FOSTER CARE AS A MITIGATING CIRCUMSTANCE IN CRIMINAL PROCEEDINGS

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> *It is the judge who can appreciate the full complexity of the offender and his crime, and no prescriptive set of laws can appreciate the subtleties in determining the punishment that justice demands. If the 600-plus pages of the most recent set of sentencing guidelines have taught us anything, it is that punishment cannot be reduced to an algorithm.*[1]

The sensationalism of many criminal trials, especially those of a capital nature, often result from the aggravating circumstances impacting the victim.[2] Conversely, the mitigating circumstances that affect the accused's criminality rarely grab headlines.[3] During the sentencing phase of a criminal trial, mitigating factors may justify leniency or otherwise serve to lessen the sentence for the crime with which the accused has been charged.[4] Whether a particular factor will be considered a mitigating one will depend upon the particular facts of the case. The federal Sentencing Reform Act of 1984[5] provides guidance in this process,[6] but

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1. Myron H. Thompson, Op-Ed., *Sentencing and Sensibility*, N.Y. TIMES, Jan. 21, 2005, http://www.nytimes.com/2005/01/21/opinion/21thompson.html?_r=1.

2. An aggravating circumstance can be defined as the following: "1. A fact or situation that increases the degree of liability or culpability for a criminal act. 2. A fact or situation that relates to a criminal offense or defendant and that is considered by the court in imposing punishment (esp. a death sentence)." BLACK'S LAW DICTIONARY 277 (9th ed. 2009).

3. A mitigating circumstance can be defined as the following:

> 1. A fact or situation that does not justify or excuse a wrongful act or offense but that reduces the degree of culpability and thus may reduce the damages (in a civil case) or the punishment (in a criminal case). 2. A fact or situation that does not bear on the question of a defendant's guilt but that is considered by the court in imposing punishment and esp. in lessening the severity of the sentence.

Id.

4. *See, e.g.*, 18 U.S.C. § 3661 (2006) ("No limitation shall be placed on the information concerning the background, character, and conduct of a person convicted of an offense which a court of the United States may receive and consider for the purpose of imposing an appropriate sentence.").

5. Pub. L. No. 98-473, 98 Stat. 1987 (1984) (codified as amended in scattered sections of 18 and 28 U.S.C.).

each state maintains the discretion to dictate its own criteria within the confines of constitutional constructs.[7] The United States Supreme Court has increasingly

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6. *See* U.S. SENTENCING GUIDELINES MANUAL § 1A3.1 (2011), *available at* http://www.ussc.gov/Guidelines/2011_guidelines/Manual_PDF/Chapter_1.pdf (explaining that the guidelines are promulgated by the United States Sentencing Commission pursuant to 28 U.S.C. § 994(a) (2006)).

7. For example, COLO. REV. STAT. § 18-1.3-1201(4) (2010) permits the following factors to be considered as mitigating circumstances:

> (a) The age of the defendant at the time of the crime; or
> (b) The defendant's capacity to appreciate wrongfulness of the defendant's conduct or to conform the defendant's conduct to the requirements of law was significantly impaired, but not so impaired as to constitute a defense to prosecution; or
> (c) The defendant was under unusual and substantial duress, although not such duress as to constitute a defense to prosecution; or
> (d) The defendant was a principal in the offense which was committed by another, but the defendant's participation was relatively minor, although not so minor as to constitute a defense to prosecution; or
> (e) The defendant could not reasonably have foreseen that the defendant's conduct in the course of the commission of the offense for which the defendant was convicted would cause, or would create a grave risk of causing, death to another person; or
> (f) The emotional state of the defendant at the time the crime was committed; or
> (g) The absence of any significant prior conviction; or
> (h) The extent of the defendant's cooperation with law enforcement officers or agencies and with the office of the prosecuting district attorney; or
> (i) The influence of drugs or alcohol; or
> (j) The good faith, although mistaken, belief by the defendant that circumstances existed which constituted a moral justification for the defendant's conduct; or
> (k) The defendant is not a continuing threat to society; or
> (l) Any other evidence which in the court's opinion bears on the question of mitigation.

Id.

The United States Supreme Court has indicated that the Eighth Amendment demands vigorous consideration of mitigating evidence, especially in capital cases. For example, in Woodson v. North Carolina, 428 U.S. 280 (1976) (plurality opinion), the Court struck down North Carolina's mandatory death sentencing scheme. Writing for the plurality, Justice Stewart found such a scheme unconstitutional because, inter alia, it "exclude[d] from consideration in fixing the ultimate punishment of death the possibility of compassionate or mitigating factors." Id. at 304.

The concentration on the consideration of mitigating evidence was perhaps most notably addressed by the Supreme Court two years later in *Lockett v. Ohio*, where the Court granted certiorari to review a decision of the Ohio Supreme Court that allowed Lockett to be sentenced to death for aggravated murder and aggravated robbery. 438 U.S. 586, 589-94 (1978). A plurality of the Court held that the scheme of a limited number of factors affecting sentencing, as set forth in the Ohio death penalty statute and used at Lockett's sentencing, failed to permit an individualized consideration of mitigating factors applicable to Lockett's case. *Id.* at 606, 608 (plurality opinion). In order to satisfy the constitutional requirements of the Eighth and Fourteenth Amendments, the Court held that a state's death penalty statute must allow an individualized consideration of all relevant mitigating factors as part of the sentencing process, and that a sentencing authority is not to be precluded from considering, as a mitigating factor, any aspect of the accused's character that would justify a sentence other than death. *Id.* at 608; *see also* Abdul-Kabir v. Quarterman, 550 U.S. 233, 246 (2007) ("[O]ur cases ha[ve] firmly established that sentencing juries must be able to give meaningful consideration and effect to all mitigating evidence that might provide a basis for refusing to impose the death penalty on a particular individual . . . ."); Tennard v. Dretke, 542 U.S. 274, 278 (2004) (stating that the Eighth Amendment requires that the sentencing authority be able to "consider and give effect" to mitigating evidence); Atkins v. Virginia, 536 U.S. 304, 320 (2002) ("The reduced capacity of mentally retarded offenders provides a . . . justification for a categorical rule making such offenders ineligible for the death penalty."); Zant v. Stephens, 462 U.S. 862, 874-79 (1983) (upholding the constitutionality of Georgia's

addressed the importance of clarity in the presentation and consideration of mitigating evidence, which is integral to the trial and sentencing of an accused.[8]

Should a history of foster care involvement serve as a legitimate mitigating circumstance for a defendant in a criminal trial?[9] Although this article does not provide a definitive answer, it does attempt to provide a better understanding of the foster care experience to those contemplating the question. Part I provides a general introduction to the topic of foster care. Part II discusses different types of foster care. Part III discusses the impact of foster care on children. Finally, Part IV offers a brief conclusion.

I. GENERAL PURPOSE AND PARAMETERS OF FOSTER CARE

Foster care is defined as the placement of a child into a supervised environment, other than that of the biological family, as directed by social service agencies or the juvenile justice system.[10] According to the most recent report released by the Adoption and Foster Care Analysis and Reporting System, there are more than 400,000 children in foster care across the United States.[11] "Foster care

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two-part sentencing scheme which, at the definition stage, prescribed the death penalty for specific aggravating circumstances, while, at the selection stage, permitted an individualized determination of sentencing on the basis of the accused's character and the circumstances of the crime).

8. *See* United States v. Booker, 543 U.S. 220, 226-27 (2005) (addressing sentencing guidelines as applicable to the Sixth Amendment when the judge finds aggravating or mitigating evidence not taken into account by the jury when determining sentencing guidelines); Rompilla v. Beard, 545 U.S. 374, 377 (2005) (addressing counsel's obligation, despite concerns of the unavailability of mitigating evidence, to make reasonable efforts to seek out information likely to be used by the prosecution as aggravating evidence); Blakely v. Washington, 542 U.S. 296, 301-05 (2004) (mandating determinate sentencing of the accused and proscribing the trial judge's use of aggravating circumstances to enhance the sentence when the circumstances were not submitted to the jury in accordance with the Sixth Amendment's guarantee of trial by jury); Wiggins v. Smith, 539 U.S. 510, 514, 537-38 (2003) (holding that the failure of counsel to further investigate his client's history for mitigating evidence did not meet the effective assistance standard required by the Sixth Amendment and prejudiced the petitioner, and pointing to petitioner's alleged victimization while in foster care as potential mitigating evidence); Williams v. Taylor, 529 U.S. 362, 370-71 (2000) (addressing counsel's failure to introduce mitigating evidence during the sentencing phase of the accused's trial in the context of an ineffective assistance of counsel claim); Morgan v. Illinois, 504 U.S. 719, 729 (1992) (holding that the selection of jurors who would automatically vote to impose the death penalty without considering aggravating and mitigating factors is inconsistent with the impartiality requirement of the Due Process Clause of the Fourteenth Amendment).

9. According to the Court in *Penry v. Lynaugh*, a jury in a capital case "must be allowed to consider and give effect to mitigating evidence relevant to a defendant's character or record or the circumstances of the offense" because "the punishment should be directly related to the personal culpability of the defendant." 492 U.S. 302, 327-28 (1989), *abrogated on other grounds by Atkins*, 536 U.S. at 305. Pursuant to *Lockett* and its progeny, the Court in *Penry* held the accused was entitled to a jury instruction allowing the consideration of mitigating evidence of his mental retardation and childhood abuse in determining whether he should be sentenced to death. *Id.* at 315. The Supreme Court later held in *Atkins* that execution of mentally retarded criminals is "cruel and unusual punishment" prohibited by the Eighth Amendment. 536 U.S. at 321.

10. Susan M. Kools, *Adolescent Identity Development in Foster Care*, 46 FAM. RELATIONS 263, 263 (1997).

11. CHILDREN'S BUREAU, U.S. DEP'T OF HEALTH & HUMAN SERVS., THE AFCARS REPORT: PRELIMINARY FY 2010 ESTIMATES AS OF JUNE 2011, at 1 (2011), *available at* http://www.acf.hhs.gov/sites/default/files/cb/afcarsreport18.pdf.

placement is most often precipitated by stressful family circumstances that endanger a child and/or deem the biological parent(s) unable or unavailable to adequately care for the child. These include child abuse and neglect, parental substance abuse, and family homelessness."[12] In addition, some children are placed as a result of other forms of parental dysfunction, parental death, or because of child mental health service needs that the biological family cannot afford.[13]

The effects of abusive, neglectful and other traumatic experiences have been linked to the development of a number of emotional/mental, social/behavioral, and relational problems, including—but not limited to—anxiety, depression, substance abuse, and attachment issues.[14] Not surprisingly, research[15] suggests that significant

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12. Kools, *supra* note 10, at 263 (citing H.R. REP. NO. 101-395, at 25-33 (1990)) (arguing that increasing levels of reported child abuse and neglect, homelessness for families with children, and a rise in drug and alcohol abuse among parents have all contributed to a growth in the number of children that need out-of-home care); RODGER B. WHITE & MARY BENEDICT, U.S. DEP'T OF HEALTH & HUMAN SERVS., HEALTH STATUS AND UTILIZATION PATTERNS OF CHILDREN IN FOSTER CARE: FINAL REPORT 9-10 (1985) (identifying parental abuse and neglect of children as primary reasons for foster care placement); ROBERT E. BARKER ET AL., OUT-OF-HOME CARE: AN AGENDA FOR THE NINETIES, REPORT AND RECOMMENDATIONS OF THE CWLA TASK FORCE ON OUT-OF-HOME CARE 3 (1990) (arguing that children, and consequently the child welfare system, bear the burden of prevalent social problems in the United States like homelessness, poverty, and abuse); CHILDREN'S DEFENSE FUND, THE STATE OF AMERICA'S CHILDREN 1995 YEARBOOK 64-65 (Belva Finlay ed., 1995) ("[B]etween 15 and 30 percent of children in foster care were removed from their families or remained in care primarily because of housing problems.").

13. *See* ADMIN. FOR CHILDREN & FAMILIES, U.S. DEP'T OF HEALTH & HUMAN SERVS., NAT'L SURVEY OF CHILD AND ADOLESCENT WELL-BEING: ONE YEAR IN FOSTER CARE WAVE 1 DATA ANALYSIS REPORT 12 (2003) [hereinafter ADMIN. FOR CHILDREN & FAMILIES, NAT'L SURVEY OF CHILD AND ADOLESCENT WELL-BEING] (explaining that, in the year surveyed, many children were placed in foster care because of parental failure to provide for their basic needs, while about 8% to 10% of children were placed in foster home for non-abuse or neglect-related issues, including a need for mental health services).

14. KATHERINE KORTENKAMP & JENNIFER EHRLE, URBAN INSTIT., THE WELL-BEING OF CHILDREN INVOLVED WITH THE CHILD WELFARE SYSTEM: A NATIONAL OVERVIEW 1-2 (2002), *available at* http://www.urban.org/url.cfm?ID=310413; Ana M. Cause et al., *Effectiveness of Intensive Case Management for Homeless Adolescents: Results of a 3 Month Follow-Up*, 2 J. EMOTIONAL & BEHAV. DISORDERS 219, 219, 225 (1994); Daniel A. Hughes, *Adopting Children with Attachment Problems*, 78 CHILD WELFARE 541, 542-44 (1999).

15. It is important to note that research on the effects of foster care suffers from a number of methodological flaws such as lack of comparison groups, use of regional samples, and an emphasis on cross-sectional rather than longitudinal studies; studies also frequently reach inconsistent results. *See* Aubyn C. Stahmer et al., *Associations Between Intensity of Child Welfare Involvement and Child Development Among Young Children in Child Welfare*, 33 CHILD ABUSE & NEGLECT 598, 599 (2009) ("Given the lack of a comparison group in many of the studies, the paucity of longitudinal studies, use of regional samples and the inconsistency of results, available data are difficult to interpret."). Comparing studies is further complicated by the number of potential confounding factors operating on foster youth: it is unclear whether the relative negative outcomes for foster care youth are a function of their abusive family backgrounds or the effects of foster care placement. *See* Benjamin Kerman et al., *Outcomes for Young Adults Who Experienced Foster Care*, 24 CHILD. & YOUTH SERVICES REV. 319, 323 (2002) ("Birth family, individual child characteristics and service history likely all contribute to outcomes from the foster care experience. . . . [Yet a] child's age at the time of placement, gender, prior placements, and race are often the only child characteristic [sic] available for use in statistical models endeavoring to understand child welfare outcomes."). *But see* Joseph J. Doyle Jr., *Child Protection and Child Outcomes: Measuring the Effects of Foster Care*, 97 AM. ECON. REV. 1583, 1584 (2007) ("Meanwhile, those children who are removed are likely those who would benefit most from placement, and a

emotional or behavioral difficulties affect as many as 80% of children in foster care[16] compared to only 16% to 21% of children in the general population.[17] Relative to children from similar socioeconomic and demographic backgrounds, foster children remain at a significantly greater risk for psychological disorders.[18] The impact of these disorders is considerable. As young adults, foster youth with untreated mental disorders can find themselves homeless, incarcerated, or confined to psychiatric facilities.[19]

Foster care is a heterogeneous experience influenced by the specific personal characteristics of each child. Age is one such factor, as children entering foster care at a younger age appear more amenable to new living situations than older children.[20] Older children may have developed survival strategies that were adaptive in their families of origin, but prove to be maladaptive in new environments, hampering their ability to form new relationships with both adults and peers.[21] This problem is compounded by the fact that the assessment and service delivery approaches used by today's child welfare systems were developed for very young or school-age children.[22] These approaches are typically applied to

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comparison of average outcomes may overstate the benefit of removal for marginal cases.").

16. *See* Robin Chernoff et al., *Assessing the Health Status of Children Entering Foster Care*, 93 PEDIATRICS 594, 597-98 (1994) (reporting survey results that more than half of children over the age of three require mental health services); June M. Clausen et al., *Mental Health Problems of Children in Foster Care*, 7 J. CHILD & FAM. STUD. 283, 292 (1998) (finding 75-80% of school-age children surveyed exhibited behavioral or social problems); *cf.* Ann F. Garland et al., *Racial and Ethnic Variations in Mental Health Care Utilization Among Children in Foster Care*, 3 CHILD. SERVICES: SOC. POL'Y, RES., & PRACTICE 133, 141-42 (2000) (describing the overall high need for and use of mental health services among children in foster care, but finding racial and ethnic discrepancies among the recipients of mental health services).

17. *See* U.S. DEP'T OF HEALTH & HUMAN SERVS., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 123 (1999) (estimating that "almost 21 percent of U.S. children ages 9 to 17 had a diagnosable mental or addictive disorder associated with at least minimum impairment"); Robert E. Roberts et al., *Prevalence of Psychopathology Among Children and Adolescents*, 155 AM. J. PSYCHIATRY 715, 716 (1998) (conducting a review of fifty-two mental health studies of children published between 1963 and 1996 and finding a mean prevalence rate of 15.8%).

18. John Landsverk & Ann F. Garland, *Foster Care Pathways to Mental Health Services*, *in* THE FOSTER CARE CRISIS: TRANSLATING RESEARCH INTO POLICY AND PRACTICE 193, 194-96 (Patrick A. Curtis et al. eds., 1999); *see also* Linnea Klee & Neal Halfon, *Mental Health Care for Foster Children in California*, 11 CHILD ABUSE & NEGLECT 63, 64 (1987) (reporting the prevalence of mental health problems among children in foster care). *See generally* Daniel J. Pilowsky & Wendy G. Kates, *Foster Children in Acute Crisis: Assessing Critical Aspects of Attachment*, 35 J. AM. ACAD. CHILD ADOLESCENT PSYCHIATRY 1095, 1095 (1995) (explaining that children in foster care often need emergency psychiatric intervention due to the disruption of the parent–child relationship).

19. Mark Courtney et al., *Foster Youth Transitions to Adulthood: A Longitudinal View of Youth Leaving Care*, 80 CHILD WELFARE 685, 706, 709-10, 713 (2001); Robert Rosenhack & Alan Fontana, *A Model of Homelessness Among Male Veterans of the Vietnam War Generation*, 151 AM. J. PSYCHIATRY 421, 421, 424-25 (1994); Ann. B. Shalay & Peter H. Rossi, *Social Science Research and Contemporary Studies of Homelessness*, 18 ANN. REV. SOC. 129, 140 (1992); Ezra S. Susser et al., *Childhood Antecedents of Homelessness in Psychiatric Patients*, 148 AM. J. PSYCHIATRY 1026, 1028 (1991).

20. Mimi V. Chapman & Sharon L. Christ, *Attitudes Toward Out-of-Home Care Over 18 Months: Changing Perceptions of Youths in Foster Care*, 32 SOC. WORK RES. 135, 141-42 (2008).

21. *Id.* at 142-43.

22. MADELYN FREUNDLICH ET AL., JIM CASEY YOUTH OPPORTUNITIES INITIATIVE, THE ADOLESCENT BRAIN: NEW RESEARCH AND ITS IMPLICATIONS FOR YOUNG PEOPLE IN TRANSITIONING FROM FOSTER CARE 5, 7 (2011).

all young people in foster care, including teens and young adults whose needs are considerably different.[23]

The element of race also factors into a child's experience in foster care. African American children are more likely to stay in foster care longer and experience more foster care placements; they are less likely to receive adequate services while in care or be adopted or reunified with their families.[24] Given these longer stays in foster care, African American children may be more vulnerable to the risk factors associated with foster placement.[25]

Other factors affecting the foster care experience include the type of abuse experienced prior to placement,[26] length of time in foster care,[27] gender,[28] and, critically, the type of placement.[29] Foster children may be placed in a variety of supervised settings including foster family care, group homes, and other forms of residential treatment.[30]

II. TYPES OF FOSTER CARE PLACEMENTS

A. Traditional Foster Homes

Traditional foster family care appears to yield better outcomes than residential care; unfortunately, difficulties recruiting and retaining foster parents have limited the availability of this option:

> Broad social and economic changes, such as larger numbers of women working out of the home and an increase in single parent families, have made the recruitment of foster parents more challenging. Additionally, although many foster parents leave fostering because they age and retire, many others leave because they are dissatisfied with their experiences as foster parents.[31]

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23. *Id.*

24. DOROTHY ROBERTS, SHATTERED BONDS: THE COLOR OF CHILD WELFARE 23 (2002).

25. *See id.* at 19 (explaining that once African American children enter the foster care system, they remain there longer, are moved more often, and receive less desirable placements than white children).

26. *See* Melissa Jonson-Reid & Richard P. Barth, *From Placement to Prison: The Path to Adolescent Incarceration from Child Welfare Supervised Foster or Group Care*, 22 CHILD. & YOUTH SERVICES REV. 493, 503 (2000) (comparing incarceration rates for children who experienced neglect, physical abuse, sexual abuse, and other forms of abuse prior to entering foster care).

27. *See, e.g.*, Sonya J. Leathers, *Foster Children's Behavioral Disturbance and Detachment from Caregivers and Community Institutions*, 24 CHILD. & YOUTH SERVICES REV. 239, 251 (2002) (finding that study participants lived in non-relative care for an average of 3.8 years and that 37% experienced three or four placements during this time).

28. *Id.* at 257-61 (finding that placement movement was related to poorer school investment for girls and difficulty forming strong relationships with foster parents for boys).

29. *See* Jonson-Reid & Barth, *supra* note 26, at 498 (classifying placement types as family homes (kin or non-kin), group homes, or other).

30. Kools, *supra* note 10, at 263.

31. KATHY BARBELL & MADELYN FREUNDLICH, CASEY FAMILY PROGRAMS, FOSTER CARE TODAY 19 (2001).

The shortage of willing foster parents poses many difficulties. One result of the smaller pool of foster parents is the reduced ability to match foster parents and foster child with respect to certain characteristics. For example, "[c]hildren from families with limited English proficiency are frequently placed with English-only families. This can create significant cultural confusion for the child during placement . . . ."[32] The shortage of foster parents also increases the risk of "stretching" (i.e., convincing foster parents to accept children for whom they may feel uncomfortable caring).[33] One study on the adoption of older children found "a tendency for stretching to be associated with placement disruption."[34] It is logical to assume that the same would be true for foster care.[35]

B. *Kinship Care*

Given the increasing number of children placed in foster care and the corresponding decrease in available foster homes, many child welfare workers choose to place foster children with caretakers known to the child rather than seeking out a designated foster family.[36] This option is known as kinship care[37] and is a rapidly growing trend.[38] Although children are assumed to be better off when placed with relatives, research has produced mixed results.[39]

Many placement specialists prefer kinship care to non-relative family care, citing benefits such as eliminating the trauma and psychological damage associated with placing children with strangers,[40] maintaining the children's connection with

32. Sandra Bass et al., *Children, Families, and Foster Care: Analysis and Recommendations*, 14 FUTURE CHILD. 5, 15 (2004).

33. Brian Minty, *Outcomes in Long-Term Family Foster Care*, 40 J. CHILD PSYCHOL. & PSYCHIATRY 991, 991 (1999) (citing RICHARD P. BARTH & MARIANNE BERRY, ADOPTION & DISRUPTION: RATES, RISKS, AND RESPONSES 15 (1988)).

34. *Id.*

35. *Id.*

36. *See* Rob Geen, *The Evolution of Kinship Care Policy and Practice*, 14 FUTURE CHILD. 131, 134 (2004) (finding that almost all states seek out kin when children cannot remain with their biological parents).

37. Heather M. Farineau & Lenore M. McWey, *The Relationship Between Extracurricular Activities and Delinquency of Adolescents in Foster Care*, 33 CHILD. & YOUTH SERVICES REV. 963, 964 (2011).

38. Howard Dubowitz et al., *Children in Kinship Care: How Do They Fare?*, 16 CHILD. & YOUTH SERVICES REV. 85, 85 (1994). *See generally* Geen, *supra* note 36, at 132 (acknowledging the role of kinship caregivers as a resource for children who must be removed from their birth parents by public agencies).

39. *See* Geen, *supra* note 36, at 142 (explaining that two studies that compared the rate of abuse by kin and non-kin foster parents reached conflicting results).

40. Farineau & McWey, *supra* note 37, at 964 (citing Dubowitz et al., *supra* note 38, at 86 (explaining that proponents of kinship care argue that placement with kin has advantages over foster care)); *see* NAT'L COMM'N ON FAMILY FOSTER CARE, A BLUEPRINT FOR FOSTERING INFANTS, CHILDREN, AND YOUTHS IN THE 1990S, at 95 (1991) (observing that keeping children connected to their own families and reducing the potential trauma of sudden placement with strangers has obvious value); Stephen Wolkind & Alan Rushton, *Residential and Foster Family Care*, *in* CHILD AND ADOLESCENT PSYCHIATRY: MODERN APPROACHES 252 (Michael Rutter et al. eds., 3d ed. 2002) (highlighting the greater risk of health and developmental problems for children living in out-of-home placements); James P. Gleeson & Lynn C. Craig, *Kinship Care in Child Welfare: An Analysis of States' Policies*, 16 CHILD.

their cultural heritage and traditions,[41] and preserving caregiving routines.[42] Other benefits include greater satisfaction reported by the children,[43] potentially reduced likelihood of re-victimization,[44] and significantly lower likelihood of experiencing multiple placements.[45] In fact, compared to children living in foster-care placements, children placed in kinship homes have been found to show lower levels of internalizing and externalizing behaviors,[46] although not without inconsistencies.[47]

Despite these observations, some researchers have voiced concerns about placing children within the same family context that produced parents who were unable to care for their children.[48] Kinship foster caregivers are often single, older, less educated, poorer,[49] less adequately prepared for their care-giving roles,[50] and

& YOUTH SERVICES REV. 7, 12-14 (1994) (placing children with their relatives provides continuity of environment and extended family relationships); Amy Holtan et al., *A Comparison of Mental Health Problems in Kinship and Non-Kinship Foster Care*, 14 EUR. CHILD & ADOLESCENT PSYCHIATRY 200, 200 (2005) (finding positive outcomes in children placed within their own communities, which is analogous to kinship placement).

41. Geen, *supra* note 36, at 143.

42. *See* Catherine R. Lawrence et al., *The Impact of Foster Care on Development*, 18 DEV. & PSYCHOPATHOLOGY 57, 72 (2006) (explaining that placement with relatives may present an environment that necessitates fewer changes in caregiving routine).

43. *See* Leslie Wilson & James Conroy, *Satisfaction of Children in Out-of-Home Care*, 78 CHILD WELFARE 53, 66 (1999) (finding that children living in family foster care were far more likely to say they felt loved and safe than their counterparts living in group care arrangements).

44. Susan J. Zuravin et al., *Child Maltreatment in Family Foster Care*, 63 AM. J. ORTHOPSYCHIATRY 589, 592 (1993) (concluding that regular care homes were 2.4 times more likely to have a confirmed report of maltreatment than kinship homes). *But see* JILL DUERR BERRICK ET AL., CHILD WELFARE RES. CTR., KINSHIP CARE IN CALIFORNIA: AN EMPIRICALLY BASED CURRICULUM 141 (1995) (finding that child welfare workers believed children were at risk of abuse by a new caregiver in 17% of kin placements compared to 15% of non-kin placements).

45. *See* SANDRA BEEMAN ET AL., UNIV. OF MINN. SCH. OF SOC. WORK, KINSHIP FOSTER CARE IN MINNESOTA: A STUDY OF THREE COUNTIES 47 (1996) (indicating that more children in kinship foster care were in their first placement compared to children in non-kinship foster care, who were more likely to experience multiple placements since removal); Alfreda P. Iglehart, *Kinship Foster Care: Placement, Service and Outcome Issues*, 16 CHILD. & YOUTH SERVICES REV. 107, 119 (1994) (placing a child in a relative's home initially seems to reduce the number of subsequent placements).

46. *See* Connie Cheung et al., *Understanding Contextual Effects on Externalizing Behaviors in Children in Out-of-Home Care: Influence of Workers and Foster Families*, 33 CHILD. & YOUTH SERVICES REV. 2050, 2058 (2011) (finding that children placed in kinship foster care showed lower levels of externalizing behavior than children in non-kinship care); Holtan, *supra* note 40, at 201-02 (finding that out of 214 children living in kinship and non-kinship foster care in Norway, the kinship group had fewer out-of-home placements, higher competence, and fewer mental health problems than the non-kinship group); Lawrence et al., *supra* note 42, at 71-72 (finding that foster children placed in familiar settings exhibited lower levels of internalizing behavior); James A. Rosenthal & Herman F. Curiel, *Modeling Behavioral Problems of Children in the Child Welfare System: Caregiver, Youth and Teacher Perceptions*, 28 CHILD. & YOUTH SERVICES REV. 1391, 1404 (2006) (finding a greater occurrence of behavior problems in foster children placed in non-kinship care).

47. *See* Megan Tripp De Robertis & Alan J. Litrownik, *The Experience of Foster Care: Relationship Between Foster Parent Disciplinary Approaches and Aggression in a Sample of Younger Foster Children*, 9 CHILD MALTREATMENT 92, 99 (2004) (finding no significant difference in the level of aggression exhibited by kinship and non-kinship foster children).

48. Dubowitz et al., *supra* note 38, at 86.

49. *See* Bass et al., *supra* note 32, at 17 ("Kin tend to be older, are more likely to be single, have lower educational attainment, and are more likely to be in poor health than nonrelative caregivers.");

receive less support from caseworkers.[51] Additionally, when compared with non-relative foster care placements, kinship placements are more likely to delay reunification[52] and are more likely to permit unsupervised contact between biological parents and children.[53] Some argue that foster children in kinship care face significantly greater environmental challenges than their counterparts in non-relative foster care,[54] and others have found a greater risk of delinquency for foster children placed with relatives than for those placed with non-relatives.[55]

C. *Group Residential Care*

Some children are placed in group residential foster care rather than with families.[56] Overall, the evidence suggests that group home placement is detrimental to children.[57] In a study comparing young children reared in foster family homes to

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EMILY ZIMMERMAN ET AL., UNITED WAY OF N.Y.C., KINSHIP AND NON-KINSHIP FOSTER CARE IN NEW YORK CITY: PATHWAYS AND OUTCOMES 35 (1998) (stating that kinship foster parents have lower levels of income and education than non-kinship foster parents and are mostly single females).

50. Geen, *supra* note 36, at 135-36.

51. *See* RICHARD P. BARTH ET AL., FROM CHILD ABUSE TO PERMANENCY PLANNING: CHILD WELFARE SERVICES PATHWAYS AND PLACEMENTS 210 (1994) ("Services provided by placement agencies were much more likely to be offered to foster parents than kinship foster parents."); *see also* Jill Duerr Berrick et al., *A Comparison of Kinship Foster Homes and Foster Homes: Implications for Kinship Foster Care as Family Preservation*, 16 CHILD. & YOUTH SERVICES REV. 33, 36 (1994) (stating that studies in Maryland and New York City showed poorly documented or inadequate supervision by caseworkers of kinship foster homes); Geen, *supra* note 36, at 139 ("Although state policies indicate that kin are generally eligible to receive the same services as non-kin foster parents, past research has clearly shown that in practice, kin foster parents and the children in their care receive fewer services.") (footnote omitted).

52. Geen, *supra* note 36, at 141 ("Caseworkers, administrators, and kin agree that greater access to children and the reduced stigma associated with kinship care reduce the motivation of birth parents to reunify with their children.") (footnote omitted); *see also* SANDRA STUKES CHIPUNGU ET AL., U.S. DEP'T OF HEALTH & HUMAN SERVS., CHILDREN PLACED IN FOSTER CARE WITH RELATIVES: A MULTISTATE STUDY 15 (1998) ("More nonrelative (57%) than relative (43%) foster care providers reported an interest in adoption.").

53. *See* Dubowitz et al., *supra* note 38, at 86 (discussing studies suggesting that kinship care may enable unsupervised visits, since "placements in kinship care are often made after minimal screening, and with little ongoing support and monitoring"); *see also* Bass, *supra* note 32, at 17 ("Children who live in kinship care are more likely to have unsupervised parental visitation than are children in nonrelative care, which may put the children at a greater risk of being re-abused."); Geen, *supra* note 36, at 139 ("Child welfare workers report that they often have difficulty preventing unsupervised parental contact when children are placed with kin. Parents often make unscheduled visits with children in kinship care and are also much more likely than are parents of children in nonkin foster care to see their children in the foster home rather than at an agency or visitation center.").

54. Jennifer Ehrle & Rob Geen, *Kin and Non-Kin Foster Care—Findings from a National Survey*, 24 CHILD. & YOUTH SERVICES REV. 15, 26-27 (2002).

55. *See* Joseph P. Ryan et al., *African American Males in Foster Care and the Risk of Delinquency: The Value of Social Bonds and Permanence*, 87 CHILD WELFARE 115, 134 (2008) ("[C]hildren in relative care homes were significantly more likely to experience a delinquency petition compared to children in nonrelative placements."). *But see* Cheung et al., *supra* note 46, at 2058 ("Children placed in kinship care show lower levels of externalizing behavior in comparison to non-kinship foster care.").

56. *See generally* Jill Duerr Berrick et al., *Specialized Foster Care and Group Home Care: Similarities and Differences in the Characteristics of Children in Care*, 15 CHILD. & YOUTH SERVICES REV. 453, 453-54 (1993) (comparing different foster care models).

57. *See, e.g.*, *id.* at 467 (reporting findings that group home children were "a highly disturbed

those in group homes, children in group care displayed similar levels of behavior problems but more compromised mental development and adaptive skills.[58] Those in group homes have also been found to be more likely to engage in delinquent behavior and suffer from heightened behavioral problems.[59] In fact, the relative risk of delinquency is at least double for adolescents who have experienced at least one group home placement compared to youths in traditional foster care placements.[60] In contrast, children removed from group institutions and placed in family foster care displayed higher I.Q. scores compared to children remaining in institutions, in particular those removed prior to reaching twenty-four months of age.[61]

In attempting to understand the negative effects of group care one must consider the possibility of selection effects, whereby children who prove difficult to tolerate in family settings are placed in group homes.[62] Group settings provide limited opportunities to create or repair enduring relationships with family and caring adults, and social interaction in the group home setting is confined largely to staff and other foster children residents.[63] Adolescents in group homes may have more opportunities to seek out peers with similar propensities for delinquency, and delinquent peers can teach their friends similar behaviors, thus increasing the risk of delinquency for youth in group homes, a phenomenon referred to as the "negative effects of peer contagion."[64] The effects of exposure to deviant peers have been well established for a variety of externalizing behaviors.[65]

D. Therapeutic Foster Care

Some foster care settings are categorized as therapeutic foster care ("TFC"), sometimes termed treatment foster care, specialized foster care, or family-based treatment.[66] TFC "is a relatively new way of caring for children who need to be

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group" in terms of social and emotional characteristics as compared with their national peer group); Joseph P. Ryan et al., *Juvenile Delinquency in Child Welfare: Investigating Group Home Effects*, 30 CHILD. & YOUTH SERVICES REV. 1088, 1089-90 (2008) [hereinafter Ryan et al., *Juvenile Delinquency in Child Welfare*] (discussing numerous studies of group foster homes which found that group homes expose foster children to high risk peers while cutting them off from "nondelinquent and prosocial peers," enhance social anxiety, increase truancy, and limit involvement in school activities).

58. Brenda Jones Harden, *Congregate Care for Infants and Toddlers: Shedding New Light on an Old Question*, 23 INFANT MENTAL HEALTH J. 476, 485-86 (2002).

59. *See, e.g.*, Ryan et al., *Juvenile Delinquency in Child Welfare*, *supra* note 57, at 1093, 1097 (finding that "40% of all arrests in the child welfare system are associated with a group home placement" and that placing foster children in group homes actually increases the risk of arrest).

60. *Id*. at 1094.

61. Nathan A. Fox et al., *The Effects of Severe Psychological Deprivation and Foster Care Intervention on Cognitive Development at 8 Years of Age: Findings from the Bucharest Early Intervention Project*, 52 J. CHILD PSYCHOL. & PSYCHIATRY 919, 920 (2011).

62. Cheung et al., *supra* note 46, at 2058.

63. *See* Madelyn Freundlich & Rosemary J. Avery, *Planning for Permanency for Youth in Congregate Care*, 27 CHILD. & YOUTH SERVICES REV. 115, 117 (2005) ("Research documents the negative outcomes for youth who 'age out' of foster care without the benefit of strong connections with their families or other committed adults.") (citation omitted).

64. Ryan et al., *Juvenile Delinquency in Child Welfare*, *supra* note 57, at 1089.

65. Cheung et al., *supra* note 46, at 2058.

66. Anita M. Larson, *Cross System Comparisons of Children in Treatment Foster Care: Using Agency Data to Study Cross-System Child Outcomes*, 32 CHILD. & YOUTH SERVICES REV. 89, 89

removed from their homes and who have intensive mental, emotional, behavioral, or medical needs."[67] The goal of TFC is to provide a normal home-based setting that also meets the unique needs of these children, avoiding more structured institutional settings and creating "a therapeutic environment in the context of a nurturing home."[68] TFC parents are specially trained to deal with the specific mental health needs of foster care children.[69]

Although "[r]esearch on children in treatment foster care is limited, especially when compared with the volume of literature on children in non-specialized foster care,"[70] TFC has gained some empirical support in the juvenile delinquency literature.[71] Further, TFC is increasingly being implemented with non-delinquent children in foster care.[72] For children with multiple co-morbid mental disorders, TFC has been reported to improve outcomes with results that include decreases in aggression, reduction in institutionalization and increases in positive adjustment.[73]

(2010).

67. *Id.*

68. Robert Racusin et al., *Community Psychiatric Practice: Psychosocial Treatment of Children in Foster Care: A Review*, 41 COMMUNITY MENTAL HEALTH J. 199, 210 (2005) (citing BETH A. STROUL & ROBERT M. FRIEDMAN, A SYSTEM OF CARE FOR CHILDREN AND YOUTH WITH SEVERE EMOTIONAL DISTURBANCES (1986)).

69. *See* Larson, *supra* note 66, at 89-91 (describing TFC programs in several states).

70. *Id.*

71. *See* Tamara L. Brown et al., *Multisystemic Treatment of Violent and Chronic Juvenile Offenders: Bridging the Gap Between Research and Practice*, 25 ADMIN. & POL'Y MENTAL HEALTH 221, 226-34 (1997) (discussing a case example where the application of family-based therapeutic treatment improved the behavior of a sixteen-year-old male with a history of stealing, substance abuse, school fighting, and truancy); Patricia Chamberlain & John B. Reid, *Using a Specialized Foster Care Community Treatment Model for Children and Adolescents Leaving the State Mental Hospital*, 19 J. COMMUNITY PSYCHOL. 266, 268, 273-75 (1991) (discussing an experimental study where specialized foster care treatment succeeded as a viable alternative to hospitalization for children with a history of chronic truancy, running away from home, drug/alcohol dependency, and suicide attempts); Scott W. Henggeler et al., *Multisystemic Therapy with Violent and Chronic Juvenile Offenders and Their Families: The Role of Treatment Fidelity in Successful Dissemination*, 65 J. CONSULTING & CLINICAL PSYCHOL. 821, 822-30 (1997) (discussing experimental findings where therapeutic treatment led to decreased incarceration rates of juvenile delinquents); Sonja K. Schoenwald et al., *Multisystemic Therapy Versus Hospitalization for Crisis Stabilization of Youth: Placement Outcomes 4 Months Postreferral*, 2 MENTAL HEALTH SERVICES RES. 3, 4-8 (2000) (discussing experimental findings where family- and home-based therapy successfully prevented the hospitalization of adolescents with suicidal or homicidal behavior, psychosis, or threat of harm to self or others due to mental illness).

72. *See* Scott W. Henggeler et al., *Home-Based Multisystemic Therapy as an Alternative to the Hospitalization of Youths in Psychiatric Crisis: Clinical Outcomes*, 38 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 1331, 1332-35 (1999) (discussing a study where therapeutic methods were more effective than emergency hospitalization at increasing youths' family functioning and school attendance); Linda A. Reddy & Steven I. Pfeiffer, *Effectiveness of Treatment Foster Care with Children and Adolescents: A Review of Outcome Studies*, 36 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 581, 582-85 (May 1997) (evaluating published studies dating from 1974 to 1996 where TFC was applied to children with behavioral problems requiring out-of-home placement); Schoenwald et al., *supra* note 71, at 4-8 (discussing experimental findings where therapeutic treatment successfully prevented the hospitalization of a significant proportion of adolescents with psychological and mental illness).

73. *See* Hewitt B. Clark et al., *An Individualized Wraparound Process for Children in Foster Care with Emotional/Behavioral Disturbances: Follow-Up Findings and Implications from a Controlled Study*, *in* OUTCOMES FOR CHILDREN AND YOUTH WITH EMOTIONAL AND BEHAVIORAL DISORDERS AND THEIR FAMILIES 513, 516-17, 533 (Michael H. Epstein et al. eds., 1998) (discussing study results that

One researcher described TFC as effective in offering young drug abusers and juvenile delinquents a new start and an opportunity to form positive relationships with adults.[74]

However, other literature suggests that these gains are limited. One extensive review found that TFC was significantly successful in increasing placement permanency and improving children's social skills.[75] It also found that TFC was only modestly successful in reducing the level of psychiatric and behavioral problems in children and improving functional outcomes.[76] Cross-sectional analyses of serious problem behaviors have generally shown that children in long-term treatment foster care resemble their counterparts in regular or family foster care settings, although they are less disturbed than children in group treatment settings.[77]

In sum, while family foster care appears to be the placement of choice, there is a shortage of individuals willing to serve as foster parents.[78] Kinship care yields mixed results.[79] Group care appears to have a clearly negative impact upon foster children,[80] and TFC, perhaps the most specialized type of individualized care a foster child can receive, nonetheless shows limited successful outcomes.[81]

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showed male children with a history of harming themselves or others, drug and alcohol use, and abnormal sexual behavior reduced their externalizing and delinquent behaviors after TFC treatment compared to male children who received no such treatment); Chamberlain & Reid, *supra* note 71, at 268, 273-75 (discussing study results where participant behavior became more manageable following transfer to a specialized foster care environment where their histories included suicide attempts, drug/alcohol dependency, multiple runaways, chronic truancy, and sexual abuse); Hewitt B. Clark et al., *Improving Adjustment Outcomes for Foster Children with Emotional and Behavioral Disorders: Early Findings from a Controlled Study on Individualized Services*, 2 J. EMOTIONAL & BEHAV. DISORDERS 207, 214-15 (1994) (discussing study results where behaviorally and emotionally disturbed children in TFC showed significantly better emotional and behavior adjustment, were less likely to run away, engage in serious criminal activity, or be incarcerated than similar children who did not receive specialized care); Patricia Chamberlain & Mark Weinrott, *Specialized Foster Care: Treating Seriously Emotionally Disturbed Children*, CHILD. TODAY, Jan. 1990, at 27, 27 (discussing study results where application of a specialized foster care program affected youths with a history of chronic delinquency, severe problems with aggression, school, and family in that they were incarcerated less frequently and for shorter periods of time than youths who were not in such a program).

74. Ingeborg Marie M. Helgeland, *What Works? A 15-year Follow-up Study of 85 Young People with Serious Behavioral Problems*, 32 CHILD. & YOUTH SERVICES REV. 423, 428 (2010).

75. Reddy & Pfeiffer, *supra* note 72, at 584.

76. *Id.*

77. Gay Armsden et al., *Children Placed in Long-Term Foster Care: An Intake Profile Using the Child Behavior Checklist/4-18*, 8 J. EMOTIONAL & BEHAV. DISORDERS 49, 60 (2000).

78. BARBELL & FREUNDLICH, *supra* note 31, at 19.

79. *See* Dubowitz et al., *supra* note 38, at 102 (discussing the prevalence of health and behavioral problems and the risk of school-related problems for children in kinship care); Geen, *supra* note 36, at 136-37 (discussing the difficulty that kinship caregivers may face in raising a child since they often have fewer resources, greater stressors, and less preparation than non-kin foster parents).

80. Ryan et al., *Juvenile Delinquency in Child Welfare*, *supra* note 57, at 1095-96 (discussing a higher risk of delinquency for children in group home placements).

81. *See* Reddy & Pfeiffer, *supra* note 72, at 584 (analyzing results that indicate TFC is modestly successful in reducing the level of psychiatric and behavioral problems in children).

III. IMPACT OF FOSTER CARE ON CHILDREN

These findings notwithstanding, some research suggests that foster care can have a positive impact on children. One study of children ages eleven to fourteen found that, although placement caused severe disruption because of the need to adjust to new neighborhoods, schools, families, and friends, the children were positive when describing their lives and circumstances.[82] Another study asserted, tentatively, that adolescents in long-term foster care demonstrate decreases in externalizing and internalizing problems over time, and that foster care may be particularly helpful for children who entered the system as a result of sexual abuse or neglect.[83]

Early studies suggested that older children in long-term foster care showed improvements in overall well-being.[84] Some studies suggested that foster care youth fared as well or better than their non-foster care peers who came from similar family backgrounds.[85] Other studies showed that children's physical and emotional health and school performance improved after being placed in foster care.[86]

In addition, current and former foster children who were interviewed for one study expressed that they generally had positive feelings about their foster care placements.[87] Most youth believed that foster placement was in their best interest and reported that, without child welfare intervention, their home environments would have deteriorated.[88] Studies using both small and large samples found high satisfaction of children with their caregivers and few reports of serious problems.[89] In fact, one sample of Canadian foster children consistently rated their foster families as emotionally "healthier" than their biological families.[90] A large proportion of children in out-of-home care reported feeling safer in their caregiver's home than they did in their birth parent's home.[91]

Although one 2004 study suggested that most children in foster care were

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82. Penny Ruff Johnson et al., *Family Foster Care Placement: The Child's Perspective*, 74 CHILD. WELFARE 959, 963, 965-67 (1995).

83. Lenore M. McWey et al., *Changes in Externalizing and Internalizing Problems of Adolescents in Foster Care*, 72 J. MARRIAGE & FAM. 1128, 1135-36 (2010).

84. *See id.* at 1131 (discussing a 2006 study that found that older adolescents, who had favorable opinions of their current foster care living situation, were no more depressed than adolescents in the comparison sample).

85. Peter J. Pecora, *Educational and Employment Outcomes of Adults Formerly Placed in Foster Care: Results from the Northwest Foster Care Alumni Study*, 28 CHILD. & YOUTH SERVICES REV. 1459, 1463 (2006) (citing Cheryl Buehler et al., *The Long-Term Correlates of Family Foster Care*, 22 CHILD. & YOUTH SERVICES REV. 595, 623 (2000)).

86. *Id.* (citations omitted); *see also* Johnson et al., *supra* note 82, at 966, 973 (discussing positive feedback from foster youths about their placement).

87. Heather N. Taussig et al., *Children Who Return Home From Foster Care: A 6-Year Prospective Study of Behavioral Health Outcomes in Adolescence*, 108 PEDIATRICS, July 2001, electronic article e10, at 6, *available at* http://pediatrics.aappublications.org/content/108/1/e10.full.pdf.

88. *Id*.

89. Johnson et al., *supra* note 82, at 965-67; Leslie Wilson & James Conroy, *Satisfaction of Children in Out-of-Home Care*, 78 CHILD. WELFARE 53, 60-62, 66 (1999).

90. Kathleen Kufeldt et al., *How Children in Care View Their Own and Their Foster Families: A Research Study*, 74 CHILD. WELFARE 695, 702 (1995).

91. Johnson et al., *supra* note 82, at 963, 969.

happy were happy with their caregivers,[92] the same study and others showed that most children nonetheless missed their biological families after separation[93] and wished to have more connection with them.[94] The separation experience, both at the time of removal and in the subsequent months and years, leaves most children feeling unhappy, depressed, or upset.[95] In fact, the clinical literature links conflicting loyalties between foster and biological families with severe behavioral issues such as suicide attempts.[96] Placement can precipitate idealization of the child's biological parents, which is also viewed as problematic,[97] with some workers describing a need to counter children's "unrealistic fantasy of a perfect family."[98]

In describing the positive impact of foster care some researchers are more reserved, citing studies of children in out-of-home care without a comparison group that have suggested that children's academic, developmental and behavioral scores neither improve nor decline, but rather remain consistent while the children are in out-of-home care.[99] Other studies of older children suggest that while foster care does not impact negatively on children's educational achievement or social adjustment, there are actually few protective factors associated with foster care.[100]

Sadly, notwithstanding the relatively positive findings cited above, a great deal more research points to negative outcomes for children who have experienced foster care. Children in foster care often come into state care due to their exposure to abuse or neglect, family dysfunction and a number of other risk factors that threaten their healthy development.[101] Twenty-five percent of foster children suffer from health problems and lag behind their peers in general cognitive and social development.[102] A large majority of the children lag considerably behind age-

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92. Chapman & Christ, *supra* note 20, at 136 (citing Mimi V. Chapman et al., *Children's Voices: The Perceptions of Children in Foster Care*, 74 AM. J. ORTHOPSYCHIATRY 293, 294 (2004)).

93. *Id.*; *see also* Johnson et al., *supra* note 82, at 967 (describing how 56% of children surveyed reported missing their parents "most of the time").

94. Chapman & Christ, *supra* note 20, at 136.

95. DAVID FANSHEL & EUGENE B. SHINN, CHILDREN IN FOSTER CARE: A LONGITUDINAL INVESTIGATION 375-76, 412-13 (1978); Johnson et al., *supra* note 82, at 970.

96. Pilowsky & Kates, *supra* note 18, at 1096.

97. Jay Peters, *True Ambivalence: Child Welfare Workers' Thoughts, Feelings, and Beliefs About Kinship Foster Care*, 27 CHILD. & YOUTH SERVICES REV. 595, 599 (2005).

98. *Id.* at 599.

99. Anthony N. Maluccio & Edith Fein, *Growing Up in Foster Care*, 7 CHILD. & YOUTH SERVICES REV. 123, 125 (1985); *see also* Minty, *supra* note 33, at 997 (suggesting that the success of foster home placement is largely conditional on early and long term placement, which requires a supply of good long-term foster parents and the participation of agencies willing to work towards effective placement).

100. *See* Anthony N. Maluccio & Edith Fein, *An Examination of Long Term Foster Family Care For Children and Youth*, *in* THE STATE AS PARENT: INTERNATIONAL RESEARCH PERSPECTIVES ON INTERVENTIONS WITH YOUNG PERSONS 387, 394-95 (Joe Hudson & Burt Galaway eds., 1989) (finding that although long-term foster care yielded positive results for those in stable placements, there were still concerns for youths who experienced multiple placements); Anthony Heath et al., *The Educational Progress of Children In and Out of Care*, 19 BRIT. J. SOC. WORK 447, 458-59 (1989) (analyzing disparities between different foster children and their progress levels).

101. Brenda Jones Harden, *Safety and Stability for Foster Children: A Developmental Perspective*, 14 FUTURE CHILD. 31, 32 (2004).

102. ADMIN. FOR CHILDREN & FAMILIES, U.S. DEP'T OF HEALTH & HUM. SERVS., NATIONAL SURVEY OF CHILD AND ADOLESCENT WELL-BEING (NSCAW), NO. 1: WHO ARE THE CHILDREN IN

appropriate developmental expectations in at least one metric of well-being.[103]

In the area of physical health, pediatric and public health scholars report a higher level of childhood morbidity for foster children than for children not in the foster care system.[104] First, foster children are more likely to experience physical health and general development issues as a result of perinatal experiences.[105] For example, there has been a dramatic increase in the number of children entering foster care due to prenatal substance exposure.[106] Although researchers stress the variability in outcomes and the contribution of multiple factors, the negative effects of substance exposure on the fetus and developing child are well-established.[107] Growth irregularities and untreated medical problems are also common in foster children.[108]

FOSTER CARE? 4 (2007), *available at* http://www.acf.hhs.gov/programs/opre/abuse_neglect/nscaw/reports/children_fostercare/children_fostercare.pdf.

103. *Id.*

Mitigating circumstances, such as the impact of mental health deficits and diminished capacity on the sentencing of the accused, have gained increasing attention in recent years. In 2002, the U.S. Supreme Court ruled that executing mentally retarded individuals violated the Eighth Amendment's ban on cruel and unusual punishment. *Atkins*, 536 U.S. at 321. Atkins had previously been convicted of capital murder and sentenced to death upon a jury finding that the aggravating circumstances prescribed by the state law were met. *Id*. at 307-09. This conviction had been handed down despite the presentation of evidence showing his diminished I.Q., placing him in the category of persons classified as mildly mentally retarded. *Id*. at 308.

The decision in *Atkins* was a marked departure from the Court's decision thirteen years earlier in *Penry*, 492 U.S. 302, where the Court upheld the applicability of the death penalty to the same class of mentally retarded persons. *Id.* at 315. The decision of the Court in *Atkins* reflected a change in the national community's understanding and treatment of the mentally retarded that had been brewing prior to *Penry* since 1986 when Georgia enacted the first state statute prohibiting execution of the mentally retarded. *Atkins*, 536 U.S. at 313-14. Congress followed suit in 1988, specifically exempting the class of mentally retarded persons from legislation reinstating the federal death penalty, and in 1989, Maryland enacted a similar provision. *Id.* at 314. By 1995, nine state legislatures had enacted similar provisions, and by 2001, six additional states had joined them. *Id.* at 314-15.

The *Atkins* Court noted that because of disabilities in reasoning, judgment, and impulse control, the mentally retarded could not act with the level of moral culpability characteristic of the majority of adult criminal offenders, and that those very impairments could jeopardize the reliability and fairness required in capital proceedings. *Id.* at 306-07. Further, the Court found that the reduced capacity of mentally retarded offenders justified their categorical exclusion from the death penalty. *Id.* at 320. Citing *Lockett*, 438 U.S. 586, the Court noted the following:

> [T]he risk 'that the death penalty will be imposed in spite of factors which may call for a less severe penalty,' . . . is enhanced, not only by the possibility of false confessions, but also by the lesser ability of mentally retarded defendants to make a persuasive showing of mitigation in the face of prosecutorial evidence of one or more aggravating factors. Mentally retarded defendants may be less able to give meaningful assistance to their counsel and are typically poor witnesses, and their demeanor may create an unwarranted impression of lack of remorse for their crimes.

Id. at 320-21.

104. Jones Harden, *supra* note 101, at 37.

105. *Id.*

106. Laura Frame, *Maltreatment Reports and Placement Outcomes for Infants and Toddlers in Out-of-Home Care*, 23 INFANT MENTAL HEALTH J. 517, 520 (2002).

107. Jones Harden, *supra* note 101, at 37.

108. Neal Halfon et al., *Health Status of Children in Foster Care: The Experience of the Center for the Vulnerable Child*, 149 ARCHIVES PEDIATRIC & ADOLESCENT MED. 386, 389, 391 (1995).

In terms of cognitive and academic functioning, although a majority of foster children fall within a normal range of functioning, studies show a larger proportion of foster children exhibit delays compared with children in the general population.[109] Other research findings also indicate that a substantial proportion of foster children are at risk for school-related problems. Deficiencies in language and social skills as well as in peer relationships may threaten a foster child's school readiness.[110] More than one-third of children in care demonstrated deficient written language skills, falling below grade level, and reading and math skills were also below grade level for close to one-third of these children.[111] Approximately 30% to 40% of youths in foster care are in special education.[112] Foster children have higher rates of special education and grade retention, and studies have indicated that they are more likely to struggle with grades and achievement tests.[113] Notwithstanding these findings, "[t]he poorer academic functioning of foster children may not be attributable to their foster care experiences, per se, but to their *pre*–foster care experiences such as poverty and maltreatment."[114] Children involved with child welfare systems often exhibit poor educational outcomes due to many factors including their greater likelihood of having developmental delays[115] and of coming from families that have experienced poverty,[116] as well as traumatic stress and maternal depression leading to neglect.[117]

On the other hand, foster placement changes often force children in foster care to change schools. This situation places them at a great disadvantage. Out-of-home placements have the potential to cause school disruptions, adversely affecting attendance and engagement in school.[118] School moves tend to interfere with

109. Jones Harden, *supra* note 101, at 37.

110. ADMIN. FOR CHILDREN & FAMILIES, U.S. DEP'T OF HEALTH & HUMAN SERVS., FROM EARLY INVOLVEMENT WITH CHILD WELFARE SERVICES TO SCHOOL ENTRY: A 5- TO 6-YEAR FOLLOW-UP OF INFANTS IN THE NATIONAL SURVEY OF CHILD AND ADOLESCENT WELL-BEING 47 (2008), *available at* http://www.acf.hhs.gov/programs/opre/abuse_neglect/nscaw/reports/early_involvement/early_involvement.pdf.

111. *Id.* at 4.

112. ELISABETH YU ET AL., CHILD WELFARE LEAGUE OF AM., IMPROVING EDUCATIONAL OUTCOMES FOR YOUTH IN CARE: SYMPOSIUM SUMMARY REPORT xv (2002).

113. ADMIN. FOR CHILDREN & FAMILIES, NAT'L SURVEY OF CHILD AND ADOLESCENT WELL-BEING, *supra* note 13, at 150.

114. Jones Harden, *supra* note 101, at 37-38 (citation omitted).

115. RICHARD WERTHEIMER,.CHILD TRENDS, YOUTH WHO "AGE OUT" OF FOSTER CARE: TROUBLED LIVES, TROUBLING PROSPECTS 3 (2002).

116. Richard P. Barth et al., *Placement into Foster Care and the Interplay of Urbanicity, Child Behavior Problems, and Poverty*, 76 AM. J. ORTHOPSYCHIATRY 358, 364 (2006); *see, e.g.*, Sandra Stukes Chipungu & Tricia B. Bent-Goodley, *Meeting the Challenges of Contemporary Foster Care*, 14 FUTURE CHILD. 75, 80 (2004) [hereinafter Stukes Chipungu & Bent-Goodley] ("Poverty remains the largest risk factor for poor health and well-being outcomes for children, and for entry into the foster care system. [P]oor children are more likely to enter the child welfare system, often for child neglect, than are children from higher-income families."). *But see* Terry L. Cross, *Disproportionality in Child Welfare*, 87 CHILD WELFARE 11, 11 (2008) (explaining that "the poorest of the poor—rural African American and American Indians—actually show lower rates of maltreatment than less impoverished populations do").

117. W. Jean Yeung et al., *How Money Matters for Young Children's Development: Parental Investment and Family Processes*, 73 CHILD DEV. 1861, 1874 (2002).

118. Larson, *supra* note 66, at 91 (citing Wendy Whiting Blome, *What Happens to Foster Kids: Educational Experiences of a Random Sample of Foster Care Youth and a Matched Group of Non-*

academic progress, posing an additional challenge for children who have been removed as the result of neglect or abuse.[119] These children often have "difficulty forming peer networks and support systems, feel stigmatized because of their foster care status, and are forced to integrate different curricula and varying educational expectations."[120]

In the socio-emotional realm, there is substantial evidence that children who are victims of abuse and neglect are at high risk for emotional and behavioral problems.[121] Studies indicate that certain maltreatment can prove to be detrimental to physical health as well as mental developments including cognitive and language skills and social function.[122] Neglecting children during early developmental stages has been found to cause academic difficulties, social problems, internal issues such as depression, and external behavioral issues such as aggression.[123] Physical abuse, in addition to its effects on physical health, has been associated with cognitive delays, aggressive behavior, peer difficulties, post-traumatic stress disorder, and other externalizing and internalizing behavioral problems.[124] Established effects of sexual abuse include poor academic performance, depression, dissociation, sexual acting-out, and other high-risk behaviors in later childhood.[125] Emotional maltreatment, which is implicated in all other forms of abuse and neglect, is associated with reductions in cognitive and academic functioning as well as a variety of behavioral difficulties.[126] A lack of emotional access to parental support can cause severe delays in the physical and mental growth of children, especially at an earlier age.[127]

Maltreated children, due to the burden of separation and changing placements,

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Foster Care Youth, 14 CHILD & ADOLESCENT SOC. WORK J. 41, 45 (1997)).

119. *Id.* (citing Lisa Melman Heinlein & Marybeth Shinn, *School Mobility and Student Achievement in an Urban Setting*, 37 PYSCHOL. IN THE SCHOOLS 349, 355 (2000); Panayota Mantzicopoulos & Dana J. Knutson, *Head Start Children: School Mobility and Achievement in the Early Grades*, 93 J. EDUC. RES. 305, 310 (2000)).

120. Stukes Chipungu & Bent-Goodley, *supra* note 116, at 85.

121. Jones Harden *supra* note 101, at 34; Melissa Jonson-Reid, *Youth Violence and Exposure to Violence in Childhood: An Ecological Review*, 3 AGGRESSION & VIOLENT BEHAV. 159, 175 (1998).

122. Jones Harden, *supra* note 101, at 34 (citing DEVELOPMENTAL PERSPECTIVES ON TRAUMA: THEORY, RESEARCH, AND INTERVENTION 162 (Dante Cicchetti & Sheree L. Toth eds., 1997)).

123. *Id.* (citing Kerry E. Bolger & Charlotte J. Patterson, *Pathways from Child Maltreatment to Internalizing Problems: Perceptions of Control as Mediators and Moderators*, 13 DEV. & PSYCHOPATHOLOGY 913, 936-37 (2001)).

124. *See* Patricia McKinsey Crittenden, *Dangerous Behavior and Dangerous Contexts: A 35-year Perspective on Research on the Developmental Effects of Child Physical Abuse*, *in* VIOLENCE AGAINST CHILDREN IN THE FAMILY AND THE COMMUNITY 11, 25 (Penelope K. Trickett & Cynthia J. Schellenbach eds., 1998) (discussing the aggressive behaviors and developmental disorders that arise when children are exposed to "unpredictable" parenting during their infant and toddler years).

125. Penelope K. Trickett & Frank W. Putnam, *Developmental Consequences of Child Sexual Abuse*, *in* VIOLENCE AGAINST CHILDREN IN THE FAMILY AND THE COMMUNITY, *supra* note 124, at 39, 50-51.

126. JILL GOLDMAN ET AL., ADMIN. FOR CHILDREN & FAMILIES, U.S. DEP'T OF HEALTH & HUMAN SERVICES, A COORDINATED RESPONSE TO CHILD ABUSE AND NEGLECT: THE FOUNDATION FOR PRACTICE 37-38 (2003) *available at* http://www.childwelfare.gov/pubs/usermanuals/foundation/foundation.pdf.

127. Jones Harden, *supra* note 101, at 34 (citing Maureen M. Black et al., *Parenting Style and Developmental Status among Children with Nonorganic Failure to Thrive*, 19 J. PEDIATRIC PSYCHOL. 689, 700-02 (1994)).

are at an increased risk for these types of growth delays.[128] Separation, or loss of a relationship with natural parents, may cause grief to children as they enter into foster care.[129] Children in care also face emotional and psychological challenges as they try to acclimate to foreign and often unpredictable environments.[130] In fact, children may display signs of depression, aggression, or withdrawal within the early months of placement in foster care.[131] Children with the most severe of attachment disorders may even display symptoms of behavioral problems such as "sleep disturbance, hoarding food, overeating, self-stimulation, rocking, or failure to thrive."[132] Children in foster care experience more neglect and physical abuse than their non-foster counter-parts, and on average experience twice as many stressful life events.[133] While it may seem obvious that children in foster care experience higher levels of abuse because they typically suffer some form of maltreatment in order to have been removed from their biological families; the disparity is noteworthy considering the damaging long-term emotional and physical effects of child abuse and neglect.[134]

In fact, researchers estimate that 30% to 63% of children in foster care exhibit emotional and/or behavioral problems, either from their experiences before entering foster care or from the foster care experience itself.[135] Children entering the foster care system need access to specialized services, given their high rates of emotional, behavioral, developmental, and physical health problems.[136] A study of children in Medicaid programs in five states found that children in foster care were between 2.7 and 4.5 times more likely than nonfoster children to be prescribed psychotropic medications.[137] Children in foster care also may exhibit mental and behavioral disorders at a rate five times that of nonfoster peers.[138] In addition, children in

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128. Svetlana Yampolskaya et al., *Children Placed in Out-of-Home Care: Risk Factors for Involvement with the Juvenile Justice System*, 26 VIOLENCE & VICTIMS 231, 233 (2011).

129. Stukes Chipungu & Bent-Goodley, *supra* note 116, at 85 (citing Mark D. Simms et al., *Health Care Needs of Foster Children in the Foster Care System*, 106 PEDIATRICS 909, 909 (2000)).

130. *Id.*

131. *Id.*

132. *Id.* (citing Simms et al., *supra* note 129, at 912).

133. Robyn L. Glover & David S. Glenwick, *Stressful Life Events Experienced by Clinically Referred Foster Care and Nonfoster Care Children*, 5 J. EARLY CHILDHOOOD & INFANT PSYCHOL. 127, 136 (2009).

134. *Id.* (citing Valerie J. Edwards et al., *Relationship Between Multiple Forms of Childhood Maltreatment and Adult Mental Health in Community Respondents: Results from the Adverse Childhood Experiences Study*, 160 AM. J. PSYCHIATRY 1453, 1458 (2003); Vincent J. Felitti et al., *Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study*, 14 AM. J. PREVENTIVE MED. 245, 249-50 (1998); Judith A. Silver, *Starting Young: Improving Children's Outcomes*, *in* YOUNG CHILDREN AND FOSTER CARE: A GUIDE FOR PROFESSIONALS 3, 14-15 (Judith A. Silver et al. eds., 1999)).

135. Eleanor Stein et al., *Psychiatric Disorders of Children in Care: Methodology and Demographic Correlates*, 39 CAN. J. PSYCHIATRY 341, 346 (1994).

136. Taussig et al., *supra* note 87, at 1.

137. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-12-270T, FOSTER CHILDREN: HHS GUIDANCE COULD HELP STATES IMPROVE OVERSIGHT OF PSYCHOTROPIC PRESCRIPTIONS 7 (2001), *available at* http://www.gao.gov/new.items/d12270t.pdf.

138. John A. Landsverk et. al., Casey Family Programs, Mental Health Care for Children and Adolescents in Foster Care: Review of Research Literature 10 (2006), *available at* http://www.casey.org/Resources/Publications/pdf/MentalHealthCareChildren.pdf.

foster care have been shown to utilize psychiatric services at rates significantly higher than nonfoster children from similar socioeconomic backgrounds.[139]

Studies also indicate that children who are removed from their biological parents often show severe and profound deficits in adaptive behavior as well as serious behavior problems.[140] Adolescents in foster care have been shown to be more susceptible to behavior problems,[141] which can lead to delinquency.[142] Several factors may account for the increase in problematic behavior associated with out of home care.

First, difficult developmental challenges are inherent in the foster care experience. For example, separation from primary caregivers and placement with unfamiliar adults may pose an especially difficult hurdle for very young children.[143] Second, in addition to having to adjust to school, social, and familial changes, foster children may be impacted by weaknesses within the foster care system such as the lack of comprehensive psychological services offered to foster children and the often inadequate training and support services for foster parents.[144] Both foster children and their caregivers may have difficulty emotionally processing and committing to an experience with no defined endpoint or predictable outcome.[145]

Unlike typical biologically-related and adoptive families, foster families lack a sense of permanence. To compound this, children often enter the foster home with negative past experiences that may cause them to reflexively distrust caregivers, leading to the rejection of the foster parent.[146] Although one study shows that training foster parents extensively prior to placement results in fewer placement failures,[147] foster parents are rarely specifically trained to deal with the individual

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139. *See* John I. Takayama et al., *Children in Foster Care in the State of Washington: Health Care Utilization and Expenditures*, 271 J. AM. MED. ASS'N 1850, 1852 (1994) (finding that among children in Washington state, 25% of foster children used mental health services as compared to only 3% of nonfoster children in a comparison group).

140. Neil J. Hochstadt et al., *The Medical and Psychosocial Needs of Children Entering Foster Care*, 11 CHILD ABUSE & NEGLECT 53, 60 (1987); Lawrence et al., *supra* note 42, at 59, 73.

141. *See* Ryan et al., *Juvenile Delinquency in Child Welfare*, *supra* note 57, at 1089 (discussing behavioral problems among adolescents in group home placements).

142. *See* John H. Lemmon, *The Effects of Maltreatment Recurrence and Child Welfare Services on Dimensions of Delinquency*, 31 CRIM. JUST. REV. 5, 5-6 (2006) (noting that the effects of foster care placement may result in increased delinquency); *see also* Cathy Spatz Widom, *Understanding Child Maltreatment and Juvenile Delinquency: The Research*, *in* UNDERSTANDING CHILD MALTREATMENT AND JUVENILE DELINQUENCY. FROM RESEARCH TO EFFECTIVE PROGRAM, PRACTICE, AND SYSTEM SOLUTIONS 1, 2-7 (J. Wiig et al. eds., 2003), *available at* http://www.cwla.org/programs/juvenilejustice/ucmjd03.pdf (showing the importance of childhood victimization as a risk factor for subsequent delinquency and violence); Ryan et al., *Juvenile Delinquency in Child Welfare*, *supra* note 57, at 1089 (finding that frequent placement changes within the child welfare system significantly increase the risk of juvenile delinquency).

143. *See* Lemmon, *supra* note 142, at 6 (explaining that according to social control theory, "[u]nattached children do not feel an obligation to follow moral rules, and consequently, they fail to develop an adequate conscience, which leads to delinquency").

144. *Id.* at 25.

145. Lawrence et al., *supra* note 42, at 72.

146. K. Chase Stovall & Mary Dozier, *Infants in Foster Care: An Attachment Theory Perspective*, 2 ADOPTION Q. 55, 69-70 (1998).

147. Kathleen Sampson Eastman, *Foster Parenthood: A Nonnormative Parenting Arrangement*, 2 MARRIAGE & FAM. REV. 95, 107 (1982).

children placed in their homes.[148] Foster parents are simply ordinary people with varying levels of skill, experience, and training.[149] Furthermore, each year there are approximately 5,000 instances of re-traumatization in foster care.[150]

Maltreatment by foster parents, in the context of re-traumatization, is another factor contributing to negative outcomes for foster children.[151] The cumulative effect of early adversity followed by a period of instability substantially contributes to children's functional problems even when they finally achieve a permanent placement (e.g., adoption or reunification).[152] Nevertheless, negative outcomes for foster children can arise even when the sufficiency of care is not in question. A U.K. study of foster children, independently assessed by social workers and researchers, determined that the children were receiving good or excellent care.[153] Still, despite this finding, 30% of children were found to be manifesting some disturbance.[154] The two most likely explanations for this relatively high rate of disturbance are that (1) some child psychiatric disorders may take many years to remit, and (2) the sense of impermanence felt by foster parents and children when the foster placements, though stable, are not expected to last.[155]

The impermanency that foster children feel is exacerbated by how a significant number of these children experience multiple moves, either within the foster care system or between foster care and their family of origin, before a permanent placement plan can be implemented.[156] Changing residences has been linked to negative psychosocial outcomes such as pregnancy,[157] substance abuse,[158] and school drop-out.[159] To compound this instability, child welfare agencies suffer

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148. Linnea Klee & Neal Halfon, *Mental Health Care for Foster Children in California*, 11 CHILD ABUSE & NEGLECT 63, 69 (1987).

149. Eileen Mayers Pasztor & Kathy Barbell, *United States of America*, *in* THE WORLD OF FOSTER CARE: AN INTERNATIONAL SOURCEBOOK ON FOSTER FAMILY CARE SYSTEMS 249, 253-56 (Matthew Colton & Margaret Williams eds., 1997); Kate Wilson et al., *The Trouble with Foster Care: The Impact of Stressful 'Events' on Foster Carers*, 30 BRITISH J. OF SOC. WORK 193, 194 (2000).

150. Racusin et al., *supra* note 68, at 202 (citations omitted).

151. *See* Joseph P. Ryan & Mark F. Testa, *Child Maltreatment and Juvenile Delinquency: Investigating the Role of Placement and Placement Instability*, 27 CHILD. & YOUTH SERVICES REV. 227, 228 (2005) (stating that 9% to 29% of maltreated children engage in delinquent behavior).

152. Naomi Breslau et al., *Traumatic Events and Posttraumatic Stress Disorder in an Urban Population of Young Adults*, 48 ARCHIVES OF GEN. PSYCHIATRY 216, 217-18 (1991); Wendy Kliewer et al., *Dispositional, Environmental, and Context-Specific Predictors of Children's Threat Perceptions in Everyday Stressful Situations*, 27 J. YOUTH & ADOLESCENCE 83, 84, 96-98 (1998).

153. Minty, *supra* note 33, at 994.

154. *Id.*

155. *Id.*

156. *See id.* at 992 (discussing how 1700 foster children move in and out of adoptive care every year in England and Wales).

157. *See* Tonia Stott, *Placement Instability and Risky Behaviors of Youth Aging Out of Foster Care*, 29 CHILD & ADOLESCENT SOC. WORK J. 61, 66 (2012) (identifying a higher placement instability for foster care children as one factor that contributes to higher pregnancy rates).

158. *See* Ellen C. Herrenkohl et al., *The Psychosocial Consequences of Living Environment Instability on Maltreated Children*, 73 AM. J. ORTHOPSYCHIATRY 367, 368 (2003) (indicating that disruption in a child's living situation is linked with higher drug use).

159. *See id.* (indicating that disruption in living situation is linked with higher delinquency rates); *see also* Ryan & Testa, *supra* note 151, at 243-44 (indicating that substantiated victims of maltreatment average 47% higher delinquency rates relative to children who have not experienced abuse or neglect).

from high turnover.[160] Foster youths are exceptionally vulnerable to the activities of public child welfare caseworkers, because caseworkers are responsible for their safety, stability, well-being, and permanence.[161] Research suggests that changing a child's caseworker has negative emotional and physical consequences for the child.[162]

For the child, the experience of foster placement may be described as an ambiguous loss, one where there is no verification of death, yet there is no certainty that the person will come back or return to the way she or he used to be.[163] Ambiguous losses have no clear boundaries and no clear endpoint.[164] Often, there is no culturally or socially recognized ritual for mourning or even acknowledging what has been lost.[165] The loss of physical contact with parents and siblings, combined with multiple changes in placement and relationship disruptions, creates recurring ambiguities for young people.[166] They cannot feel certain about what has happened to them,[167] do not know who to turn to for support,[168] are unable to determine whether it is appropriate to move on,[169] and have difficulty knowing where they belong.[170] Young people remaining in foster care, who do not return home, report confusion regarding their familial memberships.[171] Even when foster children are adopted, the boundaries around the families they construct for themselves remain unclear.[172]

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160. NAT'L COUNCIL ON CRIME & DELINQUENCY, RELATIONSHIP BETWEEN STAFF TURNOVER, CHILD WELFARE SYSTEM FUNCTIONING AND RECURRENT CHILD ABUSE 6 (2006), *available at* http://www.cps.ca.gov/workforceplanning/documents/06.02_Relation_Staff.pdf.

161. *Id.* at 3.

162. Jessica Strolin-Goltzman et al., *Listening to the Voices of Children in Foster Care: Youths Speak Out about Child Welfare Workforce Turnover and Selection*, 55 SOC. WORK 47, 50 (2010).

163. *See* Robert E. Lee & Jason B. Whiting, *Foster Children's Expressions of Ambiguous Loss*, 35 AM. J. FAM. THERAPY 417, 418 (2007) (describing ambiguous loss as a state in which a caregiver is physically present but psychologically absent, or physically absent but psychologically present, or when children are in transition from one foster care system to another, or between families).

164. Pauline Boss, *Ambiguous Loss Research, Theory, and Practice: Reflections After 9/11*, 66 J. MARRIAGE & FAM. 551, 553 (2004).

165. *Id.*

166. *See* Lee & Whiting, *supra* note 163, at 419 ("Many children described an ongoing sense of loss involving parents, siblings, extended family members, friends, pets, and possessions.").

167. *See id.* (finding that foster care youth who experience ambiguous loss feel "[c]onfusion, distress, [and] ambivalence").

168. *See id.* (describing how foster care youth who go through ambiguous loss "[e]xperience helplessness, and therefore depression, anxiety, and relationship conflicts").

169. *See id.* (noting how foster care youth who experience ambiguous loss feel an "inability to 'move on'").

170. *See id.* (describing how foster care youth who experience ambiguous loss feel "[c]onfusion in boundaries and roles (e.g., who the parent figures are)").

171. *See id.* (describing how ambiguous loss results in foster care youth maintaining "[r]igidity in family roles").

172. *See* Gina Miranda Samuels, *Ambiguous Loss of Home: The Experience of Familial (Im)permanence Among Young Adults with Foster Care Backgrounds*, 31 CHILD. & YOUTH SERVICES REV. 1229, 1234 (2009) ("Among the few who had been adopted and experienced its dissolution, special cautions were offered against adoption as a guarantee for permanence."); *see also* Alicia F. Lieberman, *The Treatment of Attachment Disorder in Infancy and Early Childhood: Reflections from Clinical Intervention with Later-Adopted Foster Care Children*, 5 ATTACHMENT & HUM. DEV. 279, 279-80 (2003) (explaining how foster children who are later adopted do not trust their adoptive parents).

Over the long term, children and adolescents exposed to complex trauma are at a high risk for experiencing ongoing physical and social difficulties.[173] These young people often show a greater vulnerability to stress, an inability to emotionally self-regulate, excessive help-seeking and dependency, and social isolation and disengagement.[174] Research documents the strong relationship between trauma and emotional and behavioral difficulties.[175] The limited long-term research on children in foster care suggests that they are at risk for continued difficulties, including dropping out of high school,[176] involvement with the criminal justice system,[177] and chronic problems with employment[178] and housing.[179] When compared to the general population, adults from foster care backgrounds have higher rates of homelessness[180] and unemployment.[181]

Children placed in foster care are far more likely than other children to commit crimes,[182] drop out of school,[183] join welfare,[184] experience substance abuse problems,[185] or enter the homeless population.[186] Many youths leaving foster care end up in jail[187] or on public assistance.[188] A study of employment outcomes for youths aging out of foster care found that many were underemployed and progressing more slowly in the labor market than were other low-income youths.[189]

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173. Alexandra Cook et al., *Complex Trauma in Children and Adolescents*, 21 FOCAL POINT 4, 5 (2007).

174. *Id.*

175. Walter Prather & Jeannie A. Golden, *A Behavioral Perspective of Childhood Trauma and Attachment Issues: Toward Alternative Treatment Approaches for Children with a History of Abuse*, 5 INT'L J. BEHAV. CONSULTATION & THERAPY 222, 222 (2009).

176. Wendy Whiting Blome, *What Happens to Foster Kids: Educational Experiences of a Random Sample of Foster Care Youth and a Matched Group of Non-Foster Care Youth*, 14 CHILD & ADOLESCENT SOC. WORK J. 41, 45 (1997).

177. *See* Jonson-Reid & Barth, supra note 26, at 508 ("Males and females with prior child welfare supervised spells in foster care had a higher risk of later incarceration than children in the general population.").

178. ROBERT M. GOERGE ET AL., EMPLOYMENT OUTCOMES FOR YOUTH AGING OUT OF FOSTER CARE 1-2 (2002).

179. *See* MARTHA R. BURT ET AL., HOMELESSNESS: PROGRAMS AND THE PEOPLE THEY SERVE: FINDINGS OF THE NATIONAL SURVEY OF HOMELESS ASSISTANCE PROVIDERS AND CLIENTS 25 (1999), *available at* http://www.urban.org/UploadedPDF/homelessness.pdf (explaining that "childhood out-of-home placement in foster care is a common experience of homeless people").

180. *Id.*

181. GOERGE ET AL., *supra* note 178, at 1-2.

182. Jonson-Reid & Barth, *supra* note 26, at 508.

183. Blome, *supra* note 176, at 45.

184. *See* Courtney et al., *supra* note 19, at 711 ("Thirty-two percent of sample members reported . . . that they had received some form of public assistance since leaving out-of-home care.").

185. *See* Daniel J. Pilowsky & Li-Tzy Wu, *Psychiatric Symptoms and Substance Abuse Disorders in a Nationally Representative Sample of American Adolescents Involved with Foster Care*, 38 J. ADOLESCENT HEALTH 351, 354 (2006) ("Compared to adolescents without a lifetime history of foster care, [foster care] adolescents were slightly more likely to use alcohol, about two times more likely to engage in illicit drug use . . . , about five times more likely to be a drug-dependent . . . , and about two to four times more likely to have other substance use disorders.").

186. BURT ET AL., *supra* note 177, at 25.

187. Jonson-Reid & Barth, *supra* note 26, at 493.

188. Courtney et al., *supra* note 19, at 711.

189. GOERGE ET AL., *supra* note 178, at 1-2.

In Illinois, only half had any earnings in the two years after aging out of care.[190] Further, "nearly 20% of young prison inmates and 28% of homeless individuals spent some time in foster care as a youth."[191]

Recent research shows a birthrate to teenagers in foster care to be more than double that of the national rate (17.2% compared with 8.2%).[192] Homelessness also affects more than one-fifth of youths for at least one night in their first year following discharge from care.[193] Research suggests that, with regard to education, welfare utilization, and early childbearing status, young adults transitioning from foster care are more similar to their counterparts who are below the poverty level than to their peers in the general population.[194] Those that experience out-of-home care may be "at risk for homelessness, psychiatric illness, and criminality."[195]

IV. CONCLUSION

As the United States Supreme Court held in *Williams v. Taylor*,[196] a death penalty defendant has "a right—indeed, a constitutionally protected right—to provide the jury with the mitigating evidence that his trial counsel either failed to discover or failed to offer."[197] Similarly, the sentencing guidelines set forth in 18 U.S.C. § 3553 contain "an overarching provision instructing district courts to 'impose a sentence sufficient, but not greater than necessary,' to accomplish the goals of sentencing."[198] Courts must be impartial guardians of fairness and justice, especially in criminal proceedings. The even-handedness with which courts mete out criminal punishment is a stark criterion; the public has to determine whether, in fact, the justice system is working fairly. Whether or not foster care per se should be considered a mitigating factor is one that should be seriously considered.

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190. For a chart illustrating the percentage of youths who were never employed two years after they aged out, see *id.* at 15, Exhibit 4.

191. Doyle, Jr., *supra* note 15, at 1583 (citing BURT ET AL., *supra* note 179, at 25).

192. PETER J. PECORA ET AL., CASEY FAMILY PROGRAMS, ASSESSING THE EFFECTS OF FOSTER CARE: EARLY RESULTS FROM THE CASEY NATIONAL ALUMNI STUDY 23 (2003), *available at* http://www.casey.org/Resources/Publications/pdf/CaseyNationalAlumniStudy_FullReport.pdf.

193. *Id.* at 24.

194. WESTAT INC., A NATIONAL EVALUATION OF TITLE IV-E FOSTER CARE INDEPENDENT LIVING PROGRAMS FOR YOUTH. PHASE 2 FINAL REPORT VOL. 1, at 5-2 (1991); Ronna J. Cook, *Are We Helping Foster Care Youth Prepare for Their Future?* 16 CHILD. & YOUTH SERVICES REV. 213, 213 (1994).

195. Clara Daining & Diane DePanfilis, *Resilience of Youth in Transition from Out-of-Home Care to Adulthood*, 29 CHILD. & YOUTH SERVICES REV. 1158, 1160 (2007).

196. 529 U.S. 362.

197. *Id.* at 393.

198. Kimbrough v. United States, 552 U.S. 85, 101 (2007) (quoting 18 U.S.C. § 3553(a) (2006 & Supp. V 2007)).