1

A Risk and Resilience Framework for Child, Youth, and Family Policy

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Social policies and programs for American children, youth, and families have undergone frequent shifts in philosophy and direction in the past century. Many policy frameworks—selective eligibility, universal prevention, rehabilitation, punishment—have contributed to the conceptual bases for services, programs, and interventions targeting young people. The most consistent characteristic of American social policy for children, youth, and families may be the sheer inconsistency of efforts aimed at helping the nation's most vulnerable populations.

Recent advances in understanding the developmental processes associated with the onset or persistence of childhood and adolescent problems warrant new thinking about policies and programs. We now know more than we ever have about why some children and adolescents develop social and health problems, and—in the case of such problems as sexually transmitted diseases, drug use, and delinquency—why some youths appear to make choices that lead to poor outcomes at home and in the school and community. Unfortunately, this knowledge is not yet systematically applied

to policy or program design. The result is poorly specified, inadequately integrated, and often duplicative services for children and families. The motivation for this volume comes from the growing recognition that knowledge gained from understanding the developmental trajectories of children who experience social and health problems must be used to craft more effective policies and programs.

Coming of Age in America

Children, youth, and families face enormous developmental challenges in American society. At no time in the country's history have young people and their parents been confronted simultaneously by such a wide array of positive and negative influences and opportunities. Most children and youth become healthy adults who participate in positive—or "pro-social"—activities and are guided by interests that lead to meaningful and fulfilling lives. For some American children and youth, however, the path to adulthood is filled with risk and uncertainty. Because of the adversities they face, the prospect of a successful future for such young people is sometimes bleak.

The health of America's children and youth at the turn of the twenty-first century can be graphically conceptualized as a portrait of contrasts. Some rates of problem behavior—most notably violent offending and teen pregnancy—have decreased significantly in the past 8 to 10 years. Following a period of rapid increase between the late 1980s and 1995, the violent juvenile crime rate returned to its pre-1988 level and has remained stable since 1996 (Snyder, 2003). Encouragingly, teen birth rates among females between 15 and 17 years old declined 24 percent between 1996 and 2001. Only 25 births per 100,000 young women were recorded in 2001 (Centers for Disease Control and Prevention, 2001).

The promising news illustrated by a reduction in the prevalence of some types of childhood and adolescent problems is juxtaposed against disturbing accounts of school violence, persistent rates of substance use by young adolescents, the introduction of new and dangerous drugs, and unacceptably high rates of childhood poverty. Thirty-seven accounts of school violence were recorded in the nation's schools between 1974 and 2000 (Vossekuil, Fein, Reddy, Borum, & Modzeleski, 2002). The nation's deadliest school incident occurred in Littleton, Colorado, where, in April 1999; 14 students and one teacher died at Columbine High School following a shooting spree by two alienated and angry classmates. Sporadic acts of school violence have occurred in virtually every region of the United States in the years following Columbine.

Drug use among American youth continues to impose significant individual and societal costs upon the nation. Since 1991, reports have shown an increasing trend among young adolescents in the prevalence of smoking, alcohol consumption, and other drug use (Johnston, O'Malley, & Bachman, 2004). Despite recent leveling of these trends, the number of eighth-grade students reporting lifetime use of any illicit drug increased from 19 percent in 1991 to 23 percent in 2003. Illicit drug use among tenth-grade students increased from 31 percent to 41 percent between 1991 and 2003. Particularly concerning is evidence indicating that 12 percent of the nation's high school seniors tried ecstasy in 2002, an increase from 6 percent in 1996 (Johnston et al., 2004).

Many social and health problems are related to poverty. Nearly 17 percent of children under the age of 18 live in poverty in the United States, a condition that significantly affects individuals, families, and communities (U.S. Census Bureau, 2003). Children are more likely than all other age groups in the country to be poor (Cauce, Stewart, Rodriguez, Cochran, & Ginzler (2003). Youth of color are disproportionately represented in poverty. At the turn of the millennium, childhood poverty rates varied markedly by race and ethnicity—26 percent for American Indians, 24 percent for African Americans, and 23 percent for Hispanics. This compares to 11 percent for Asian and Pacific Islanders and 8 percent for non-Latino whites (Dalaker & Proctor, 2000). Poverty has negative effects on several key outcomes during childhood and adolescence, including school achievement and delinquency (Brooks-Gunn & Duncan, 1997). Poverty is also associated with adverse consequences during adulthood and later stages of life (McCord, 1997). The persistent nature of behaviors typified by involvement in antisocial conduct, or arising from environmental conditions such as poverty, requires well-reasoned and innovative policy and program responses.

Policy and Program Responses to Childhood and Adolescent Problems

Experts from criminology, education, medicine, psychology, public health, sociology, and social work agree that there is no single pathway leading to school failure, drug use, delinquency, and other problems. Rather, it is the accumulation of risk—the sheer number of adversities and traumas confronted by children and families—that seems to disrupt normal developmental trajectories (Rutter, 2001). Jessor and Jessor's (1977) assertion in the mid 1970s that a small group of youth engage simultaneously in a variety of dangerous and costly problem behaviors has been well supported in the past

25 years. Indeed, the same academically marginalized youths who are involved in drug use may also be at risk of sexually transmitted diseases and violent victimization from family members or partners. Despite the fact that we know far more about these youths, their friends, and their families (e.g., Elliott, Huizinga, & Menard, 1989; Huizinga, Loeber, & Thornberry, 1994; Loeber, Farrington, Stouthamer-Loeber, & Van Kammen, 1998; Robins & McEvoy, 1990; White, Loeber, Stouthamer-Loeber, & Farrington, 1999), few innovative policy strategies for reducing the number of children and adolescents who experience problems have been introduced. One of the looming challenges for advocates and experts is to find ways to incorporate into public policies and programs the new knowledge emerging from research.

Currently, social policies and programs for children, youth, and families in the United States are highly fragmented. Many policies aimed at improving conditions for vulnerable and high-risk populations fail to consider the number, nature, or severity of problems experienced by American families. Other policies and resultant programs are duplicative, leading to a host of eligibility and implementation conflicts in the areas of child welfare, mental health, substance abuse, juvenile justice, education, and others.

The application of theoretical and empirical evidence to the design of social policies and programs aimed at improving the lives of children, youth, and families is limited. Social policy is often hurriedly created in the context of significant community events or trends that have attracted public attention and compel legislation. In some cases, policies developed in reaction to specific events lead to decisions that fail to account adequately for unforeseen or unintended long-term consequences. A case in point is that of the extensive juvenile justice reforms implemented across the country in the early to mid 1990s. Faced with increased rates of gang activity and violent youth crime, nearly all states enacted reforms emphasizing strict sanctions and punishments for young offenders. Many of these reforms—most notably boot camp programs and the extensive use of judicial waivers for serious offenders (i.e., where some juvenile offenders were prosecuted in criminal courts and exposed to adult rather than juvenile sanctions)—subsequently produced mixed or ineffective results (Jenson, Potter, & Howard, 2001).

We have learned quite a lot about the causes and progression of childhood and adolescent problems in the past several decades. Advances in understanding the life course development of problem behavior among children and youth, however, have been used primarily to enhance prevention and treatment strategies (Biglan, Brennan, Foster, & Holder, 2004). Aside from the ecological perspective (Bronfenbrenner, 1979, 1986), conceptual models that inform the design and direction of social policies for

children, youth, and families are sorely lacking. In this book, we argue that a public health framework rooted in ecological theory and based on principles of risk and resilience is beginning to define a new and useful conceptual model for the design of social policy across the substantive areas of child welfare, education, mental health, health, developmental disabilities, substance use, and juvenile justice.

Public Health Frameworks for Social Policy

Public health frameworks for understanding and preventing childhood and adolescent problems have become widely used to promote positive youth outcomes in the emergent field of prevention science (Biglan et al., 2004; Hawkins, Catalano, & Miller, 1992). At its core, a public health approach to ameliorating youth problems considers the presence or absence of risk and protective factors in the design and selection of interventions. Closely related to principles of risk and protection is the concept of resilience, the ability to overcome adverse conditions and to function normatively in the face of risk. A public health perspective for policy development aimed at children, youth, and families must incorporate the key concepts of risk, protection, and resilience.

Risk and Protection

In the context of childhood and adolescence, risk factors are individual, school, peer, family, and community influences that increase the likelihood of such problem behavior as dropping out of school or becoming a juvenile delinquent. The identification of risk factors for a variety of childhood and adolescent problems has gained widespread acceptance in the prevention field in the past decade (Biglan et al., 2004; Gottfredson & Wilson, 2003; Romer, 2003). Its origins, however, date to the late 1970s and early 1980s, when researchers and policymakers began placing greater importance on understanding the individual, family, social, and community factors that commonly occurred in the lives of troubled children and youth (Rutter, 1979, 1987). The emphasis on understanding the underlying causes of childhood and youth problems led investigators to identify specific factors that were consistently associated with the occurrence of adolescent problem behaviors. This approach, adapted from public health efforts to identify risk factors associated with such problems as smoking and heart disease, led to the use of "risk-based" strategies to prevent childhood and adolescent problems (Hawkins et al., 1992).

Risk Factors

The earliest risk factor models were primarily lists of the correlates of adolescent problems (e.g., Garmezy, 1971). These models were drawn from previous research that identified risk factors for adolescent problem behaviors such as substance abuse and delinquency (e.g., Hawkins, Jenson, Catalano, & Lishner, 1988). Early models often failed to consider the temporal relationship of risk factors to the occurrence of specific behaviors or to examine the additive and interactive effects of risk factors. Recent reviews of risk factors for adolescent problem behaviors (e.g., Fraser & Terzian, in press; Fraser, Kirby, & Smokowski, 2004; Hawkins, Herrenkohl, Farrington, Brewer, Catalano, & Harachi, 1998; Jenson & Howard, 2001; Thornberry, 1998) have improved on earlier efforts by limiting their selection of studies to those in which the risk factor clearly preceded a problem behavior. Longitudinal studies have also been conducted to better understand the processes by which risk factors influence behavior over the course of childhood and adolescence (e.g., Hawkins, Catalano, Kosterman, Abbott, & Hill, 1999; Loeber et al., 1998; Spoth, Redmond, & Shin, 1998). We adopt Fraser and Terzian's (in press) definition of a risk factor in this book:

> Broadly defined, the term *risk factor* relates to any event, condition, or experience that increases the probability that a problem will be formed, maintained, or exacerbated (p. 5).

This definition recognizes that the presence of one or more risk factors in a person's life may increase the likelihood that a problem behavior will occur at a later point in time. The presence of a risk factor does not ensure or guarantee that a specific outcome—school failure, for example—will eventuate. Rather, its presence suggests an increased chance or probability that such a problem may develop. Common risk factors for childhood and adolescent problems by level of influence are shown in Table 1.1. These and other factors are discussed in relation to specific topics presented in Chapters 2–8.

Closely linked to risk factors are protective factors, which are characteristics and conditions that buffer exposure to risk.

Protective Factors

Experts favoring less of a deficit-based model to understanding childhood and adolescent problems have advocated a framework based on characteristics that *protect* youth from engaging in problem behaviors. There is some debate about the exact definition of *protection* and about how to put protective factors into practice (Fraser et al., 2004; Rossa, 2002). Most

Table 1.1 Common Risk Factors for Childhood and Adolescent Problems by Level of Influence[a]

Environmental Factors
Laws and norms favorable to antisocial behavior
Poverty and economic deprivation
Low economic opportunity
Neighborhood disorganization
Low neighborhood attachment
Interpersonal and Social Factors
Family communication and conflict
Poor parent–child bonding
Poor family management practices
Family alcohol and drug use
School failure
Low commitment to school
Rejection by conforming peer groups
Association with antisocial peers
Individual Factors
Family history of alcoholism
Sensation-seeking orientation
Poor impulse control
Attention deficits
Hyperactivity

a. Adapted from Fraser et al., 2004; Jenson & Howard, 1999; and Hawkins et al., 1998.

investigators agree that protective factors are attributes or characteristics that lower the probability of an undesirable outcome (Benard, 2004; Rutter, 1987; Werner & Smith, 1992). There is disagreement, however, about the independence of protective factors in relationship to risk.

The knowledge base associated with the concept of protection began emerging in the 1980s, when investigators such as Rutter (1979) and Werner and Smith (1982) observed that certain positive attributes appeared to operate in the presence of risk or adversity. The exact definition of a protective factor, however, quickly became a topic of debate. Most of this debate has centered on the confusion created when both risk and protective factors are conceptualized as representing the opposite ends of a single continuum (Pollard,

Hawkins, & Arthur, 1999). For example, consistent family management practices are often identified as important in producing positive outcomes in children. Inconsistent family management is construed as a factor leading to poor outcomes. In simple terms, consistent family management is identified as a protective factor whereas inconsistent family management is seen as a risk factor. Using risk and protection in this manner establishes the two concepts as polar opposites, with one pole representing positive outcomes and the other pole representing negative outcomes.

Therein lies the current debate among social scientists. Put succinctly, the questions are the following: (1) Do risk and protective factors represent measurable levels of an attribute or characteristic that has two poles along a single continuum? or (2) Are risk and protective factors separate and independent constructs ?

We view protection as a concept that operates as a buffering agent to risk exposure and offer the following definition from Fraser and Terzian (in press):

> protective factors (are) resources—individual or environmental—that minimize the impact of risk (p. 12).

This definition views protective traits as individual characteristics or environmental conditions that *interact* with specific risk factors present in a child or in his/her environment. We believe that protective factors operate in three ways. They serve to (1) reduce or buffer the impact of risk in a child's life; (2) interrupt a *chain* of risk factors that may be present in a young person's life (e.g., disrupt a potential chain of risk that begins with peer rejection and leads to involvement with antisocial peers and then to delinquency); and (3) prevent or block the onset of a risk factor (Fraser & Terzian, in press).

Table 1.2 shows common protective factors discussed by authors in subsequent chapters.

Resilience: When a Child Prevails Over Adversity

Resilience is one's capacity to adapt successfully in the presence of risk and adversity (Garmezy, 1986; Luthar, 2003; Olsson, Bond, Burns, Vella-Brodrick, & Sawyer, 2003). Numerous examples of young people and adults who have "overcome the odds" associated with the negative effects of risk come from child welfare (Festinger, 1984), juvenile justice (Vigil, 1990), substance abuse (Werner & Smith, 2001), and other service delivery settings. We conceptualize resilience as the outcome of a process that takes into account level of risk exposure and the presence or absence of

Table 1.2 Common Protective Factors for Childhood and Adolescent Problems by Level of Influencea

Environmental Factors
Opportunities for education, employment, and other pro-social activities
Caring relationships with adults or extended family members
Social support from nonfamily members
Interpersonal and Social Factors
Attachment to parents
Caring relationships with siblings
Low parental conflict
High levels of commitment to school
Involvement in conventional activities
Belief in pro-social norms and values
Individual Factors
Social and problem-solving skills
Positive attitude
Temperament
High intelligence
Low childhood stress

a. Adapted from Fraser et al., 2004; Jenson & Howard, 1999; and Hawkins et al., 1998.

protective factors. When exposure to risk is high, evidence suggests that most children and adolescents experience some type of problem or developmental difficulty (Cicchetti & Rogosch, 1997). Protective factors exert influences on developmental outcomes where risk is high, but they may be relatively benign in circumstances where risk is low (Fraser, Richman, & Galinsky, 1999).

Sameroff and colleagues (Sameroff, 1999; Sameroff & Fiese, 2000; Sameroff & Gutman, 2004) have used the phrase *promotive factor* to refer to attributes or characteristics that have positive effects on people's lives, irrespective of the level of risk exposure. They argue that promotive factors (e.g., high intelligence) have direct effects on child and adolescent outcomes. Tests of the direct impact of promotive effects have been relatively limited to date (Sameroff, Bartko, Baldwin, Baldwin, & Siefer, 1999).

Increasingly, experts are viewing resilience as the outcome of an interactive process involving risk, protection, and promotion. Thus, adaptation—expressed through individual behavior—is interpreted as an interactive product involving the presence or absence, level of exposure, and the strength of the specific risk, protective, and promotive factors present in a person's life.

Applying Principles of Risk and Resilience to Social Policy

Applications of public health principles have primarily been used to develop specific clinical or programmatic interventions in school and community prevention settings (Cicchetti, Rappaport, Sandler, & Weissberg, 2000; Luthar & Cicchetti, 2000; Marsten, 2001). The result has been impressive. Recent research identifies a number of efficacious risk-based interventions aimed at preventing child and adolescent problems such as substance abuse (Foxcroft, Ireland, Lister-Sharp, Lowe, & Breen, 2003; Gottfredson & Wilson, 2003) and delinquency (Catalano, Arthur, Hawkins, Berglund, & Olson, 1998; Catalano, Loeber, & McKinney, 1999). Research and governmental entities, concerned with improving the dissemination of effective programs, have made lists of effective interventions available to practitioners, educators, and the general public (Campbell Collaboration Library, 2004; Center for the Study and Prevention of Violence, 2004; Schinke, Brounstein, & Garnder, 2002). This, in turn, has led to greater use of empirically based interventions by members of the practice community.

A logical next step in the application of the risk and resilience model requires extending the framework to the development of a broader cross section of programs and public policies (Fraser & Galinsky, 2004). To date, only limited examples of this process exist. Investigators in the public health field have applied principles of risk, protection, and resilience to design prevention strategies that target risk factors for AIDS. Evidence suggests that the implementation of this approach has led to reductions in the spread of AIDS in many parts of the world (Sorenson, Masson, & Perlman, 2002).

A second example of using a public health framework to affect program and policy change comes from innovations in substance abuse prevention. Hawkins, Catalano, and Associates (1992) have created a theoretically based prevention process designed to help community leaders develop and implement effective substance abuse prevention programs. The Communities That Care (CTC) program is based on the social development model (SDM), a general theory of human behavior that integrates perspectives from social control theory (Hirschi, 1969), social learning theory (Bandura, 1989), and differential association theory (Sutherland, 1973; Matsueda, 1982). The SDM specifies the mechanisms and causal pathways by which risk and protective factors interact in the etiology of various behaviors, including adolescent drug use (Catalano & Hawkins, 1996). The model proposes that four protective factors inhibit the development of antisocial behaviors in children: (1) *bonding,* defined as attachment and commitment to family, school and positive peers

(Garmezy, 1986); (2) *belief in the shared values or norms* of these social units; (3) *external constraints* such as clear, consistent standards against drug use (Hansen, Malotte, & Fileding, 1988; Scheier & Botvin, 1998) and (4) *social, cognitive and emotional skills* that provide protective tools for children to solve problems (Rutter, 1987), that assertively and confidently perform in social situations (Werner & Smith, 1982), and that resist influences and impulses to violate their norms for behavior (Hansen, Graham, Sobel, Shelton, Flay, & Johnson, 1987).

In the CTC model, coalitions are formed to engage in systematic prevention planning that requires communities to identify prevalent risk and protective factors for adolescent problems in their localities. Following the assessment of such factors, communities are encouraged to select prevention strategies on the basis of available empirical evidence (Hawkins et al., 1992). Although the CTC model falls short of satisfying the criteria for a formal policy, it does initiate a process whereby knowledge of risk and protective factors becomes an integral part of program design. The model is currently undergoing a 5-year test in seven states.

As implied in the preceding examples, applying principles of risk and resilience to policy design requires an understanding of the developmental trajectories associated with the onset or persistence of child and adolescent problems. Figure 1.1 illustrates the process involved in applying a public health perspective to policy and program design for children, youth, and families.

Two additional elements in this model—ecological theory and life course development—are outlined briefly next.

Ecological Theory and Life Course Development

Mentioned earlier, we use an ecological perspective to provide a context for thinking about principles of risk, protection, and resilience over the course of child development. The ecological perspective is well known and widely applied in education, practice, and research across social work and many disciplines (Bronfenbrenner, 1979, 1986; Germain, 1991; Fraser, 2004). Ecological theory posits that development is deeply affected by interactions between the biological and psychological characteristics of the individual child and conditions in his/her environment. Environmental conditions are usually described as family, peer, school, and community influences (Bronfenbrenner, 1979, 1986). An ecological perspective views child development as a product of transactions between an organism and the context or, in the vernacular of social work, the influence of events that

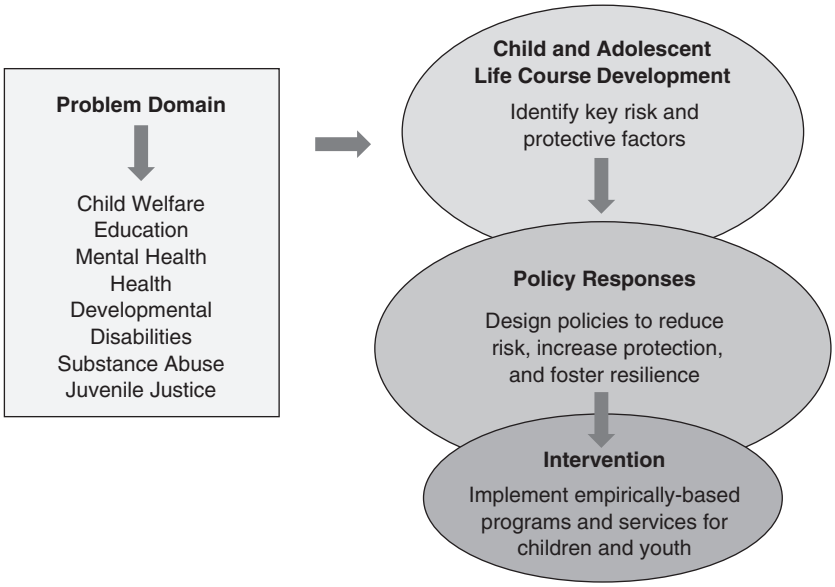

Figure 1.1 A Risk and Resilience Framework for Child, Youth, and Family Policy

occur in the lives of young people within their family, peer, school, and community settings.

We believe social policies for children, youth, and families must be framed in an ecological perspective that considers the influence of the context. For example, a child referred to the juvenile justice system lives within some type of family unit, attends a local school, and has a network of peers. Evidence indicates that both unique and interrelated risk and protective factors increase or decrease the likelihood of problem behavior within each of these domains (Fraser, 2004; Jenson & Howard, 1999). Social policies are, therefore, most likely to be effective when they address the myriad of influences that lead to the onset of problem behavior for young people. In earlier work, we have discussed risk and protective factors in the context of the ecological perspective as a way to explain the onset and prevention of childhood and adolescent problems (Fraser, 2004; Jenson, 2004). However, knowledge of such factors has seldom been used as a lens through which to examine social policy for children, youth, and families. Our intention is to show how principles contained in the ecological perspective can be used to create integrated policies that may cut across traditional policy boundaries found within systems of care for American children, youth, and families.

Summary

Knowledge gained from studies of risk, protection, and resilience has significantly affected our understanding of the onset and persistence of childhood and adolescent problems. Principles of risk, protection, and resilience have also been helpful in improving the conceptual and methodological rigor of prevention and treatment programs for children and youth (Kaftarian, Robinson, Compton, Davis, & Volkow, 2004). To date, these principles have not been systematically applied to social policies for children and families. This chapter has outlined a public health framework for child and family policy based on risk, protection, and resilience. Tenants of ecological theory and life course development were introduced as essential parts of the framework. In subsequent chapters, we more fully examine the utility of a public health framework for child and family policy.

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