in ten states, and has developed an array of services, such as shelter care, residential treatment care, and services for the young age, pregnant girls, or children with mental illness. The primary focus of the URM program is to reunite refugee children with their relatives whenever possible; therefore, refugee children in foster care are not available for adoption in accordance with standards of the UNHCR, and this leaves open the possibility of family reunification.

Discussion

Taking into account refugee children's special circumstance, a review of U.S. refugee resettlement programs suggests that refugee children's needs have been largely underserved. This situation can be explained by two policy objectives. First, the U.S. refugee resettlement programs and services focus primarily on the initial stage of resettlement. Primary resources and services are to address the refugees' most urgent needs once they reach the destination—food, shelter, health care, water and sanitation alike. Given the refugees' initial vulnerability, services are provided free of charge, and require little or no contribution from the recipients. Later on, education, skills training, psychosocial support, and other services are added to the mix, but at a minimal level. In the United States, the initial period of settlement is 6 months. In the longer term, since it is believed that a refugee's levels of vulnerability decrease, there is no systematic program available. Secondly, the primary focus of refugee resettlement services is employment, such as skills training, job development, workplace orientation and job counseling. American policymakers believe that it is crucial that employment be found soon after arrival, as employment leads not only to early economic self-sufficiency for the family, but adds greatly to the integrity of families who seek to establish themselves in a new country and provide for their own needs. Generally, the program implementation would encourage more than one member of the family becoming employed.

Obviously, the principles underlying these two policy objectives reflects economic reality and American value—returning back to normal life as quickly as possible, participating in the labor market to support family and children, self-sufficiency and independence. The impact of these policy objectives on refugee children is mixed. On one hand, the current U.S. refugee resettlement program and services can benefit refugee children by rebuilding their routine family life and strengthening their family functions quickly and effectively. Experience from other countries indicates that labor market participation is a key factor affecting the success of refugee resettlement.[19] Sustained provision of free services after the emergency phase would erode the refugee family's mechanisms. Sweden offers an example. While the Swedish government in 1985 shifted the focus of refugee resettlement from labor market integration to income support, and extended the initial stage of free services to 18 months, the overall effect of this reform was that refugees suffered substantial long-term earnings losses, and consequently, the poverty rate among refugees rose.[20] Therefore, there is nothing more important than a well-functioning, economically self-sufficient family unit; the U.S. resettlement program and services might be exactly the one to fulfill children's needs for psychological and physical well-being and development.

On the other hand, refugee children and their families need to access a wide range of key services to support their transition from arrival to eventual settlement, and their needs go far beyond basic economic self-sufficiency. The lack of key services would negatively affect refugee children's development and jeopardize their process of integrating into the community. Service providers and researchers have identified many refugee children's needs during their early years in the United States that must

be addressed, such as cultural orientation, ethnic identity, family conflicts, and social adjustment at schools, to name a few. Refugee parents and families cannot easily, if not possibly, assess these needs, which centrally pertain to refugee children's development. Professional help for refugee children are of necessity. Meanwhile, more resources and long-term services are needed in order to provide and sustain ongoing emotional and psychological supports. Due to cultural misunderstandings, discrimination, identity disorientation, school adjustment problems, peer relationships, and many other factors, refugee children's daily struggles do not subside after the initial stage of resettlement. A study of refugee children from Chile and the Middle East in Sweden suggests that the poor mental health condition of refugee children persisted 13 months after resettlement.[21] And the process of assimilation of a group of people into mainstream society generally takes about three generations.[22] As such, the U.S. resettlement program fails to provide refugee children with comprehensive services, and does not support them and their families for development.

As refugee children are facing increasing risks and challenges during their resettlement, how to strengthen refugee families, increase family resources, empower parents, build parents' upward initiative and persistence, and provide adequate supports to refugee children on a long-term and consistent basis is what American resettlement programs need to address.[23] Here we present a Parenting Empowerment Program provided to Somali and Somali Bantu refugees in Colorado; the program evaluation then leads to further discussions on U.S. refugee resettlement programs and practice.

SNAPSHOT OF A PARENTING EMPOWERMENT PROGRAM IN COLORADO

Program Background

Colorado has resettled more than 32 thousand refugees since 1975, coming from countries around the globe. Between the years 1984 and 2004, more than two thousand African refugees arrived in Colorado.[24] In the summer of 2004, Colorado received more than a dozen Somali and Somali Bantu refugee families for resettlement. Before arrival, these refugees had been in a resettlement process for an unexpected 5 years, moved from one refugee camp to another, and endured many challenging events, in addition to traumatizing experiences in their own country.

The Somali and Somali Bantu families arrived in Denver in 2004; many included elementary-aged children, who were eventually enrolled at a community-based elementary school. However, not fully aware of the refugee children's imminent enrollment, the school was unable to adequately prepare to receive them. In addition to communication difficulties, as most of the children only had limited English ability, school teachers increasingly expressed concerns for the safety and well-being of the children. Observations indicated that refugee parents and families were either not fully aware of the changed environment for their children, or were too vulnerable to be able to cope with these changes, or both. For example, refugee parents dropped their children off early at school and picked them up late; refugee children walked or

ran into the street without apparent caution; or children came to school unprepared for the day's work. When the elementary school recognized that it lacked the capacity to address these concerns, it reached out to the community for assistance. The effort resulted in collaboration between a local refugee resettlement agency and the community-based elementary school. A structured Parenting Empowerment Program was developed to mitigate presenting concerns over refugee children's well-being, and to empower refugee parents for their successful transition in the community.

Program Development and Implementation

The Parenting Empowerment Program was developed in 2004, and consisted of an 8-week program focusing on the following issues: (1) Parent—School Relations; (2) Discipline and Neglect; (3) Behavior Management; (4) Household Safety; and (5) Child Development. These issues were carefully chosen considering the huge difference in childcare, school system, and community environment between refugee children's original country and the United States. The program also took into account the knowledge and skills that pertain to refugee children's development and involvement in the new society. The content of the program included issues of parents' involvement in school and education; U.S. child-care policies and consequences for violating policies; appropriate and legal ways to discipline children and child abuse laws in America; and children's developmental needs at various stages of childhood.

The Parenting Empowerment Program was designed to orient refugee parents to the U.S. educational systems, familiarize them with appropriate child care in the United States, aid them in the resettlement process, promote self-efficacy, and empower parents to become effective parent advocates. The program was available to refugees living in Denver metropolitan area from Rwanda, Ethiopia, Sudan, Liberia, and Somali, and refugees entered the program through several Denver resettlement agencies. The first 8-week parenting program was held in the summer of 2004, with six Somali and Somali Bantu families participating in the program. The program was conducted at the elementary school by the agency's staff, in collaboration with staff from the school and with the assistance of translators.

Evaluation Approach

A preliminary evaluation of the initial program was conducted in the summer of 2005 in order to evaluate the perceived impact of the Empowerment Parenting Program on refugee parents. The program evaluation was designed primarily as a tool and methodology to enhance shared understanding and knowledge about various aspects of the Parenting Empowerment Program, and the residual needs and concerns of participants. The evaluation is built on the premise shared by researchers and practitioners that refugees are most intimate with their own experience, which necessitates a qualitative research approach. Considering complicated issues in the process of refugee resettlement, qualitative approaches also allow for a more participatory process that includes refugee families, resettlement agencies, school staff, and other program collaborators.

The evaluation involved a systematic collection of information from the resettlement agencies about the program activities, characteristics, and outcomes. In addition to the agency's documentation, agency personnel, program administrators, and school representatives were interviewed and consulted with throughout the project's duration. These interviews provided opportunities to further conceptualize the present problems, as well as additionally identify other concerns about refugee children's resettlement. Agency staff and other parenting program affiliates were involved in all steps of the evaluation process, also as a measure to further ensure accuracy of information and data collection. This collaborative and formative approach provided an opportunity to clarify issues and make any necessary refinements to the questioning or methodology.

Through narrative design strategies and also considering the nature of this preliminary program evaluation, open-ended in-depth interviews with refugee parents were conducted. Three refugee families participated in the evaluation; they are comprised of Somali and Somali Bantu families. Due to the absence of refugees' English proficiency, and considering the likelihood of refugees' minimum formal education and their unique culture characteristics, an interpreter, a Somali refugee, was identified and contracted with for interpretation and translation assistance. The same interpreter was used for all interviews and obtained informed consent in each case. The interview questions were designed to explore the perceived impact of the Parenting Empowerment Program. The interview script was derived from the program content. Because of the level of parents' education, English language proficiency, and other cultural factors, the degree of comprehension of the questions was uncertain in all cases. To mitigate miscommunication most questions were rephrased several times to facilitate accurate translation.

Perceived Needs of Refugee Parents

Program documentation records indicated that this group of Somali and Somali Bantu refugees participated in a 2-week cultural orientation session in a Kenyan refugee camp, in preparation for their resettlement in the United States. Their resettlement process in Colorado consists of two phases; the first phase lasted up to 1 year and was the period when refugees were received and resettled through local resettlement agencies. The second phase could last up to 5 years and is considered the service phase of resettlement. Upon arrival in the United States, case managers were assigned to each Somali and Somali Bantu family. Case managers are responsible for receiving refugees at the airport and then transporting them to housing, securing them food, and leaving them to rest and reflection. They are also responsible for orienting them to life in the United States.

Conversations with agency and school personnel revealed multiple concerns toward refugee children's well-being and their families' ability in caring for these children. Information gathered from interviews suggested several perceived needs of refugee parents. The first and most important of their needs is to acquire English language skills. Lack of English proficiency not only has blocked communications between

school and refugee parents, but also caused difficulties for parents in helping their children with school work and school adjustment issues. High levels of stress have been observed for refugee parents. Refugee parents reported frustration to their case managers over the fact that they cannot read the letters sent home by school officials. It was also reported that refugee parents, without an understanding of American culture and social context, had a difficult time "taking in" all the necessary information at once. In addition to the challenges of language, refugee parents expressed unfamiliarity with the concept of "parent involvement in education," which is a well-grounded educational approach in the United States. As one refugee parent put it, in their country of Somalia, "teachers teach and parents parent—there is no interaction." Refugee parents' lack of knowledge about U.S. educational system and their lack of the interaction with schools could jeopardize refugee children's settlement and adjustment.

Therefore, it is perceived that refugee parents need support ranging from abilities in reading and speaking English in order to communicate with school teachers, to orientations of parent involvement in children's education and coping with American educational system, and knowledge of appropriate child care in the United States. In doing so, it is anticipated that refugee parents would be better prepared to help their children adjust to the new school, new community, and new country. The importance and necessity of continuing and further developing the Parenting Empowerment Program has been recognized by the school principal, resettlement agency staffs, and teachers.

Need Assessment

The Parenting Empowerment Program is empowering parents to begin taking greater control over issues related to their children's safety, care, discipline, and education. Although language barriers had a noticeable and adverse impact on the ability of some refugees to fully and actively participate in the program, despite the use of translators, all participants expressed value in participating in the program. However, interviews with refugee parents revealed a variety of compelling issues and themes; there are still remaining unmet needs that will impact further empowerment as part of the resettlement process.

From interviews with refugee parents, the Parenting Empowering Program effectively highlighted the differences and legal forms of childcare. Participants in this study articulated an understanding of what constitutes child care in America, and learned the importance of, such issues as dropping off and picking up their children on time from school, including the legal implications of not being in compliance. Nevertheless, cultural variances emerged during all interviews. One mother mentioned that she now understood she had to watch her children at all times. She connoted that "the child care in the U.S. is not the same at home in Somalia; kidnapping is not a problem—if children get lost in Somalia, they are eventually found by police and returned home." As a result of the parenting program, refugee parents were also made aware of other environmental issues and different standards of raising children in the United States. One mother stated that the program clarified expectations about

nutrition, sleep/rest needs at different stages of development, and the importance of helping children with homework. The session on child safety particularly had a positive impact and had changed refugee parents' caregiving practice. Participants talked about placing knives safely out of the reach of children, having ready access to important telephone numbers, and bathing children and preparing food in hygienic ways; they also followed these practice at home.

Regardless of the awareness and knowledge refugee parents have gained about appropriate ways of child care in the United States, all parents in this study expressed difficulties related to fulfilling some parental responsibilities as suggested in the program. Again, not being able to speak English blocked their involvement in their children's education, and made it difficult to help their children with homework and effectively communicate with the school. Interviews revealed that refugee parents still needed help from the resettlement agency. In one case, a staff person from the agency visited refugee families' homes on a weekly basis to help their children with homework and to help parents with their English. In addition, the parenting program has also caused unpredicted consequences. For example, one mother asked to learn more about how to handle conflicts with her children. She felt unable to discipline them because she was informed during the program that in America she should never hit her children. She was worried because her child had threatened to "report her" if she used physical means for discipline. The mother felt her parenting authority was being restricted, and she was lacking full information about normative child discipline in the United States. While this confusion is normal for refugee parents especially during their resettlement and adjustment period of time, parents' responses to the program suggested unmet needs and implications for future program development.

Although the Parenting Empowerment Program aims to educate refugee parents for the good of their children, the issue of unemployment and family poverty emerged strongly in this study. For some refugee parents where English proficiency and any degree of formal education were lacking, frustrations over the need to learn skills and finding jobs were evident. They expressed dissatisfaction with the quality of their life in the United States, saying it was "a hard life." Most refugee parents in this study were either still unemployed or had difficulty keeping a job. Regardless of job training and searching efforts, limited English and lack of culturally appropriate work training hampered their ability to remain employed and self-sufficient. Accessing services was another expressed impediment to successful resettlement of refugee families. In particular, refugee parents expressed the need of monetary assistance for extended periods of time. One family in this study reported that the employment training, financial management, and resettlement services were helpful, but the reality was they lacked sufficient income for rent and were threatened with eviction.

Implications and Recommendations

The Parenting Empowerment Program was a response to problems jeopardizing the resettlement of Somali and Somali Bantu refugee families. Their problems were

perceived to be the inability to care for their children in their new community appropriately, as well as in American society in general. Following the parenting program, positive changes in parent behavior were observed and anecdotally reported. These include such behaviors as getting children to school on time, paying close attention to traffic while taking children across streets, and being mindful of children's safety at home. Despite the positive impact of the parenting program, Somali and Somali Bantu refugees appear to need longer-term, population-specific intervention, if integration and sustained empowerment are expected. This evaluation suggests that refugee families have faced a multitude of difficulties during their resettlement, that consequently make refugee parents unaware of their children's needs, or insufficiently capable of supporting them. As such, refugee families might endanger their roles and functions in the process of refugee children's social and human development.

Learning from this Parenting Empowerment Program, we summarize following recommendations. First, the U.S. refugee resettlement policies should still emphasize job training and employment. Apart from the assumption that refugees receive adequate assistance that enables refugee families to be financially secure and to live properly in the United States, this evaluation reveals that unemployment and poverty are still clear and compelling issues. As employment remains a challenge to durable resettlement, it is recommended that the strengths of Somali and Somali Bantu people—their experience in agriculture, strong community orientation, social capital in family and religion—could be used as leverage to identify and develop employment opportunities and training priorities.

Meanwhile, as language is still a critical barrier for a successful and smooth refugee resettlement, it is recommended that funding for long-term language training should be provided to resettlement agencies. Taking into account the difficulties and time invested to overcome many identifiable employment barriers, long-term assistance, and efforts aimed at poverty relief are critical. While this Empowerment Parenting Program in Colorado focused on refugee children, the program evaluation reveals the necessity of reforming thoroughly U.S. resettlement policies and programs, which heavily focus on the early stages of settlement, and largely ignores the long-term needs of refugee families and children, greatly impacting those with unique situations and needs.

Also, as indicated in the Empowerment Parenting Program, collaborations between resettlement agencies and interstate social service agencies would contribute to positive impacts on refugee families. It is recommended that government funding should support collaborative approaches, including education, training, and service provisions. While resettlement and other social service agencies serve the same population at different stages of refugees' resettlement, adjustment and assimilation processes, interand intra-agency approaches would increase programming effectiveness and efficiency. Nevertheless, provision of services developed specifically for refugee children remains essential and lack of such services would lead to further concerns over refugee children's development. Experiences from this Empowerment Parenting Program suggest that educating, training, and empowering refugee parents are helpful. However, due to the barriers that refugee families have endured, the parenting program and

other family strengthening programs fail to address the specific challenges that refugee children continue to face.

SUMMARY AND CONCLUSION

Overall, like many refugee groups from the world, Somali and Somali Bantu refugees studied face clear and distinct resettlement challenges. From the positive experience of the Parenting Empowerment Program, there is an opportunity for the resettlement agency to further impact empowerment growth with strategic planning and selective partnerships. This evaluation study indicates that long-term resettlement success is contingent on recognizing the distinct challenges that each refugee group is presenting, as refugees work to become responsible and supportive parents to their children, and contributing members of American society.

It is recognized that refugee children are living in a rapidly changing American society. The majority of post-9/11 refugees might be subjected to increased discrimination, while simultaneously living below the poverty level. Changes in American social and political dynamics have resulted in tightened funding for refugee resettlement services. For refugee children, there is no current policy that ensures refugee children's long-term development. This presents a mandate for policymakers to begin deliberations on the future of U.S. refugee resettlement programs, from the perspective of children as primary and compelling stakeholders.

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