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JUSWR

A JOURNAL OF UNDERGRADUATE SOCIAL WORK RESEARCH, POLICY REVIEWS, & OTHER CREATIVE WORKS

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School of Social Work
UNIVERSITY OF ILLINOIS URBANA-CHAMPAIGN

JUSWR

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Editor's note: To be accepted for publication, the primary author of all submissions must be an undergraduate student at UIUC. Those authors and peer editors listed as having a bachelor's degree earned it after JUSWR's submission deadline. Congratulations to them.

About the Journal

Acknowledgements

We would like to express our gratitude to Dr. Benjamin Lough for supporting our efforts to continue publishing undergraduate students' original work in the Journal of Undergraduate Social Work Research (JUSWR): A Journal of Undergraduate Research, Policy Reviews, and Other Creative Works. We also thank the School of Social Work faculty for the encouragement they extended to the authors of the JUSWR 10th issue. We further wish to acknowledge and extend a very special thanks to the faculty and PhD student advisors for their extraordinary mentoring, guidance, and support on behalf of the student authors.

Dr. Rachel Garthe is our Undergraduate Research Coordinator. She brings her enthusiasm and her extensive knowledge of research to our advisory board. We are grateful for her expertise, guidance, and steady support.

Last, but far from least, the JUSWR Advisory Board and Senior Editor wish to express our pride in and gratitude for our peer editors and graduate student advisors. These stellar students understood they were making a commitment: to participate in mandatory training, to review materials, and to offer viable, supportive recommendations to the student authors. We especially are grateful for their flexibility and dedication. Well done!

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Dear Reader:

Welcome to the 10th volume of the Journal of Undergraduate Social Work Research (JUSWR): A Journal of Undergraduate Research, Policy Reviews, and Other Creative Works. This journal is a result of a highly collaborative effort between students, faculty, and staff. Undergraduate peer editors were instrumental in selecting, editing, and submitting recommendations for research pieces to be accepted for publication. These undergraduate peer editors worked closely with the Senior Editor, Rebecca Dohleman Hawley, who did an outstanding job providing feedback, guidance, and prowess throughout the entire publication process. Graduate student advisors assisted with reviewing pieces and providing feedback. Faculty members also generously mentored their students in the writing and publication processes, of which we are grateful for their time and energy. As the Undergraduate Research Coordinator for the School of Social Work and Advisory Board Member of the JUSWR, I approached my role with commitment and enthusiasm, assisting with the peer editor training and editing process. Together, this collaborative team proudly brings you the 10th volume of JUSWR.

Volume 10 has excellent pieces. This year's volume includes pieces from students studying Social Work, Psychology, Brain and Cognitive Science, Global Studies, Spanish, Informatics, Anthropology, Law, Criminality and Society, and Sociology. Pieces include research studies examining timely and relevant topics, across macro social work topics (e.g., social and ethical risks of artificial intelligence; care practices and government policies in childcare institutions in Nepal; and conditional and unconditional cash supports in child welfare), meso social work topics (e.g., using logic models to evaluate violence prevention programs), and micro/meso social work topics (e.g., help-seeking for gender-based violence among college students; comparing family expectations and practice realities in child welfare supports). This volume also includes a literature review examining resilience and protective factors among Black youth exposed to trauma and adverse childhood experiences. Together, these pieces describe a research agenda dedicated to translational science.

As you flip through the current and previous issues of this journal, you will see a glimpse into the knowledge, creativity, critical thinking, and thoughtfulness of the authors across these diverse platforms. Students make contributions that advance social and economic justice, further enhancing their own and their readers' appreciation toward our diverse and constantly evolving social world.

As the Undergraduate Research Coordinator for the School of Social Work, I am honored to join such a remarkable editorial team and direct undergraduate research efforts. The journal originated with the aim of supporting undergraduate research and scholarly work, becoming a platform for students to disseminate their findings and work.

Some of the ways students can become involved in research at the School of Social Work include: 1) participating as a Research Assistant to a faculty-directed research project, or 2) leading their own area of research with an Independent Study or Project. Students can find more information about these opportunities in the Course Catalog (SOCW 310, 418, and 480). It is from these projects that many students submit posters and papers to this journal or present at the University of Illinois Undergraduate Research Symposium. Other research opportunities include authoring or co-authoring research papers and presentations for peer- reviewed journals and academic conferences, serving as a peer editor for the journal, or pursuing the Undergraduate Research Certificate Program offered by the Office of Undergraduate Research.

I am pleased to announce the 10th volume of JUSWR. This publication provides clear and compelling evidence of the high quality of undergraduate social work research and creative works that contribute to knowledge permeating the School of Social Work and the University of Illinois at Urbana-Champaign.

Sincerely,
Rachel Garthe, PhD
Associate Professor & Undergraduate Research Coordinator
School of Social Work



Literature Review

Beyond Survival: Reframing Resilience and Protective Factors Among Black Youth Exposed to Trauma and ACEs

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Abstract

Adverse Childhood Experiences (ACEs) and trauma exposure have profound effects on the mental health and wellbeing of Black youth, particularly in the context of structural inequities such as racism, poverty, community violence, and limited access to supportive resources. While resilience is often portrayed as a positive outcome in the trauma literature, traditional resilience narratives can inadvertently reinforce masking, emotional suppression, and survival-based coping. The current study is a review of the literature, critically examining how dominant understandings of resilience may obscure the distinction between surviving adversity and authentic healing from it. Instead of viewing resilience only as strength, endurance, or adaptability, this paper considers how culturally rooted protective factors can support the wellbeing of Black youth who have experienced trauma and ACEs. The review particularly highlights the role of communal and familial support, spirituality, racial identity, social support, and healing-centered engagement. Findings suggest protective factors are most effective when they promote emotional safety, belonging, vulnerability, and collective care instead of encouraging youth to "tough it out." From this review, it is proposed that social work practice, policy, and future research should move beyond resilience-only frameworks, and favor culturally responsive, healing-centered approaches that support authentic wellbeing among Black youth.

Keywords: adverse childhood experiences; African American; resilience; trauma; cultural competency, culturally responsive

About the author: *Tasia* recently earned her BSW and will begin UIUC's MSW program in the Fall 2026. Her research interests include adverse childhood experiences within Black communities, culturally responsive approaches to trauma, and healing-centered frameworks that support Black youth beyond survival-based resilience.

Introduction to ACEs and Trauma in Black Communities

Adverse Childhood Experiences (ACEs) are defined as traumatic or stressful events that one experiences before the age of 18 (Felitti et al., 1998). The specific variables used to measure ACEs include various forms of abuse, including physical, emotional, and sexual abuse; dysfunctional household experience factors such as caregivers or household members experiencing mental illness or substance abuse, having incarcerated relatives or household members, exposure to intimate partner violence, and having parents or caregivers divorce or separate (Starecheski, 2015). ACEs are linked to a host of negative outcomes throughout childhood and into adulthood (Bellis et al., 2017). African American youth report higher rates of ACEs than their White and Hispanic counterparts. For instance, Hampton et al. (2021) found Black youth's report of ACEs surpasses Latinx individuals in ACE prevalence. ACEs have a significant impact on African Americans' mental health; those who have experienced four or more ACEs are 3.69 times more likely to report depression and 2.59 times more likely to express anxiety than those who have not (Assini-Meytin 2022).

While it is important to acknowledge the traditional ACEs as stated above, there is another set of variables that contribute to childhood adversity. These variables are known as "structural ACEs." Homelessness, food hardship, exposure to neighborhood violence, and limited access to high-quality healthcare and education are considered structural or expanded ACEs (Lê-Scherban et al., 2018; Merrick et al., 2018). Black children and families are disproportionately exposed to ACEs, including adversities resulting from structural and systemic inequities (Hampton-Anderson et al., 2021). An analysis of nationally representative data from the 2016 National Survey of Children's Health found 61% of non-Hispanic Black children had experienced at least one measured ACE, compared with 40% of non-Hispanic White children.

Additionally, 33% of Black children had experienced two to eight ACEs, compared with 19% of White children (Sacks & Murphey, 2018). Thus, understanding ACEs and structural ACEs within Black and African American communities is a critical area of research. The current study reviewed the literature on resilience and culturally rooted protective factors, aiming to synthesize research in these areas to inform social work practice, policy, and research.

Traditional Resilience Narratives

Researchers who focus on the link between trauma and mental health often frame ***resilience*** as an individual's ability to endure and adapt to hardship and adversity in order to continue functioning despite experiences that could be potentially traumatic (Masten et al., 2007). In addition, traditional resilience frameworks frequently emphasize traits such as strength, perseverance, emotional toughness, and adaptability (Luthar, 2006). In many cases, resilience is often praised as the ability to “push through” one’s suffering and overcome obstacles by oneself. While resilience can serve as an important protective factor, these narratives may oversimplify the experiences of marginalized communities such as the Black community by equating survival with healing (Hampton-Anderson et al., 2021; Watkins, 2025).

Recent literature has begun to critically analyze the way resilience is discussed within Black communities. This discussion occurs particularly when resilience becomes associated with emotion suppression and masking. Masking refers to concealing emotional distress and suppressing vulnerability to maintain an outward appearance of strength, self-reliance, and emotional control (Watkins, 2025; Woods-Giscombé, 2010). Watkins (2025) works to challenge dominant understandings of resilience by arguing resilience can be socially enforced rather than an act of free choice. Similarly, Woods-Giscombé (2010) explains the superwoman schema that is imposed on Black women. Woods-Giscombé explains how Black women are often expected to

appear emotionally strong, self-reliant, and unaffected by adversity even while experiencing significant psychological distress. These expectations can create pressure to suppress vulnerability and emotional pain in order to maintain an image of strength.

As a result, survival is still seen as healing. Black youth who are exposed to trauma are praised for their ability to endure hardship while their emotional well-being remains to be neglected. Although the narratives of resilience intend to be empowering, unintentionally they can reinforce the idea of masking, untreated trauma, and the normalization of suffering rather than promoting authentic healing and emotional safety (Watkins, 2025; Woods-Giscombe, 2010).

Literature Gap

Existing literature surrounding trauma and ACEs among Black youth frequently emphasizes pathology, deficits, and survival outcomes. For example, the majority of the research focuses on the prevalence of trauma exposure, mental health disparities, behavioral outcomes, and Black youth's ability to endure adversity despite systematic barriers (Felitti et al., 1998; Hampton-Anderson et al., 2021). While this research remains critically important, fewer studies examine whether traditional notions of resilience truly support authentic well-being and emotional healing.

Resilience is often discussed through an individualistic framework that prioritizes perseverance and endurance rather than prioritizing emotional safety, vulnerability, and collective healing. In addition, healing-centered approaches have received limited attention, as well as culturally grounded protective factors such as community and familial support, spirituality and religion, racial identity, and emotionally affirming relationships. Due to these

factors, there is a need for research that critically examines resilience-based narratives while also exploring protective factors supporting genuine well-being rather than survival (Watkins, 2025).

Thesis Statement

While in many settings, resilience is viewed as a positive outcome among Black youth who are exposed to trauma and ACEs, the framework of traditional resilience can unintentionally reinforce masking, emotional suppression, and coping mechanisms based in survival. Instead of equating endurance with healing, protective factors grounded through culture such as communal support, spirituality, racial identity, and emotionally affirming relationships opens space for more healing-centered pathways that contribute to authentic well-being. By reframing resilience through culturally adapted and trauma-informed perspectives, helping professionals can better support vulnerability, emotional safety, and long-term well-being of Black youth.

Traditional Notions of Resilience and Their Limitations

Traditional resilience frameworks often are rooted in Eurocentric and individualistic interpretations of coping and adversity (e.g., Luthar, 2006; Masten et al., 2007). Western trauma literature frames resilience as an individual's ability to overcome hardship through perseverance, emotional strength, and self-discipline. These frameworks frequently add an emphasis on personal responsibility. Furthermore, these narratives champion the capacity to "push through" adversity while frequently neglecting the profound systemic inequities and structural conditions that facilitate trauma exposure. Consequently, traditional resilience is typically quantified by an individual's ability to maintain productivity amidst profound suffering, rather than evaluating whether they have been afforded the necessary access to emotional safety and authentic healing-centered support.

For Black children and adolescents, these approaches can be limiting as they fail to account for the radicalized and structural adverse childhood realities that shape traumatic experiences. Exposures to community violence, intergenerational trauma, economic inequities, and racism are not just hardships but instead are connected to larger forms of systematic oppression (Hampton-Anderson et al., 2021). Watkins (2025) critiques traditional resilience approaches by arguing that resilience has been historically constructed through a colonial and individualistic lens. Watkins argues these lenses prioritize adaptation over collective wellbeing. Similarly, approaches based on healing justice challenge the idea that healing should occur solely at an individual level and instead add emphasis on collective care, relational healing, and the importance of addressing systemic harm.

Watkins (2025) describes resilience as a paradox in which cultural strength and survival coexist alongside psychological harm. Her work argues that resilience can function as a form of physical violence. This is because individuals are expected to continuously adapt to oppression without opportunities for rest, healing, or emotional expression. Comparably, Woods-Giscombé's (2010) Superwoman Schema concept explains how Black individuals may create an internal demand leading one to believe they must remain strong, care for others, and suppress distress despite experiences of trauma and chronic stress. Although this framework is primarily discussed in relation to Black women, Black youth can experience similar internal demands surrounding emotional strength and survival. However, there remains a significant gap in the literature examining the long-term effects of adverse childhood experiences (ACEs) and how they relate to masking and trauma suppression across gender among Black youth. Addressing this gap can contribute to a broader understanding of resilience among Black youth.

These resilience expectations can create harmful outcomes because it normalizes emotional suppression as strength. Black youth exposed to trauma may learn to hide emotional pain, internalize stress, and avoid seeking help with their mental health. This transitions resilience from a protective factor into a survival strategy that prioritizes endurance of adversity over one's emotional wellbeing.

Survival Versus Healing

Survival and healing are often treated as interchangeable within resilience literature, but Watkins (2025) challenges this assumption by framing resilience as a paradox that can represent both cultural strength and psychological harm. Survival refers to the ability to endure hardship and continue functioning in the face of trauma, while healing involves emotional processing, vulnerability, safety, and long-term wellbeing. Many resilience narratives emphasize survival outcomes by praising individuals for enduring suffering, rather than examining whether emotional healing has actually occurred.

Coping methods for Black youth exposed to trauma and ACEs may include survival-based behaviors such as emotional repression, hyper-independence, hiding suffering, or avoiding vulnerability to maintain beliefs of strength. While these tactics may assist individuals to survive hazardous circumstances in the short term, they may also lead to untreated trauma, emotional isolation, burnout, and long-term mental health difficulties (Woods-Giscombé, 2010). The prioritization of endurance in literature narratives of resilience risk normalizing suffering as a sign of wellness, as the capacity to tolerate pain is conflated with posttraumatic growth.

Healing-centered practices counter this notion by emphasizing emotional safety, collaborative care, and real wellbeing, not just surviving. Healing-centered frameworks ask not if Black youth can survive adversity, but if Black youth are given the support, acceptance, and

tools to heal from adversity. This difference should be considered when thinking about protective variables because not all forms of resilience are necessarily related to long-term emotional wellness.

Reframing Protective Factors Through a Healing-Centered Lens

Recent literature has increasingly added emphasis to the importance of culturally grounded protective factors. These factors support authentic wellbeing among Black youth who have been exposed to trauma and adversity. Rather than prioritizing hyper-independence or emotional suppression, healing-centered approaches focus on collective care, emotional validation, and supportive relationships. Reed (2020) Conducted a systematic review that identified various protective factors associated with positive outcomes among African American youth. These factors include strong family relationships, community support, mentorship, spirituality, and positive social connections. These findings suggest resilience is not strengthened through forced self-reliance but instead is strengthened through relational systems that promote emotional safety, belonging, and collective healing.

Likewise, Boyd (2025) argues that conversations surrounding Black youth and mental health and suicide prevention must move beyond narratives that solely focus on deficits and instead aim to amplify culturally grounded strengths and protective factors. Boyd adds an emphasis on the importance of supportive community relationships, culturally affirming spaces, and a sense of emotional connectedness that all promote mental wellbeing among Black youth. These approaches challenge the traditional resilience narratives that overlook psychological distress and unmet mental health needs while praising endurance and emotional toughness. Rather than enforcing survival onto Black youth, Boyd advocates for approaches that

acknowledge vulnerability, emotional expression, and relational support as critical variables of wellbeing.

Mashonga and Henneberger (2020) further support the importance of relational protective factors. It was found social support systems and emotional connectedness are strongly associated with positive mental health outcomes. Their findings reinforce the idea that protective factors are most effective when they create opportunities and spaces for emotional validation, belonging, and supportive interpersonal relationships. Collectively, this literature suggests authentic resilience is not rooted in silent endurance or hyper-independence, but in access to communal care, affirming relationships, and environments that allow Black youth to heal without shame.

Culturally Grounded Protective Factors and Healing

In addition to relational support systems, these protective factors play important roles in supporting emotional well-being in trauma-exposed Black youth. For example, Walker & Hill (2016) discovered spirituality and faith-based coping have been consistently identified as impactful sources of emotional grounding, giving hope, encouraging one's purpose in life, and community togetherness among Black communities.

Boyd (2025) also identifies spirituality and cultural identity as important protective factors that contribute to resilience and suicide prevention among Black youth. Instead of only acting as coping mechanisms for survival, these culturally grounded supports promote emotional affirmation, self-worth, and psychological wellbeing. Positive racial and cultural identity may also buffer against the harmful effects of systemic oppression and trauma by fostering pride, creating resistance to internalized stereotypes, and fostering belonging (Seaton et al., 2019). Through racial socialization and identity affirmation, Black youth may develop stronger emotional resilience and a greater sense of self-worth despite exposure to adversity.

However, literature also brings caution to how we approach these culturally protective factors to avoid reinforcing the harmful narrative of endurance. Woods-Giscombé's (2010) work on the Superwoman Schema demonstrates how cultural expectations surrounding strength and self-sacrifice can sometimes contribute to emotional suppression and chronic stress. Similarly, spiritual or cultural frameworks that prioritize enduring hardship without emotional expression may unintentionally reinforce masking and survival-based coping. Therefore, protective factors should not simply encourage Black youth to tolerate adversity, but rather create opportunities for emotional safety, vulnerability, healing, and authentic wellbeing.

Healing-centered engagement frameworks further support this distinction by shifting the focus away from trauma alone and toward collective healing, culture, identity, and restoration (Ginwright, 2018). Ginwright argues healing-centered approaches move beyond asking, "What happened to you?" and instead ask "What is right with you?" while recognizing the importance of culture, spirituality, relationships, and community in the healing process. This perspective challenges resilience frameworks rooted solely in survival by emphasizing emotional restoration, collective care, and long-term wellbeing rather than merely the ability to endure suffering.

Implications for Social Work Practice

In review of this literature, the critiques of conventional resilience frameworks have significant implications for social work practice with Black youth exposed to trauma and ACEs. Social workers should be wary of assuming that a young person's ability to function, succeed academically, meet behavioral expectations, or remain emotionally composed indicates emotional well-being. If resilience is defined only as endurance, practitioners might miss signs of masking, emotional suppression, untreated trauma, and hyper-independence. This point is particularly true when working with Black youth who have already experienced the burden of

racialized expectations to be strong, act mature, and be unaffected by adversity. A strengths-based approach should not romanticize suffering but instead recognize the difference between survival-based coping and authentic well-being (Saleeby, 2013; Miller, 2017)

Trauma-informed practice and healing-centered practice require a created safe space where Black youth can feel comfortable enough to be vulnerable without shame or fear of judgment (Wilson, 2025). Social workers should ask Black youth not only how they have survived but also what support they need, what they need to feel safe, and what connections would be most helpful. Through the lens of cultural humility, social workers can avoid assuming resilience reflects healing and instead create safe spaces for Black youth to define their own needs, strengths, and pathways toward recovery. In practice, this can include incorporating culturally responsive protective factors into assessment, intervention, and planning. The culturally protective factors social workers should aim to implement are familial and communal support, spirituality, racial identity, and affirming relationships (Boyd, 2025). Ginwright's (2018) healing-centered engagement framework can be especially useful as it aids in shifting the focus from trauma exposure alone to culture, identity, collective care, and restoration. In practice, this means supporting Black youth as whole people connected to their families, communities, histories, and cultural strengths, not just as individuals who have experienced harm.

In addition, social workers need to be aware of the framing of protective factors. Pathways to healing include spirituality, family support, and racial identity, which validate emotions, foster belonging, and create meaning. But these same factors can be negative if they reinforce silence, endurance, or the expectation that Black youth must simply "be strong." So cultural practice needs to be able to hold both strength and vulnerability. Rather than helping

Black youth appear resilient, the goal should be to facilitate their emotional safety, access to care, and long-term well-being (Bollers, 2025; Ginwright, 2018).

Policy Implications for Future Research

Policy efforts should be directed toward culturally grounded mental health services that support Black youth before trauma becomes a crisis (Alvarez, 2022). This includes increased funding for school-based mental health programs, Black-led community organizations, mentoring programs, and accessible trauma-informed services in communities that experience structural ACEs at a higher rate. Policies also should target the larger conditions that create the need for resilience in the first place, including racism, poverty, housing instability, community violence, and unequal access to healthcare and education. Supporting Black youth is not only about promoting individual coping but also reducing systemic harm that leads to repeated exposure to adversity.

From this literature review, several future research directions are recommended. Future research needs to continue to explore resilience from a more critical and culturally responsive perspective. Further research is needed on masking, emotional suppression, hyper-independence, and survival-based coping among Black youth exposed to trauma. Research also needs to explore how protective factors such as spirituality, racial identity, family support, and community connection can promote authentic well-being, rather than just helping youth cope with adversity. Moreover, future work should center the voices of Black youth themselves to further understand how they frame resilience, healing, safety, and support in their lives.

Conclusions

This literature review examined how traditional conceptualizations of resilience might unintentionally perpetuate survival-based coping, masking, and emotional suppression in Black youth exposed to trauma and ACEs. Resilience is often talked about as a good thing, but we need to ask ourselves if resilience is about healing or just rewarding toughness. This expectation of strength for Black youth can mask emotional distress and hinder deeper attention to vulnerability, safety, and well-being.

Protective factors in culture like communal support, spirituality, racial identity, and emotionally affirming relationships offer more healing-oriented ways toward well-being. But these protective factors should be interpreted with caution. They make space for emotional expression, belonging, collective care, and authentic healing and are most protective in this space. Black youth should not have to mask their vulnerability or endure suffering to be considered resilient. The real measure of resilience is not how much pain people can withstand but whether individuals and communities have the support, resources, and safety to heal and to thrive.

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Research Study

When Empathy Becomes Code: The Social and Ethical Risks of AI Therapy

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Abstract

As artificial intelligence (AI) becomes increasingly integrated into mental health care, AI-powered chatbots are being promoted as accessible, affordable, and stigma-free alternatives to traditional therapy. While these tools may help address shortages in available mental health services, their rapid adoption raises significant ethical, social, and clinical concerns. This paper critically examines the rise of AI therapy through a sociological and policy-oriented lens, arguing that AI chatbots cannot safely replace human clinicians due to their limited capacity for genuine empathy, inadequate clinical judgment, and potential to disseminate misinformation. Drawing on existing literature, professional guidelines, and real-world case examples, this analysis highlights the risks related to emotional harm, privacy violations, algorithmic bias, and the reinforcement of existing inequalities in mental health care. The paper further explores how AI therapy reflects broader cultural trends toward the commodification and automation of care. Finally, it emphasizes the need for stronger regulatory oversight, transparency, and ethical safeguards, advocating for a hybrid model in which AI supports, rather than replaces, human clinicians. By prioritizing human well-being over technological efficiency, this paper underscores the importance of maintaining empathy, accountability, and equity in the future of mental health care.

Keywords: Artificial intelligence, mental health care, AI therapy, ethics and regulation, health inequality

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Introduction

Late at night, a college student opens an AI chatbot to talk about the anxious thoughts consuming her mind. The chatbot patiently listens to her anxious thoughts patiently and responds reassuringly and even goes so far as to offer coping strategies. It feels like therapy, but when her thoughts start to spiral and become darker, the chatbot's tone remains cheerful. Despite the change in input, she realizes there is no human on the other side of the screen. As artificial intelligence begins to replicate empathetic language, our society is faced with an important question: can a machine truly understand human pain and suffering?

Artificial intelligence is increasingly becoming integrated into mental health care through chatbots that simulate human conversation. Marketed as innovative solutions to the mental health crisis, these systems promise affordable, stigma-free, and 24/7 support to millions who would otherwise remain untreated. Research from the American Psychological Association and others warn unregulated AI chatbots can spread misinformation, violate patient privacy, and erode the trust essential to the therapeutic relationship (Abrams, 2025; Tekin & Delehanty, 2025).

These concerns are especially salient to social work practice, as social workers have an obligation to protect client well-being, ensure informed consent, and provide competent, person-centered care. When AI tools are positioned as substitutes for therapy rather than as supplemental tools, they raise ethical and policy questions about safety, accountability, and equity in mental health services. These equity concerns are compounded by algorithmic bias, as chatbots trained on non-diverse datasets often perform less reliably for low-income, non-English speaking, and neurodivergent users, risking treatment avoidance among the very populations these tools claim to serve (Khawaja and Bélisle-Pippon, 2023).

Drawing on existing scholarship, professional guidelines, and real-world case examples, this policy and ethical analysis argues that while AI therapy tools may help increase access to mental health support, they cannot ethically replace human clinicians, whose years of supervised training, relational expertise, and capacity of nuanced judgement cannot be algorithmically replaced. By substituting genuine empathy with algorithmic imitation, AI therapists risk weakening therapeutic standards and deepening existing inequalities in mental health care.

Background: The Rise of AI Therapists

Over the past several years, artificial intelligence has rapidly transitioned from experimental research to everyday use. AI-powered chatbots such as Woebot, Wysa, and Replika were among the first to use natural language processing to simulate therapeutic dialogue, offering users instant emotional support through friendly, conversational interfaces (Haque and Rubya 2022). With the development of more advanced large language models, these tools have become increasingly human-like in tone and responsiveness, blurring the lines between informal emotional support and formal psychotherapy.

This rapid expansion has been fueled by a national shortage of licensed mental health professionals and the rise of therapy costs, as well as cultural acceptance of digital health interventions (Counts 2023). However, as Abrams (2025) of the American Psychological Association warns, the use of generic, unregulated AI chatbots as substitutes for trained therapists showcases a “dangerous trend”, especially when users mistake simulated algorithmic responses for professional care. Likewise, Wells (2025) at *Stanford HAI* acknowledges that the enthusiasm around AI in mental health often overlooks potential harm, such as misinformation, privacy breaches, and the weakening of clinical standards.

Ethical and Clinical Concerns

Despite AI-therapy's promise of accessible and stigma-free mental care, researchers stress these systems pose grave ethical and clinical concerns. One of the most urgent issues in AI therapy is the absence of empathy, which is essential to the therapeutic relationship. Unlike a human therapist, an AI system has no subjective feeling, consciousness, or genuine "lived experience" of its own to draw on, which makes an empathy it displays a simulation rather than something authentically felt. As mentioned in Feske, Henningsen, and Buyx (2019), while AI can mimic supportive dialogue, it cannot truly understand or reciprocate human emotion. Therefore, this lack of emotional reciprocity undermines psychotherapy, which is dependent on genuine human connection, trust, and the therapist's ability to nonverbal cues and emotional nuance.

Misinformation presents another critical danger. According to Dypiango (2025), AI chatbots have produced misleading or dangerous responses in response to prompts about self-harm or severe distress. This is particularly dangerous because without human oversight or clinical judgement, AI chatbots risk providing misinformation, creating false reassurance, and failing to escalate emergencies properly. This is especially dangerous when someone is experiencing suicidal ideation, because the chatbot cannot fully understand the complex human emotion behind the screen and can give misdirected advice. A striking example showing the dangers of AI therapy is the case of a Belgian man committing suicide after months of talking to a chatbot that reinforced his fears and encouraged self-destructive thinking (Bharade 2023). Although this is an extreme case, it demonstrates how unregulated AI systems can unintentionally validate harmful thoughts rather than intervene appropriately, revealing the profound danger of treating chatbots as substitutes for trained human clinicians. This circles back

to the idea that chatbots cannot fully comprehend human emotions, which makes them fundamentally incapable of providing the empathy, nuance, and clinical judgement needed in moments of vulnerability or crisis.

Additionally, real-world uses of AI mental health tools reveal further ethical risks. For example, the mental health platform Koko secretly used AI to generate responses for users seeking emotional support, and many users reported the replies felt cold and emotionally invalidating, demonstrating how easily unregulated AI systems can be misused in sensitive contexts (Ingram 2023). Emotional dependency also poses a danger, and these problems are intensified by algorithmic bias: because AI is trained on non-diverse datasets, it may misinterpret the language of marginalized or neurodiverse users, overlooking distress or responding in ways that are dismissive or inappropriate.

Privacy and data protection also bring up several ethical concerns. Sensitive and personal mental health information is at risk of being shared with AI systems, and in turn can be stored, analyzed, and potentially sold by AI developers without the users' full understanding or consent. These practices break confidentiality, which undermines ethical standards of psychotherapy and weakens professional standards.

Proponents of AI therapy argue these tools offer meaningful advantages, particularly for people who are experiencing long waitlist times, financial barriers, or stigma when facing traditional mental care. AI therapy provides 24/7 accessibility, lower costs, and anonymity, which are features that human therapists cannot always provide. However, while these benefits are prevalent, it is important to acknowledge these benefits do not outweigh the risks. It may sound revolutionary in theory, but when applied to the real world, we see just how dangerous these situations can turn. But are these benefits worth the potential loss of life? Moreover,

relying solely on regulation assumes developers will follow guidelines voluntarily or that oversight agencies can keep up with the rapid technological change. Therefore, while AI may play a supportive role in expanding access, the argument that it can safely replace human therapy is flawed.

Sociological and Cultural Perspectives

AI therapists are a direct application of artificial intelligence, natural language processing, and algorithmic design within healthcare. Through a sociological lens, AI therapists are not neutral tools. They reflect cultural values surrounding efficiency, productivity, and profit in healthcare, while also reshaping how people experience intimacy, trust, and vulnerability in therapy. They reveal how technological innovation both mirrors and transforms society's understanding of mental health.

On a personal level, these platforms promise affordable, stigma-free mental health support that is convenient and accessible. But at a societal level, these platforms raise deeper questions: Can algorithms reciprocate human empathy? What happens when therapy becomes automated? How might this technology reflect and reproduce existing qualities, such as who receives access to human therapists versus who receives access to AI therapists?

The growing acceptance of AI and algorithmic therapy reflects a broader commodification of care, where emotional care is reframed as a product that can be automated and optimized. As Wells (2025) observes, this technological shift is not merely about innovation but also mirrors society's prioritization of efficiency and cost reduction over the personal and relational depth reflected in traditional therapy. When psychotherapy becomes an on-demand service that is moderated by algorithms, the human aspect of care--that is essential to therapy--becomes reduced to a transactional exchange of data and programmed responses.

Through a cultural perspective, the acceptance of AI therapists exposes and potentially worsens social inequalities in access and quality of care. While some argue AI therapy provides more accessibility and expands availability to underserved populations, Tekin and Delehanty (2025) warn these underserved populations might be receiving substandard, automated care while wealthier populations receive quality care with human therapists. This two-tier system reflects existing class divides present within healthcare systems, which turns digital therapy into a substandard, "second-class" form of mental health support.

Culturally, the normalization of AI therapy reinforces our society's comfort with technological innovation in intimate spaces. As mentioned in Fiske et al. (2019), people are starting to anthropomorphize machines and attribute human characteristics like empathy to places where they do not exist. The blurred line between human and machine boundaries has significant consequences for the way people define trust, connection, and vulnerability. A deeper, long-term implication is that reliance on AI for emotional support and guidance can reshape lower expectations surrounding human relationships, in turn promoting emotional detachment and self-reliance instead of independence and empathy.

Using sociological perspective allows the individual to see that AI therapy is not just a clinical tool, but as a reflection of a larger cultural movement. Care becoming data-driven, relationships becoming automated, and inequality embedded in design are all aspects of this cultural transformation. Understanding these social dimensions is critical to ensuring technological progress in mental health care does not come at the expense of humanity.

Policy, Regulation, and Future Direction

In order to meaningfully address the ethical and social concerns surrounding AI therapy, it is essential to examine the regulatory landscape and consider what policies, safeguards, and

oversight structures are necessary to ensure responsible development. Currently, AI-driven mental health tools are advancing much more quickly than the regulations designed to govern them. While a small subset of mental health technologies classifies as “software as a medical device”, most AI chatbots marketed as for mental health remain unregulated (Herpertz et al. 2025). This lack of regulation allows companies to release systems that mimic therapeutic interactions without being held to the same ethical standards as licensed professionals. As Abrams (2025) notes, this regulatory gap becomes especially concerning given that AI chatbots can create inaccurate and biased responses, in turn creating a dangerous situation for people who are in crisis.

Professional organizations have attempted to respond, but their guidelines remain voluntary instead of enforceable. The American Psychological Association warns chatbots are not replacements for trained professionals and may expose users to misinformation and privacy risks (American Psychological Association, 2025).

Effective policy must therefore address three areas: transparency, safety oversight, and equity. First, developers should be required to disclose the model’s training data, limitations, and known risks, allowing users to be informed about the potential risks and make their own decisions. Secondly, any AI system providing mental health guidance should undergo a pre-market review, which would include safety audits, continuous monitoring for harmful outputs, and requirements for human-in-the-loop escalation during crises. Third, policymakers must ensure that AI therapy does not become a “second-class” form of care disproportionately offered to low-income individuals under the guise of “accessibility”.

Looking forward, a hybrid model - where AI tools support, but do not replace, human clinicians offers the most ethical path. For example, AI can help with administrative tasks,

symptom tracking, and psychoeducation, which allows therapists to focus on the relational and emotional aspect of care that cannot be automated. Future research should prioritize long-term outcome studies, culturally responsive design, and development processes that collaborate closely with both clinicians and users. By centering human well-being instead of technological efficiency, policymakers and practitioners can shape AI mental health technologies in ways that enhance care without putting users at risk.

Conclusion

As AI becomes more integrated into mental health care, it reveals a central tension between technological efficiency and the human qualities essential to therapy. Although AI tools may increase access and convenience, it does not outweigh the risks posed by AI therapy, including misinformation, lack of empathy, privacy concerns, and the reinforcement of existing inequalities. These systems mirror broader cultural trends toward commodified, automated care, which undermine the human relationships central to effective therapy. Looking into the future, AI should complement rather than replace human clinicians, led by strong regulation, transparency, and ethical oversight. Ultimately, the future of mental health care should prioritize well-being over technological convenience, recognizing no algorithm can replicate the depth of human empathy.

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Hurtful or Helpful? Comparing Family Expectations and Practice Realities of Child Welfare Support

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Abstract

The child welfare system aims to ensure child safety through family-centered case practice, yet a gap remains between the resources families identify and the services they receive. While prior research indicates families involved with the child welfare system value practical resources, timely responsiveness, and relational support, family voices are frequently underrepresented in service design and delivery. To better understand the disconnect, this study explores the support caregivers identify as necessary for achieving self-sufficiency, the services they report receiving, and how these experiences shape their interactions with the child welfare system. Using a mixed-methods design, this study integrates semi-structured interviews with quantitative survey data from families participating in the Empower Parenting with Resources (EmPwR) study. Early findings indicate that although some families described positive experiences with caseworkers facilitating service referrals, families frequently described services as compliance-driven and focused on short-term crisis management rather than sustained support for addressing ongoing family needs. Although caseworkers serve as critical system navigators, agency constraints often limit the support they can provide, leaving families with the burden of managing services themselves. These findings suggest that greater attention to families' self-identified needs may strengthen efforts to promote financial stability and long-term family well-being.

Keywords: child welfare, family-centered, practical support, self-sufficiency, service delivery

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Introduction

The child welfare system aims to promote child safety through a family-centered approach that emphasizes collaboration and support. In principle, this means families should receive support using a collaborative partnership that promotes empowerment and self-sufficiency. Prior research shows child welfare-impacted families often value practical resources, timely responsiveness, and relational support. However, family voices are often underrepresented in service design and delivery, creating a mismatch between what families say they need and what the system often provides. If support does not match family-identified needs, then, in reality, family-centered practice may not feel that way. This disconnect may shape how families experience and navigate the system while limiting the effectiveness of family-centered practice. This study examines the relationship between families' self-identified needs for self-sufficiency and the support they report receiving through the child welfare system, while recognizing that caseworkers also operate within broader institutional constraints.

Specifically, this study explores the supports caregivers identify as necessary for achieving stability and self-sufficiency, the supports they report receiving from intact workers, and how these experiences shape their interactions with the child welfare system.

Literature Review

Research suggests caregivers' perspectives are not consistently incorporated into service planning. Although child welfare caseworkers operate within significant organizational and policy constraints, many families impacted by the child welfare system report barriers related to inadequate services. These barriers include service accessibility, availability, and awareness, as well as an inability for service providers to meet family needs (Banda et al., 2024). In addition, research suggests services are often not well aligned with families'

needs (Estefan, et al., 2012). Clear communication and rapport between caregivers and caseworkers are important components of family-centered practice. Clear communication strengthens trust, improves relationships, and helps families understand recommended services, and also promotes collaboration between caregivers and caseworkers when selecting services and resources. Collaborative decision-making increases the likelihood that services align with families' identified needs while addressing barriers to engagement. Families also benefit from assistance navigating complex service systems and accessing concrete resources that address their individual needs.

Families impacted by the child welfare system often experience multiple co-occurring stressors. These stressors create a sense of urgency as families work toward stability. Meeting case plan requirements while addressing daily family needs can place additional demand on caregivers. Caregivers must balance case requirements while also advocating for the supports their families need (Armstrong, et al., 2019). Often, time is a limited resource for families, particularly those navigating child welfare services. Research suggests families are more likely to experience family-centered services when support is timely, and caregivers are positioned as the decision-makers (Pettigrew et al., 2024). Families who perceive services as impractical, inaccessible, or poorly aligned with their needs are less likely to engage in available supports (Kemp, 2009). These findings highlight a disconnect between the goals of family-centered practice and caregivers' experiences receiving support. The literature suggests meaningful family-centered partnerships, timely support, and services that align with caregivers' unique needs.

Methods

Data were drawn from the Empower Parenting with Resources (EmPwR) study, which is a mixed-methods research study being conducted through the University of Illinois, examining the effects of unconditional cash gifts on families receiving intact services The EmPwR study examines whether a monthly unconditional cash gift affects child neglect and child welfare involvement. The study aims to enroll 800 families, half will be randomly selected to receive a cash gift in an amount determined by their family size, which refers to the number of children under the age of 18, and geographical cost of living in their region of Illinois. The cash gift will average approximately $500 per month. All families participating in the study are enrolled for a year. Interview participants were randomly selected while maintaining equal representation across all four study regions. Interviews are conducted virtually using Zoom, with a total number of 74 interviews completed at the time of this project. This analysis focused on three interview participants who represented common lived experiences of the larger interview group, related to our identified themes. Qualitative data were analyzed using matrix analysis to identify themes among caregiver interviews. Themes for this project emerged from caregiver interviews, in which EmPwR families were describing their desired needs for support, emphasizing a gap between what they needed and what their caseworkers provided. Underlying themes were identified as they relate to the reasons behind the existence of this gap within the system that families experience. Nuances such as children's needs and parental relationships, varied across families, but commonalities existed in factors related to the timeliness of services provided, the quality of services as they relate to families' needs, and the practicality of services.

All participants have the chance to complete three different surveys, one at the time of consent, a second at 6 months of participation, and a final one in their 12th month of participation

in the study. Participants received an Amazon eCode for survey completion. Participation in each survey was voluntary, and participants could complete any or all survey waves. The surveys assess several domains related to family well-being, including socio-economic status, parental mastery, family relationships, and physical and mental health The surveys are offered to all consenting participants, and 271 baseline, 130 6-month, and 39 12-month surveys have been completed to date. Relevant survey items for this study are provided in Appendices A and B.

Results

Early analysis of EmPwR caregiver interviews several recurring themes related to caregivers' experiences with support and service provision. Several caregivers described differences between the supports they identified as most helpful and the services they reported receiving. Figure 1 provides examples of these themes drawn from caregiver interviews. Three caregiver families here were chosen as they are felt to represent the common lived experience of families involved in child welfare. While the nuances of each family's lived experience may differ, the underlying themes explored, what caregivers describe as necessary for achieving family self-sufficiency, what they report actually receiving, and how this shapes their experience within the child welfare system, are similar across participants in both control and treatment groups.

Caregiver interviews highlighted three recurring themes related to service delivery: practicality, timeliness, and responsiveness. The first example in Figure 1 features a working single mother of four in the treatment group who described receiving services that did not align with her family's practical needs. She described needing flexible bedding, such as waterproof sleeping bags, to meet the needs of her children with medical conditions. Instead, she reported receiving traditional mattresses, which she anticipated would not meet her family's

long-term needs, making future out-of-pocket purchases inevitable. The second example illustrates caregivers' experiences with service timeliness. This caregiver, a working mother of five, described waiting several weeks for promised winter coats, receiving them only after they were needed. This caregiver described delays between promised support and when services were actually provided. The third example illustrates a caregiver's experience with service responsiveness. This caregiver, a working single mother of four, described feeling that her caseworker assumed she was seeking public assistance rather than support to regain stability. She explained she was seeking support to get back on her feet but perceived the services she received, including drug testing, as unresponsive to her family's immediate needs. Together, these examples suggest caregivers value supports that are practical, timely, and responsible to their identified needs.

Survey findings show the financial circumstances caregivers in the treatment group faced while receiving intact family services, including difficulties meeting basic household needs, covering routine expenses, and managing unexpected costs. Figure 2 presents the percentage of treatment-group caregivers reporting five forms of financial hardship at baseline, 6 months, and 12 months. Among treatment-group caregivers who completed the baseline survey, 74% reported having no emergency funds, 61% said they could not cover one month of expenses, 56% reported spending more than their income, 51% reported food did not last for the month, and 43% reported missing a rent or mortgage payment. Taken together, these baseline findings suggest many caregivers entered the study experiencing multiple, overlapping forms of financial hardship.

Some hardship indicators declined over time. Among caregivers in the treatment group, the percentage reporting they could not cover one month of expenses decreased from 61% at

baseline to 54% at 12 months. Reports that household spending exceeded household income fell from 56% to 32%, while missed rent or mortgage payments declined from 43% to 31%. In contrast, reports of worrying about expenses (78% to 81%), lacking emergency funds (over 70% across waves), and food insecurity (51% to 54%) changed little over time.

Figure 3 presents the percentage of caregivers reporting spending across basic-needs categories, including food at home, housekeeping supplies, child clothing and shoes, utilities, and phone or internet. These were the most commonly reported spending categories across survey waves. Because the figure reports whether spending occurred rather than the amount spent, the findings reflect the prevalence of spending rather than its magnitude. Together, the survey findings provide additional context for the financial circumstances' caregivers described during the interviews.

Discussion

Findings from this project suggest caregivers experienced support as less helpful when it was delayed, impractical, or mismatched with their identified needs. Findings suggest the effectiveness of child welfare support depends on fit: whether support is timely, flexible, and responsive to lived realities. These themes highlight caregivers' experiences when services fall short in meeting the needs they identify. When help is promised but not delivered promptly, families are left to meet their needs using the resources available to them, often causing them to rely on informal support networks, such as family members or friends, to get support. When offered support does not meet the unique nuances of each family, participants described frustration and, in some cases, reduced trust in a system intended to support family-centered practice.

The hardship data shows many caregivers continued to experience substantial economic strain from baseline through the 6- and 12-month follow-ups, particularly through persistent worry about expenses and limited emergency funds. At the same time, spending on basic needs remained common across these survey waves. The central concern was not that families were spending on necessities, but that many were doing so without the financial cushion needed to absorb unexpected or variable costs. Considered alongside the interviews, these patterns suggest caregivers were working to maintain household stability while navigating persistent economic insecurity and a service system that did not always respond to immediate material needs.

Caregivers' financial activity was concentrated in ordinary but essential areas of family life. When families are consistently paying for basic needs while also experiencing hardship, support that is delayed, narrowly targeted, or compliance-driven may not address the pressures most relevant to family stability. Mandated services may satisfy case-plan requirements without addressing caregivers' immediate material needs. In this context, the usefulness of support depends not only on whether assistance is offered, but also on whether it reflects the timing and substance of families' needs.

These findings should not be interpreted as evidence that unconditional cash alone can resolve poverty, structural inequality, or all factors contributing to child welfare involvement. The descriptive survey analyses also cannot establish the EmPwR cash gifts directly cause changes in hardship or spending. Rather, the findings demonstrate why flexibility may matter when families face multiple and changing demands. Flexible cash may complement existing child welfare services by addressing practical needs that referrals, mandated programs, and other formal supports are not designed to meet.

These findings also highlight the potential relevance of EmPwR's model of flexible cash support. Although unrestricted cash alone cannot resolve poverty or structural inequality, it may reduce some immediate tradeoffs by allowing caregivers to prioritize the routine material costs of maintaining a household and caring for children. Rather than requiring families to fit their needs into predetermined service categories, unrestricted support may provide greater agency to address practical problems as they arise. Overall, these findings suggest family-centered child welfare practices may benefit from evaluating not only whether services are provided, but also whether caregivers experience those services as responsive to their identified needs.

Limitations

This project reflects caregivers' self-reported experiences and should not be interpreted as evidence of causal effects. This project focuses exclusively on caregiver perspectives and does not incorporate the experiences or perspectives of child welfare caseworkers. Figure 1 presents three illustrative caregiver interviews selected from a larger sample of 74 interviews. Although these interviews reflect themes identified during matrix analysis, they do not capture the full range of caregiver experiences. The three interviews were selected to illustrate themes identified through the broader matrix analysis rather than to represent all caregiver experiences. However, these themes were highlighted in matrix analysis conducted before our project. Finally, because the study focuses on families receiving intact services, findings may not generalize to families involved in other child welfare service types.

Future Research

This project provides an initial exploration of the gap between caregivers' identified needs and the support they report receiving in practice. As part of the broader EmPwR study, focus groups were previously conducted with child welfare professionals to better understand their perspectives on supporting families. Future research will build on the current findings by incorporating child welfare caseworkers' voices. Including caseworker perspectives will provide a more comprehensive understanding of the systemic factors that influence service delivery. Together, caregiver and caseworker perspectives may help inform policies and practices that strengthen family-centered approaches and better align services with

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Figures

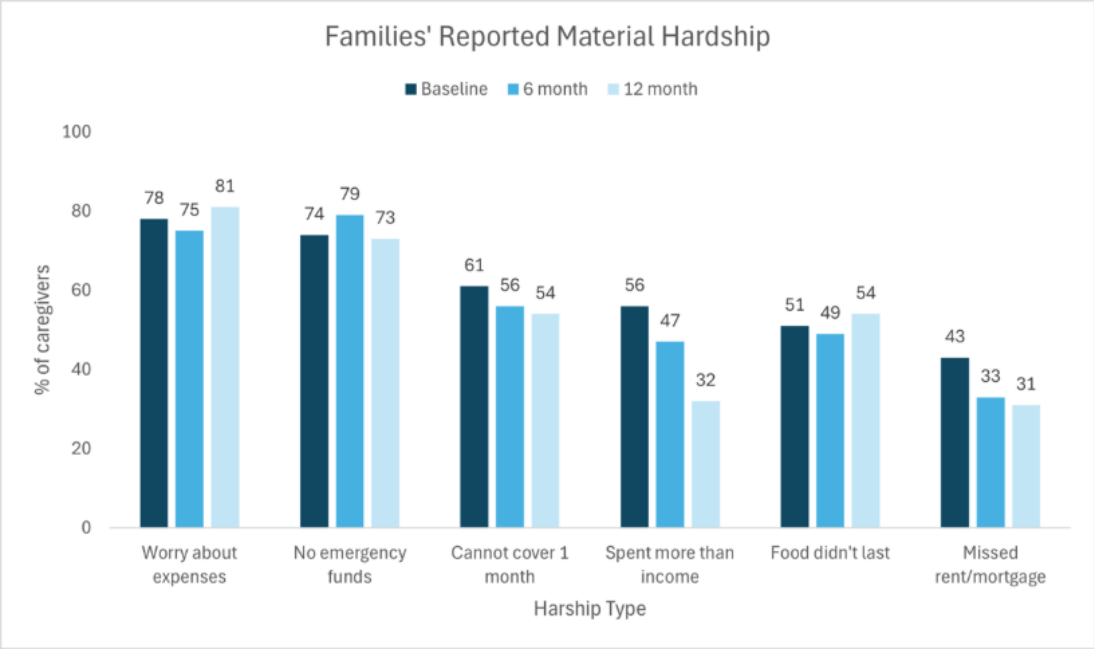
Figure 1

Service Delivery Experiences from Participant Interviews

	Need	Given	Outcome
Working single mother of 4, treatment group	*"If I can go and spend $400 on the cots and the pads that I want to get for them. Get them some waterproof sleeping bags for me. That's beneficial for me… That'll help me in a step towards our goal of easy cleanup and a way for them to be able to clean up behind themselves because that's the whole issue here."*	*"So, they're like, 'Well, we have to get you guys beds.' Well, then you're just putting more stuff in my house that I don't need."*	*"[Intact worker] come[s] in and they're telling us to clean. Well, you guys are telling us the same thing that we've been through"*
Working mother of 5, control group	*"I just wish that the resources and supports that are offered were like, didn't take so long to actually get. And like, I don't know if that's due to them having a lot of cases or what's going on, but it's like, is one family more important than the next?"*	*"...it's already been a couple weeks and I haven't gotten [winter coats] yet, but I don't want, you know, I'm trying not to be mean about it, but it's like they need it now"*	*"I mean, I don't know how the system works like, [sighs] and when I say that, I mean, like I appreciate the help that they would give, but have I seen it yet? No."*
Working single mother of 4, control group	*"It's not that I want free stuff, It's just that I want to get back on my feet"*	*"I said, 'but all you guys do is drug test me.' And I kept saying that, so I think [intact caseworker] thought I was like, well, where's my free shit?."*	*"I just don't think she was doing what I needed her to."*

Figure 2

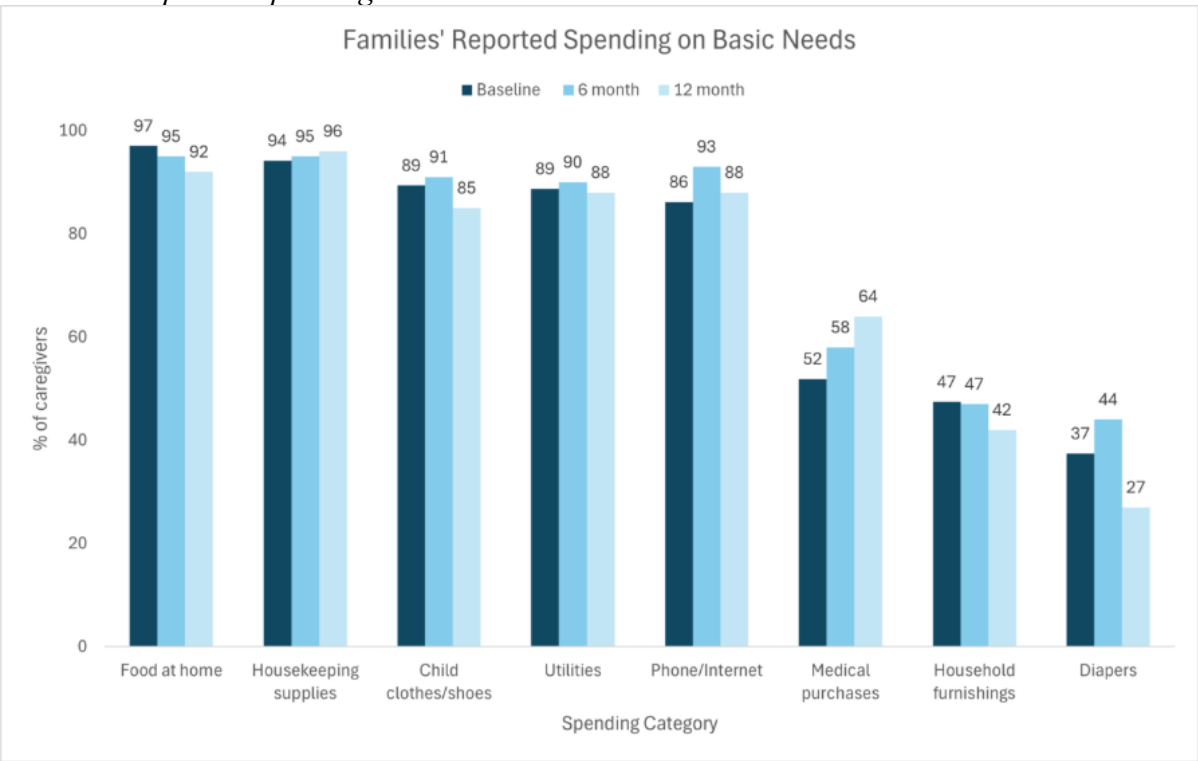
Families' Reported Material Hardship



This figure shows the percentage of caregivers reporting material hardship at baseline, 6 months, and 12 months.

Figure 3

Families' Reported Spending on Basic Needs



This figure shows the percentage of caregivers reporting any spending in each basic-needs category at baseline, 6 months, and 12 months.

Appendix A

Material Hardship

The Material Hardship measures used in the EmPwR survey assessed caregiver financial strain, housing instability, and food insecurity. For the present study, the descriptive analyses focused on six hardship indicators examined across baseline, 6-month, and 12-month waves. Food insecurity content was adapted from the *U.S. Household Food Security Survey Module* (U.S. Department of Agriculture, Economic Research Service, 2012). In the present analyses, items were examined individually and reported as percentages of treatment families endorsing each indicator at each wave.

1. How often do you worry about being able to meet your monthly living expenses?
2. In the past 12 months, would you say that your household has spent more, less, or about as much as all of your sources of income combined?
3. In the past 12 months have you ever missed a rent or mortgage payment?
4. Have you set aside emergency or rainy-day funds that could cover your expenses for 1 month in case of sickness, job loss, economic downturn, or other emergencies?
5. If you were to lose your main source of income, for example, your job or government benefits, could you cover your expenses for one month by borrowing money, using savings, selling assets, or borrowing from friends/family?
6. How true was the following statement in the last 12 months: “The food that we bought just didn’t last, and we didn’t have money to get more.”

Appendix B

Expenditures

The Expenditure measures used in the EmPwR survey assessed child-related and household spending across multiple categories. For the present study, the descriptive analyses focused on expenditure categories most directly related to household basic needs: food at home, utilities, phone/internet, housekeeping supplies, medical purchases, child clothing, diapers, and household furnishings. The REDCap expenditure instrument included both yes/no purchase items with follow-up dollar-amount questions and direct household expenditure questions asking about recent or average spending. In the present analyses, child clothing and diaper items were coded as reported spending when caregivers endorsed purchase, and household expenditure items were coded as reported spending when the reported dollar amount exceeded zero. Accordingly, findings were reported as percentages of treatment families reporting any spending in each category at each wave rather than as average dollar amounts.

1. How much does your household usually spend each month on housekeeping supplies and services, such as cleaning detergents, paper towels, sponges, or a cleaning service?
2. How much does your household usually spend each month on prescription drugs, medical equipment or supplies, over-the-counter medications, vitamins, inhalers for asthma, etc.?
3. Over the last month, how much has your household spent on clothing and shoes, including watches and jewelry?
4. Over the last month, how much has your household spent on household furnishings and equipment, including furniture, bed linens, appliances, dishes, or other housewares?
5. How much do you and everyone else in your family spend on food that you use at home in an average month? (If you receive food stamps, include them in the total amount).

Challenges and Perceptions of Nepal's Childcare Institutions: Care Practices and the Implementation of Government Policies

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Abstract

In Nepal, a staggering 9% of children are categorized as orphaned and vulnerable population (OVC). However, there is limited research examining the dynamics between key stakeholders in caretaking the OVC in Nepal: The Government of Nepal (GoN), which legislates policy standards, and the NGOs managing childcare institutions, such as childcare homes and orphanages. The study aims to identify best care practices for children's development as perceived by administrators and to explore their attitudes toward government policies. Findings reveal (1.) policy perceptions as unrealistic given Nepal's weak socio-economic context, and (2.) an adversarial relational dynamic between the state and NGOs. Findings, analyzed using the collective governance and policy transfer theories, highlight the need for policies adapted to Nepal's socioeconomic context and increased cooperation between the GoN and NGO administrators.

Keywords: childcare institutions; child welfare; policy perception; state-NGO relationship

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This research was conducted in fulfillment of the capstone for the Bachelor of Arts in Global Studies at the College of Liberal Arts & Sciences at the University of Illinois Urbana - Champaign.

Introduction & Literature Review

Children comprise nearly a third of the global population and are universally recognized as one of society's most vulnerable groups. Of the 2.2 billion children worldwide, almost 153 million children are orphans (UNICEF) who face even greater risks of violence, child trafficking, and sexual exploitation. Orphan rates in Nepal are difficult to accurately measure, with estimates varying widely. Some sources suggest roughly 1 million children are orphans (GlobalGiving, 2024), while others report much lower numbers, such as approximately 13,000 orphaned children (Fernandez et al., 2020). These discrepancies themselves highlight a major developmental issue: a lack of reliable data. There is also limited credibility in available data due to incidents of orphan trafficking. Therefore, the staggering 1 million Nepali "orphans" could be more accurately referred to as "orphans and vulnerable children" (OVC), which includes children who have parents, but whose basic needs may not be met.

Orphan trafficking is broadly defined in existing literature as the process by which children, irrespective of their orphan status, are placed into childcare institutions through a series of lucrative events for exploitation and profit (Van Doore, 2022). Despite limited research on how international law views the displacement of children from their families and the subsequent labeling of their “orphan” status, orphan trafficking in South Asia has become more prominently severe with the rise of poor families being coerced into giving up their children “in exchange for money by unscrupulous institutions and adoption agencies hoping to profit from either the residence or trafficking of children” (Van Doore, 2016). In many cases, children registered in these childcare institutions are “paper orphans,” a term coined by Katherine E. Van Doore (2016, p. 379) to describe the false classification of children with living parents as either orphans or partial orphans, with at least one living parent (Van Doore, 2016, p. 381). Notably, incidents of NGOs operating childcare institutions and contributing to this highly profitable business are not uncommon among developing countries, with countries such as

Cambodia, Ghana, and Uganda also reporting several cases of orphan trafficking (Van Doore, 2016, p. 381). In many cases, government officials are also involved in the corrupt practice of orphan trafficking.

In Nepal, incidents of orphan trafficking can be traced back to the Nepalese Civil War (1996-2006), when traffickers exploited the conflict by taking children away from families who were fearful of possible forced conscription into the Maoist army, especially in rural areas where Maoist forces had infiltrated (Punaks & Feit, 2014, p. 180). In recent years, traffickers have posed as educators or related figures, deceiving rural families with the promise of educational opportunities for their children in urban areas, where such resources are generally adequate compared to rural Nepal. In some instances, parents themselves sign papers stating "their kid is officially an orphan" to enroll their children into institutions, where they are promised better access to development resources (Saxe-Smith, 2015, p. 3).

Additionally, institutional care, including orphanages, children's homes, and residential facilities, is generally assumed to be a temporary or last resort for childcare. Research indicates growing up in such settings "can damage and delay children's development" while also exposing them to risks of neglect, violence, and abuse (Save the Children UK, 2009). In resource-limited environments, such institutions are particularly prone to transforming into profit-driven business models, where money and donations are "elicited from well-meaning tourists and donors" (Hopes and Homes for Children, 2024). To prevent such cycles, it is widely recommended that OVC be placed in family-based alternatives like kinship care, foster care, or adoption. However, this is often not the reality in resource-limited countries. Driven by a lack of development and a cycle of poverty, many children from rural Nepal are "obliged to live in foster/children's homes scattered throughout the country" (The Kathmandu Post, 2023). Essentially, rural parents feel obliged to send their children to

institutions in more urban areas, where they hope to secure better opportunities and services unavailable in their own communities.

While the existing literature discusses the causes of high orphan rates in Nepal, there is a notable gap in research regarding the collaborative role of the government and non-governmental organizations (NGOs) in managing nearly one million institutionalized children under government policies. This study seeks to address this gap by analyzing how the engagement between the Nepali government and NGOs shapes the development of institutionalized Nepali children, particularly focusing on the relational dynamics between two key actors: (1) the Government of Nepal (GoN), which frames and enforces policies related to institutional administration, and (2) the NGOs, that administer childcare institutions, like orphanages, children's homes, and residential care, ideally within governmental regulations. Due to insufficient empirical findings, existing child welfare practices may fail to achieve their maximum impact. For meaningful progress, all involved parties must be well-informed and collaborate on designing new strategies to address the complexities associated with OVC's development in Nepal. Specifically, this study explores the following research questions: (1) What are the key characteristics of effective care practices, as perceived by childcare institutions' administrators, that promote children's development in Nepali institutions? (2) Additionally, how do administrators of childcare institutions in Nepal perceive the policies and their implementation by the GoN? Overall, the study will outline the perceptions of childcare institutions' administrators, offering recommendations for improving OVC well-being to Nepali bureaucrats and policymakers. In addition, the findings of this study may prompt further research on complexities shaping the relational dynamics between the GoN and administrators of Nepali childcare institutions.

Theoretical Frameworks

In recent years, the concept of "collaborative governance" has emerged as a strategy

highlighting the importance of stakeholders partnering with public agencies in shared forums to reach consensus-driven decisions (Ansell & Gash, 2007, p. 543). Collaborative governance responds to the failures of downstream policy implementation (Ansell & Gash, 2007, p. 544), which often neglects the linkage between policy design and its translation into actionable programs and services. Collective governance bridges this gap by promoting cooperation among multiple stakeholders to ensure practical, ground-level application of policies. Additionally, Dr. Mark Evans, in *Policy transfer in global perspective*, defines "policy transfer" as a method by which knowledge about policies from one sector or governance level informs the development of policies in another (Evans, 2004, p. 1). Evans (2009) distinguishes between two forms of policy transfer: voluntary (lesson-learning) transfers and coercive (negotiated or direct) transfers. Policy transfer is also facilitated by international organizations (IOs), which establish globally informed standards primarily informed by the resource-rich contexts of developed countries. When these policies are transferred to developing countries, resource constraints and socioeconomic realities often challenge their effective implementation.

Methodology

This study employed a qualitative research design to explore: (1) The key characteristics of effective care practices, as perceived by childcare institutions' administrators, that promote children's development in Nepali institutions. (2) Administrators' perceptions of the Government of Nepal's (GoN) childcare policies and their implementation. Twenty childcare institutions, including orphanages, children's homes, and residential facilities, were selected across Nepal's largest urban agglomeration: the Kathmandu Valley. They were randomly selected from a list provided by the National Child Rights Council (NCRC), the government agency granting researchers permission for research relating to children. The listed institutions were then contacted via the numbers on the

internet (e.g., websites, social media channels) for recruitment. A few institutions were selected based on word-of-mouth recommendations from other participants. Overall, 30 staff members participated in 15-30-minute semi-structured interviews consisting of eight core questions (attached in the Index), with follow-up questions based on participants' answers. Most institutions quickly scheduled interviews, often on the same day. Interviews were conducted in Nepali, the participants' language, which the lead researcher also speaks fluently. The researcher either translated and recorded participants' responses during the interview or, with permission, recorded the audio and later translated and transcribed their responses. In the interviews, participants, who were either founders or active staff of the institutions, discussed care practices and state-NGO collaboration. Demographic details were omitted for anonymity. Data were transcribed and thematically analyzed by the lead researcher, research assistant, and AI-ChatGPT. AI-ChatGPT was used at the conclusion of data analysis to triple-check and identify key themes in responses, ensuring any gaps missed by the researcher or assistant were identified. Overall, the literature review, findings, and discussion involved archival, policy, and ethnographic research. Limitations include resource constraints, limited perspectives from administrators, government, children, and policy documents, which affect the depth of analysis.

Results

Theme 1: Best Care Practices for OVC's Development

Participants (n = 30) unanimously identified nutrition, education, healthcare, and extracurricular activities as core components of children's development, though the prioritization of each varied across institutions. Many highlighted psychological well-being and a familial, nurturing environment as equally essential for OVC well-being, given their disadvantaged backgrounds:

- "Children's development is characterized by nutritious food, often avoiding fast food."
- "We encourage children to drink water first thing in the morning. Also, we promote physical exercise in the form of yoga, taekwondo, and other activities, like dancing.

Several participants discussed the emotional and psychological needs of institutionalized children, especially those from rural districts like *Jumla* and *Humla*, or those affected by the Civil War. Participants reported:

- "We are taking care of children from rural parts, like Jumla and Humla, Ones that didn't even know how to clean up after eating or even how to dress themselves."
- "We have a lot of children from after the Civil War, who have lost their parents."
- "Most times, they feel as though their background weighs them down."

To address these challenges, many participants identified partnerships with external resources, such as psychiatrists, psychologists, and motivational speakers, as key mechanisms supporting OVC development. They reported addressing each child's psychological needs individually, with some focusing on anger management, while others needed emotional motivation:

- "We collaborate with various psychiatric and counseling firms for long-term treatment…We have children in anger management counseling, as well as post-trauma counseling."
- "We have to fulfill their psychological and mental needs, so we have psychologists who usually help the children out."

Beyond basic care, several participants emphasized creating a familial environment within institutions and teaching children familial values. Participants reported caregivers often assume the

role of parents, with some even stating the children refer to their caretaker as *Aama* (Nepali for 'Mother') or each other as "siblings" or "family." Several participants noted:

- "The children refer to me as 'daddy,' and my wife as 'mommy'."
- "…becoming the children's parent is important for their development."
- "They are deprived of love, especially that of a mother, so we must give them that."
- "We also ensure that we give them enough love and affection, so they don't ever feel like 'orphans'."

Theme 2: Policy Provisions Referenced by Participants

In the following discussion regarding the challenges faced during policy implementation, participants repeatedly highlighted specific policies they perceived as impractical and unaffordable. These policies include requirements for life insurance, staffing, playground facilities, and room specifications. This section of the paper does not aim to verify or critique policies but rather presents the perspectives of administrators, supported by relevant reference documents. The following provides an overview of these policies for discussion:

- "The children's home shall provide health insurance for all children and, if the government assists in this regard as per the rules, it shall coordinate and support it." [Article 3, Clause 10, Sentence 11, Standards for Operation and Management of Children's Homes, 2079B.S. (2022 A.D.), Government of Nepal]

Another policy provision demands that institutions have a playground and at least 13 rooms, including (1.) girl's rooms, (2.) boy's rooms, (3.) bathrooms, (4.) a kitchen, (5.) a dining room, (6.) a study room, (7.) a medical room, (8.) an office, among others, as outlined in Table A:

S.N.	Details	Number
1	Open land or courtyard with garden and playground within the premises of the children's home	Open land according to the building
2	Clean bedroom with at least 30 square feet of space/area for each child or 12/10 feet room	5
3	Number of beds, clean bedding and sheets	20/20
4	Clean kitchen and storeroom	1/1
5	Clean dining room of at least 12/16 feet	1
6	Clean study/entertainment/library room of at least 14/24 feet	1
7	Clean first aid and supplies / counseling room	1
8	Clean office/meeting room	1/1
9	Clean toilets/bathrooms	4/4
10	Sign board with the name of the orphanage (at least one Visible place or one pasted on the wall)	1

[Article 3, Clause 5, Standards for Operation and Management of Children's Homes, 2079 B.S. (2022 A.D.), Government of Nepal.]

Similarly, an additional provision demands that institutions employ at least seven staff, including (1.) a manager, (2.) a caretaker, (3.) a cook/assistant, (4.) a teacher, (5.) a psychologist, (6.) a health worker, and (7.) a sports and entertainment assistant, as outlined in Table B:

S.N.	Employee Details	No.	Nature	Note
1	Head of the Children's Home/Manager	1	As a full-time and residential employee,	At least a Proficiency Certificate level or 12th grade pass, and have received training on child rights and child home management and two years of work experience.
2	Caretaker		As a full-time and residential employee,	Literate and experienced in the care and nurturing or children (only female caregivers are mandatory in a child care home for girls).
3	Cook/Assistant		As a full-time and residential employee,	Literate and have experience in related work.
4	Teacher		Partial	Having passed at least the Proficiency Certificate level or 12th grade and having the qualification to teach and educate children in the children's

				home.
5	Psychologist		Partial	At least a certificate in proficiency level or 12th grade and at least three months of training as a psychologist and experience (if only girls are present, only women should be psychologists).
6	Health worker		Partial	Having completed a nursing or health assistant course and having health-related work experience or having at least five years of health-related work experience in the form of a certificate or diploma
7	Sports entertainment assistant		Partial	Having experience in organizing sports activities.

[Article 3, Clause 6, Standards for Operation and Management of Children's Homes, 2079 B.S. (2022 A.D.), Government of Nepal.]

Theme 3: Perceptions of Policy Implementation

Participants noted while policies are standardized with actions such as monitoring and workshops, their implementation remains weak, mainly due to insufficient funding. They also found policies overly complex, demanding, and sometimes misaligned with local needs. Childcare administrators described adversarial interactions with government officials, often facing negative attitudes during visits. Several participants shared policy provisions often require substantial financial support to fulfill. They reported being often unaware of available funding. Even when aware of the process, the funding procedure remains lengthy and complex, often requiring extensive documentation and several steps. One participant shared:

- "…there is no funding, and when I found a funding opportunity, I went to apply (thrice), but the process was too long, complicated, and they kept on demanding various documents…"

Thus, most institutions depend primarily on private donations, with minimal financial reliance on

government support, as another participant noted:

- "Most of the financial support comes from donors…Even if there are governmental funds, normal individuals like us (social workers) are unable to understand all the technical, wordy writing."

Over half of the participants highlighted a disconnect between the policy design and ground realities. They felt policymakers lacked field experience and awareness of local challenges, often adapting foreign frameworks unsuited to Nepal's context. A participant asked:

- "…they [GoN] say every child must have life insurance, but how is it possible with limited funding?"

Other participants provided further examples:

- "For instance, they ask for various staff in sports, health, entertainment, and so on. We can't possibly employ everyone with the budget at hand."
- "The government has a lot of tough requirements…sometimes they are unnecessary. For instance, we must have 13 rooms and even a playground, but we have a lot of older children. There isn't a need for slides and swings."
- "To renew our orphanage alone, we have to visit at least 5-6 governmental departments annually."

Many participants described distrust and negative attitudes from government officials during inspections and monitoring visits. They felt that bureaucrats often assumed NGOs were misusing funds rather than supporting children effectively. One participant recalled:

- "…the government showed signs of distrust that we wouldn't be able to take care of the kids properly."

- "Instead of appreciating the work we do, the government often points out the most specific flaws of what we haven't been able to do."
- "The attitude with which the government approaches our work is pretty rough…they assume that we are working for the wrong intentions."

Discussion

The study findings offer noteworthy theoretical reflections on "collective governance," with childcare institutions often engaging in local partnerships with relevant public and private organizations. Several administrators report healthcare experts frequently volunteer to conduct medical checkups for the children, while some note that local NGOs provide recreational resources, such as dance and yoga training. Institutions also work closely with local schools to organize trips and activities, reflecting a model of multipartner governance, as coined by Emerson, Nabatchi, and Balogh (2011, p. 3), in which key community stakeholders collaborate, particularly in this case, for the shared goal of fostering children's development across Nepali childcare institutions. Notably, this form of multipartner governance may even allude to Nepal's collectivist cultural norms, as Nepali society places a high value on community interdependence and loyalty (Evason, 2017). Along the same lines, administrators revealed the importance of installing collectivist cultural values of community and family within the orphanage environment. In this context, caretakers frequently assume parental norms, with many being referred to as "mother" and "father" by the children. While this approach aligns with the global standard of resorting to institutional care as the last option for OVC by creating an environment that mimics family-based care (Save the Children, 2009), it may inadvertently subordinate individualistic values necessary for children to navigate life after leaving institutions, which is a residential institution after all. While these particular challenges are overarchingly shaped by Nepal's broader socioeconomic conditions, shaped by high poverty rates

and limited economic mobility (Kayastha, 2024), as well as the lack of governmental resources in children's development, the emphasis on collectivist values may increase dependency on both the institution and the broader community, potentially hindering the development of individualistic skills necessary for life outside the institution.

Regarding the theory of "policy transfer," the study found government policies regulating childcare institutions are becoming more standardized and stringent over the years, which is perceived by participants as a response to the growing concern regarding orphanage trafficking, the proliferation of the unnecessary institutionalization of children, and the growing understanding that institutionalization should be the last resort of care for OVC. Upon a brief policy analysis, considering the policies frequently discussed by participants, the domestic policies supporting Nepali OVC certainly mirror global standards of children's development. The 1959 United Nations (UN) Declaration of the Rights of the Child, the 1993 Hague Convention on Protection of Children and Co-operation in Respect of Intercountry Adoption, and the 2009 UN Guidelines for the Alternative Care of Children established global standards for children's development, highlighting the right of children to protection, education, health care, shelter, and good nutrition (OHCHR, 1990). As a signatory to all of these global conventions, the GoN's current domestic framework governing childcare institutions closely adheres to the principles outlined in those policies. In addition to recognizing the provision of nutritional food, education, and healthcare as fundamental care strategies for effective child development, policies are also aimed at offering children a "window to opportunity" through extracurricular activities, such as singing, dancing, and yoga, which are regarded as integral in shaping their holistic development. This approach also mirrors the UN's emphasis on holistic development in early childhood development (UNICEF, n.d.), overall

signaling a voluntary policy transfer from globally recognized standards into Nepal's domestic framework.

The voluntary transfer of policy in developing countries often emerges after the "realization that reform is needed" (Ugyel & Daugbjerb, n.d.), a concept that may apply to Nepal's situation. This is evident in the numerous policy reforms for OVC welfare incorporated into Nepal's 2015 Constitution, which aimed to "align with international and regional conventions" (Lama et al., 2023). These reforms likely reflect a period of transition following the orphanage trafficking incidents and the subsequent intercountry adoption ban imposed by several Western countries. Also, while voluntary policy transfer differs from coercive policy transfer, it is worth noting that voluntary transfer is not entirely free from external conditionalities. For example, the "desire to stand with the international community" by meeting international standards (Karna, 2017) is a prominent external condition that drives developing countries like Nepal to align with global standards, particularly when imposed bans create pressure for reform. Alternatively, voluntary policy transfer, which seeks to facilitate developmental reform, is not inherently negative and can indicate the recipient government's awareness of global standards and a desire for change, often driven by "dissatisfaction with existing policy arrangements" (Karna, 2017). However, problems arise when policies, primarily shaped by the Global North, are transferred into societies with specific needs and contexts, where the policies may not be compatible. As observed by various scholars, policy transfer to developing countries often faces limitations, due to actors such as weaker institutions, an unstable political environment, market uncertainty, limited resources, and socio-cultural differences (Dolowitz, 2003, p. 106-107). Unfortunately, this trend is reflected in the perspectives of NGO administrators when discussing policies governing Nepal's childcare institutions.

Foremost, some administrators noted the policy development process lacks input from key stakeholders, including the NGOs they administrate, and was not well-informed by research or field studies. Rather, they view it as merely mirroring global standards to fulfill the global treaty ratifications. While other administrators acknowledged the policies' intent to promote OVC's development, they were clearly critical of their practicality, often describing legal provisions as overly demanding and misaligned with Nepal's socioeconomic realities. To illustrate these concerns, participants frequently highlighted the policies mandating 13 rooms, a playground, at least seven staff members, and life insurance for all institutionalized children. Upon further examination, it is worth noting these policies not only reflect global standards but sometimes impose more stringent requirements. For instance, policy provision outlined in the GoN's Article 3, Clause 5 of the *Standards for Operation and Management of Children's Homes* (2022) aligns with Article 27 of the UNCRC, which asserts every child has the right to adequate housing facilities (OHCHR, n.d.). The policy also corresponds to Principle 89 of the 2009 Guidelines for the Alternative Care of Children, which mandates institutionalized children should have suitable facilities to meet their hygiene, sanitary, gender, and other personal needs (United Nations, 2009). The staffing requirement outlined in the GoN's Article 3, Clause 6 of the *Standards for Operation and Management of Children's Homes* (2022) policy aligns with Principle 107 of the same resolution, which recognizes the need for adequate (in numbers), well-trained, and qualified staff to provide education, psychological support, and health services (United Nations, 2009). However, Nepal's policies go beyond mirroring global standards by imposing additional requirements that NGO administrators perceive as impractical given the country's financial constraints, as highlighted in this set of policy exercises. While the UNCRC and the Guidelines for the Alternative Care of Children emphasize the importance of adequate living conditions and professional care, the GoN prescribes strict numerical requirements

for 13 room allocations and at least seven specialized staff members. Overall, Nepal's attempt at policy transfer in the case of childcare institutions faces challenges, as NGO administrators managing childcare institutions highlight the unaffordability of implementing such provisions, demonstrating the limitations of applying global standards in a resource-constrained context.

To further discuss the perceptions of NGO administrators regarding policies established and implemented by the GoN, a handful of participants shared experiences of encountering negative attitudes, stigma, and distrust from government bureaucrats, particularly during monitoring visits. These administrators reported government bureaucrats frequently insinuated the administrators of childcare institutions were involved in corruption, drawing associations with orphanage trafficking. It is worth noting that the intention of this study is not to delve into the implications of orphanage trafficking on state-NGO partnerships, but rather to present the often-overlooked perspectives of NGOs managing institutions. Therefore, the perceived rigid approach adopted by government bureaucrats, though likely driven by a legitimate intention to prevent exploitative practices like orphanage trafficking, requires closer consideration. First, it is worth recognizing orphanage trafficking involves play from both state and NGO officials. Second, the rigid and dismissive behavior of government officials, especially those in higher positions of authority, can be intimidating to NGO administrators, who often possess “particular strengths either to replace government in service delivery or to act in a complementary role” (Brinkerhoff, 2002). In the case of NGOs managing OVC, this complementary role is specifically evident, as these NGOs often operate alongside government regulations in providing various service mechanisms to Nepali OVC.

State-NGO partnership, as defined by Ansell and Gash (2007, p. 544), represents a form of “collective governance” distinct from multipartner governance, which involves a broader range of actors beyond just the government and non-governmental actors. State-NGO partnership focuses

specifically on the collaboration between governmental and non-governmental officials, which have been empirically successful in leveraging their collective resources to address development. Existing discussions highlight the importance of state-NGO partnerships, particularly in developing contexts, where NGOs are ideally not incentivized by profit and are "participatory, democratic, bottom-up, and consequently effective in developing innovative localized approaches" (Bano, 2018, p. 1271). As a result, the state-NGO partnership is normatively aimed at enhancing the country's performance while addressing NGO interests by fostering mutual respect, trust, and 'consultative planning' (Bano, 2018, p. 1271). However, their partnership is realistically "seen to be characterized by mistrust and rivalry rather than cooperation," particularly in developing countries, where state actors may facilitate "mistrust or open hostility towards the non-state sector," especially in the context of weak state capacity (McLoughlin, 2011). While the perceptions of NGO administrators alone may not be enough to capture what specifically characterizes the perceived mistrust and hostility from government bureaucrats in Nepal, it is nevertheless evident that such attitudes hinder state-NGO partnerships in OVC care.

Conclusion

Overall, the misalignment of policies with local contexts, coupled with signs of mistrust between the GoN and NGOs, reflects a generally weak state-NGO partnership in managing childcare institutions in Nepal. Theoretical frameworks such as policy transfer highlight how such policies, while standardized, can be unrealistic in the context of Nepal's low socioeconomic status. These misaligned policies, combined with concerns over orphanage trafficking, have additionally led to an adversarial relational dynamic between the GoN and childcare institutions' administrators. Policies better suited to Nepal's context, as well as stronger collective governance between the country and NGOs could better support OVC's development.

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Core Interview Questions
1. How would you characterize the healthy development of children? From your experience and understanding, what factors contribute to the healthy development of children?
2. How would you describe the overall environment and atmosphere within the childcare institution in terms of supporting children's development?
3. Can you share specific examples of programs or activities implemented to promote the development of the children?
4. Can you discuss any challenges you've observed in the institutions that may impact children's educational, social, physical, emotional or psychological development?
5. What measures are in place to address the individual needs and potential traumas of the children under the care of the orphanage?
6. In your experience, how well does the Nepali government and its policies support childcare institutions in Nepal? Where are the gaps?
7. Are there any success stories or positive outcomes that you can share regarding the impact of the institutions on children's lives?
8. Are there any negative/positive outcomes that you can share regarding the impact of institutions on children's lives?
*Would you like to share anything else?



Research-Based Poster Presentations

Using Logic Models to Evaluate Violence Prevention Programs Across Illinois

Molly Braskich and Rena Knysz

University of Illinois at Urbana-Champaign

Abstract

Community violence is a major public health concern across the United States. Logic models are essential evaluation tools that provide a framework for organizing violence prevention program services and goals. Previous research suggests community nonprofits play an important role in reducing crime rates (Sharkey, 2017). This project examines how logic models, as a visual mapping resource, can support violence prevention programs across Illinois by adding structure and identifying gaps in service. Logic models help programs identify their target populations, services provided, risk and protective factors, changes over time, and overall program effectiveness. Systematically organizing program information helps ensure state funding supports programs that are meeting community needs. Using information from program agreements, students developed logic models and offered recommendations for potential assessment tools. These models also highlighted areas where key information was lacking. Ultimately, this research helped determine whether violence prevention programs across the state were effectively reaching their goals and adequately serving communities by improving overall well-being.

Key Words: community violence, prevention, evaluation, effectiveness, structure, reporting, recommendations, well-being

About the Authors: *Molly* is a senior majoring in Social Work with a minor in Psychology. Her research interests focus on youth violence prevention, including dating and intimate partner violence, bullying, cyber-victimization, stalking, and sexual violence among adolescents and young adults.

Rena is a senior majoring in Social Work with a minor in Child Health and Well-Being. Her research interests are working with youth and adolescents, with a particular focus on violence prevention, including community violence and intimate partner violence. She is also interested in promoting the well-being and safety of young people, along with advocacy work and early intervention.

Using Logic Models to Evaluate Violence Prevention Programs Across Illinois

Molly Braskich and Rena Knysz
Department of Social Work, University of Illinois at Urbana-Champaign

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INTRODUCTION

Logic models are essential evaluation tools that provide a structured framework for organizing program activities, outputs, and outcomes. In community-based violence prevention, they help clarify how services lead to intended impacts.

Community organizations play a critical role in reducing violence and improving public safety (Sharkey, 2017), yet many face challenges in consistently evaluating program effectiveness.

Current Study
In partnership with the state agency, Illinois Criminal Justice Information Authority (ICJIA), this project provided evaluation support to organizations implementing violence prevention programs. Grant narratives were analyzed and logic models were created.

AIM

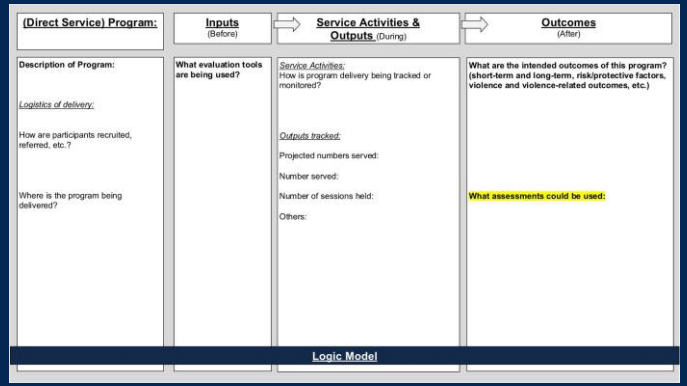
To examine how logic models support violence prevention programs across Illinois by improving program structure, identifying service gaps, and strengthening evaluation practices.

METHOD

Logic models were developed and analyzed for violence prevention programs funded by a large state agency across Illinois. In reviewing program narratives from grant proposals, organizations documented:

- Target populations
- Services provided
- Risk and protective factors
- Short and long term outcomes

Using the logic model template below, narrative information was organized for program information, inputs, service activities, outputs, and outcomes.



(Direct Service) Program:	Inputs (Before)	Service Activities & Outputs (During)	Outcomes (After)
Description of Program: *Logistics of delivery:* How are participants recruited, referred, etc.? Where is the program being delivered?	**What evaluation tools are being used?**	*Service Activities:* How is program delivery being tracked or monitored? *Outputs tracked:* Projected numbers served: Number served: Number of sessions held: Others:	**What are the intended outcomes of this program? (short-term and long-term, risk/protective factors, violence and violence-related outcomes, etc.)** **What assessments could be used:**

Logic Model

RESULTS

- **171 logic models** were completed across the funding periods of Fiscal Years (FY) 18-23, FY26
- Programs across **11 counties** were evaluated (Adams, Cook, DuPage, Iroquois, Jefferson, Kankakee, Lake, Macon, Peoria, Vermilion, and Winnebago)
- **8 different program types** addressing various community challenges

Found that there was a strong emphasis on **primary prevention** statewide and many organizations implemented multi-tiered prevention approaches.



CONCLUSIONS

Using logic models:

- Improved identification of outcomes and service gaps
- Led to using REDCap for grant reporting, which enhanced standardized data collection and analysis capacity

Logic models are effective tools for strengthening violence prevention programs. They support organizations in:

- Identifying gaps in services
- Monitoring program progress
- Aligning activities with measurable outcomes
- Demonstrating the impact of state funded initiatives

These findings highlight the importance of structured evaluation tools in improving accountability and effectiveness in community-based violence prevention.

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REDCap SHELL

ACKNOWLEDGEMENTS

We thank Dr. Rachel Garthe and Haley Miller for their guidance and support. We also recognize the critical work of violence prevention organizations across Illinois. This project was supported in partnership with the Illinois Criminal Justice Information Authority (ICJIA).

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Help-Seeking Behaviors for Gender-Based Violence among College Students at University of Illinois Urbana-Champaign

Izzy Schwartz and Brooke Swaback, BS

University of Illinois at Urbana-Champaign

Abstract

Gender-based violence (GBV), which includes sexual assault and intimate partner violence, is a public health crisis that negatively impacts the well-being of individuals and communities. Many college-aged individuals are affected by GBV, with 13% of students reporting sexual violence (RAINN, 2026). At the University of Illinois Urbana-Champaign (UIUC), 18.5% of women and 4.2% of men reported sexual assault, and 18.7% of women and 10% of men reported partner violence (Bystrynski & Allen, 2019). Help-seeking following GBV is a complex process that is reported at lower rates. Consistent with national trends, low help-seeking rates were observed on the UIUC campus (57.1% of students did not report; Bystrynski & Allen, 2019). It is crucial researchers consider help-seeking trends to strengthen existing knowledge and improve access to services. Our study aims to examine help-seeking trends based on students' characteristics (e.g., year in college, residential accommodation). We use secondary data collected from two larger studies at UIUC (N = 561 first- and second-year students). We analyze help-seeking (e.g., reporting, telling a friend) responses by student characteristics among students with GBV experiences. Findings can support university leadership in identifying critical gaps in GBV support and services.

Keywords: Gender-based violence, help-seeking behaviors, college students, campus violence, informal and formal support systems, disclosure, racial disparities.

About the Authors: *Izzy* is a junior in the School of Social Work. Her research interests include mental health accessibility, child and family welfare, and violence prevention.

Brooke recently graduated with her bachelor's degree in psychology. She currently is an MSW student at UIUC, and her research interests include adverse childhood experiences and violence prevention.

Help-Seeking Behaviors for Gender-Based Violence among College Students at University of Illinois Urbana-Champaign

Brooke Swaback[1] and Izzy Schwartz[2], Dr. Rachel Garthe[2], Apoorva Nag[2]
[1]Department of Psychology, University of Illinois Urbana-Champaign; [2]School of Social Work, University of Illinois Urbana-Champaign

INTRODUCTION

- Gender-based violence (GBV), which includes sexual assault and intimate partner violence, is a public health crisis that negatively impacts the well-being of individuals and communities.
- Many college-aged individuals are affected by GBV, with 13% of students reporting sexual violence (RAINN, 2025).
- Help-seeking following GBV is a complex process that is reported at lower rates.
- Students may choose to engage in disclosure through trusted peers (informal) and through institutional resources (formal) after a GBV experience.
- Low help-seeking rates were observed on the University of Illinois Urbana-Champaign (UIUC) campus, and of those disclosures 91.4% of students disclosed their experience to friends (Bystrynski & Allen, 2019).

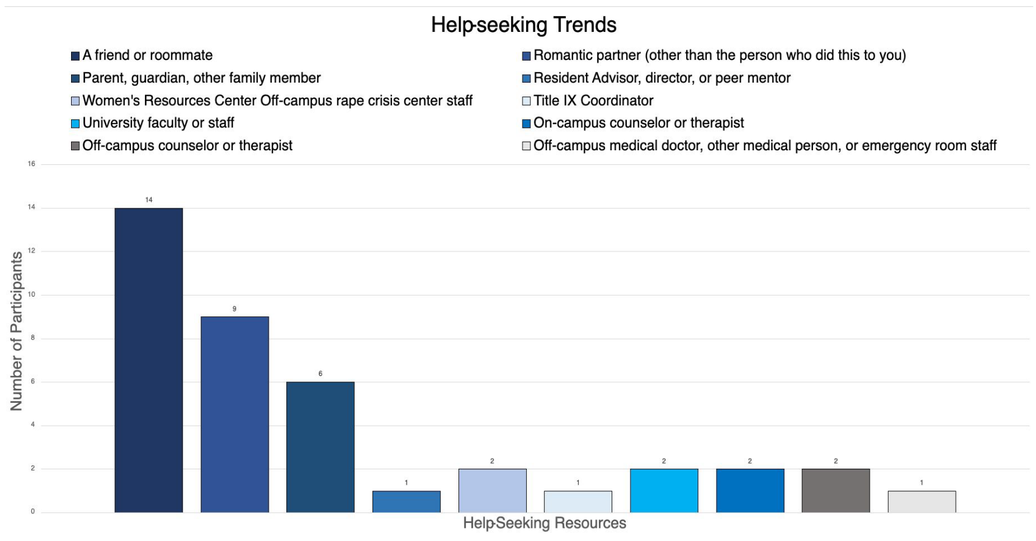
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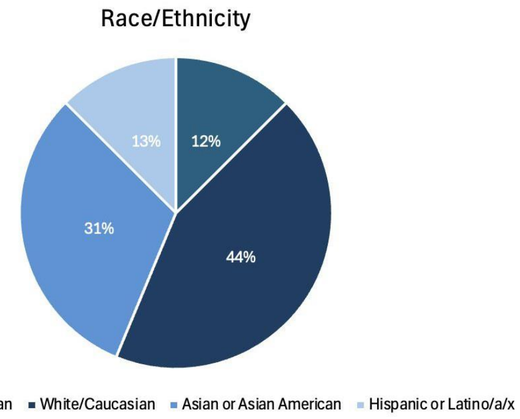
- The aim of our study is to examine help-seeking behaviors among college students who have experienced GBV.
- Specifically, secondary data showed racial diversity, which prompted our interest in examining how willingness to disclose experiences and engage in help-seeking behaviors may vary across student racial/ethnic identities.
- Additionally, our study aims to explore patterns in students' use of formal and informal support resources following experiences of GBV.

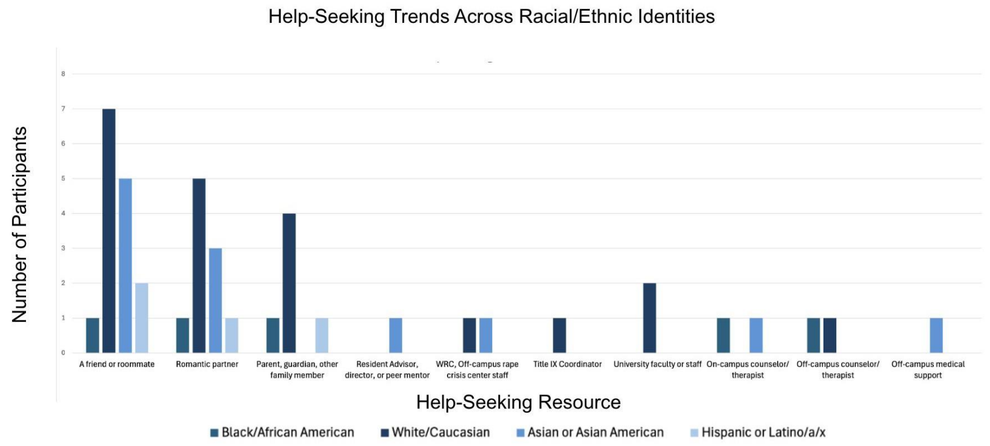
METHOD

- Secondary data were collected from 36 UIUC students (ages 18-38) who opted to participate in a study examining help-seeking behaviors.
- We excluded individuals who did not experience violence on campus and those who did not report help-seeking behaviors, resulting in a final sample of 18 participants.
- The sample consisted of 88% cisgender women, 6% transgender men, and 6% who preferred to self-describe. After providing informed consent, participants completed a 17-item survey assessing the frequency with which they experienced GBV.

RESULTS







CONCLUSIONS

- Findings highlight disparities in help-seeking behaviors across student racial/ethnic identities, suggesting that support needs and barriers are not experienced equally among students.
- Students appear less likely to access formal support services; therefore, university leadership should prioritize increasing awareness, revising existing programs, and strengthening outreach initiatives.
- Institutions should expand training opportunities for faculty, staff, and bystander training for peers to improve the quality and effectiveness of informal support systems.
- Providing students with tailored, culturally-responsive resources can improve inclusive services while addressing relevant, identity-based barriers.
- We hope that this information can support future research and guide prevention efforts, specifically prioritizing campus safety, equitable access and survivor well-being.

ACKNOWLEDGMENTS

We would like to thank and acknowledge our research mentors, Dr. Rachel Garthe and Apoorva Nag, for their guidance and unwavering support throughout this process. We hope this research contributes to ongoing efforts to better support students and strengthen resources for those impacted by gender-based violence.

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EmPwRing Families Beyond Survival: Distinguishing Conditional vs Unconditional Cash Supports in Child Welfare

Rachel Phillips, BSW, and Maritza Vazquez Barreras, BSW

University of Illinois at Urbana-Champaign

Abstract

Welfare programs, such as the Supplemental Nutrition Assistance Program (SNAP), the Temporary Assistance for Needy Families (TANF), and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), are designed to support low-income families by helping meet basic needs. However, these programs often include complex eligibility requirements and administrative burdens that create uncertainty for families. Following changes in federal policy, program requirements for restricted cash support can unexpectedly shift, leaving families vulnerable. In contrast, the Empower Parenting with Resources (EmPwR) program provides unconditional, unrestricted cash support to families involved in the child welfare system. Given the limited attention to flexible financial support programs, this study examines the differences between restricted and unrestricted cash support. In this study, 400 Illinois families participating in the EmPwR program and involved in intact family services receive approximately $500 per month for one year. Survey and interview data were analyzed to compare participants' descriptions of restricted, traditional assistance programs to unrestricted cash support through EmPwR. Early findings suggest flexible support, such as the EmPwR program, may better address families' needs than traditional welfare assistance. Future research should examine how reducing program restrictions may contribute to greater economic stability and improved family well-being.

Keywords: child welfare, EmPwR, financial assistance, unrestricted cash gifts

About the Authors: *Rachel* graduated in May 2026 with her BSW and a minor in Anthropology. She is pursuing a MSW with a concentration in Leadership and Social Change at UIUC. Her interests involve policy, human rights, and community organizing.

Maritza graduated in May with her BSW and a minor in Criminology, Law, and Society. She is pursuing a MSW with a concentration in Leadership and Social Change at UIUC. Her interests involve systemic levels, immigration, and social issues

Note: Additional contributors include Alexis Krones (Project Director, EmPwR) & Dr. William Schneider (Principal Investigator, EmPwR).

EmPwRing Families Beyond Survival: Distinguishing Conditional vs Unconditional Cash Supports in Child Welfare

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INTRODUCTION

- Public assistance programs, such as the Supplemental Nutrition Assistance Program (**SNAP),** Temporary Assistance for Needy Families **(TANF),** and Special Supplemental Nutrition Program for Women, Infants, and Children (**WIC)**, often include strict eligibility requirements and administrative barriers that can make benefits difficult to access.
- Research suggests that more flexible forms of financial support, including the Earned Income Tax Credit (EITC) and the Alaska Permanent Fund Dividend, may reduce child welfare involvement.
  - **EITC:** Associated with reductions in child maltreatment, particularly neglect.
  - **Alaska Permanent Fund**: Annual cash payments (approximately $1,000) have been associated with fewer reports of child neglect, fewer referrals for physical abuse, and lower child mortality.
- **Empower Parenting with Resources (EmPwR)** is a randomized controlled trial examining the effects of unconditional cash gifts for Illinois families receiving intact family services.
- Although considerable research has examined traditional public assistance programs, relatively little is known about how unrestricted cash support influences family well-being and child maltreatment risk.
- This study compares key characteristics of the EmPwR program with traditional public assistance programs (SNAP, TANF, and WIC).

AIM

- Determine whether flexible resources better support families' needs.
- Compare restricted and unrestricted financial assistance specifically regarding eligibility, duration, and rules.
- Examine how findings can inform future child welfare and financial assistance programs.

METHODS

- Surveys
  - Baseline N= 259
  - 6 mo. N= 137
  - 12 mo. N= 59
- Interviews
  - N= 180
  - Common themes expressed throughout interviews include experiences with and perceptions of child welfare programs.

RESULTS

Program	%	Eligibility	Duration	Amount	Rules
EmPwR	100% enrolled; 50% randomized to treatment group	• Receive intact services at one of two specific agencies in IL • Main caregiver for child or children • Sign online consent forms • Speak English or Spanish	12 Months	Average $500/month	Unconditional and unrestricted
SNAP	Base: 52.1% 6 Mo: 56.5% 12 Mo: 65%	• Monthly gross income does not exceed limit • Legal documentation of citizenship and living situation • Complete application and provide documentation at interview • Adhere to work requirements	1 month - 3 years	$292 - $2,196	Restricted to food items
TANF	12 Mo: 5%	• Must be pregnant or have dependents • Be a citizen or certain immigration status • Adhere to work requirements • Have a self-sufficient plan • Complete application and provide documentation at interview	5 years (60 months total)	$342 - $3,184	Restricted to shelter, food, and utilities
WIC	Base: 15.5% 6 Mo: 19.8% 12 Mo: 13.3%	• Income cannot exceed maximum limit • Pregnant, or had a baby in the last 6 months • Stillbirth or miscarriage in the last 6 months • Have children under 5 • Mandatory 1st visit in-person	Case specific, generally birth to age 5	$11-$74 (monthly benefit amount)	Restricted to specific food packages

*"With the **TANF**...**those programs aren't for everybody**, because if you've got a special needs kid at home...I don't really have the capacity to parent him and then turn around and go deal with other people for 20 hours a week."*
-Single mother of 3, part-time variable work, treatment group

*"I have to report SSI to everything... So if I get SSI, **it counts against us for any other social programs**...It [**EmPwR**] **was such a big help**...I wish it was something the state would implement, you know, just for-for every low-income [family]. **It would prevent a lot of things.**"*
-Mother of 2, treatment group

*"... they just **didn't offer it because maybe I don't qualify**...there are a lot of things they haven't offered me for that very reason. **It's a little more complicated.**"*
-Single mother of 6, control group

*"And the formula, if you get **WIC**, you **only get so much of that** and then you have to **buy some out of pocket**. So it was constantly trying to save up money to be able to afford formula because **you can't let your kid go hungry.**"*
-Mother of 4, control group

DISCUSSION

- Supports with more restrictions can be difficult to utilize due to strict eligibility requirements, documentation demands, and unstable access to benefits.
- In contrast, EmPwR's unconditional cash support allows families greater flexibility to meet immediate and individualized household needs.
- Findings suggest that flexible financial assistance may better support family stability and reduce barriers within the child welfare system.
- Future research should continue examining the long-term effects of unrestricted cash support on family well-being and child welfare outcomes.
- Results may help inform more flexible, family-centered child welfare services and financial assistance programs.

LIMITATIONS

- The EmPwR study is currently limited to families receiving intact services through two partner organizations in Illinois.
- TANF was not included in the baseline or 6-month surveys, limiting comparisons across all study time points.
- Findings are based on self-reported survey and interview data.

CONCLUSION

- Findings highlight the potential of unconditional cash support to reduce barriers associated with traditional assistance programs and support more family-centered approaches to financial assistance within the child welfare system.

Key Takeaways:

- Compared the accessibility of traditional assistance programs and EmPwR's unconditional cash support.
- Highlighted participants' experiences navigating child welfare and financial assistance programs.
- Demonstrated the potential of flexible financial supports to better address families' individualized needs.

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EmPwR

ILLINOIS

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