CAPD

FOSTER CARE AND EARLY CHILD DEVELOPMENT: IMPLICATIONS FOR CHILD WELFARE POLICY AND PRACTICE

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2002

INTRODUCTION

Foster children— by virtue of the fact that they are in foster care—must contend with challenges to healthy development that extend beyond the typical challenges presented to infants and children. Foster children have been faced with any of a number of risk factors including poverty, violence, abuse (emotional, physical, sexual) and neglect. Given that they are at greater risk compared to other children whose experiences have not resulted in them being placed in out-of-home care, it is important to identify the specific ways, if any, in which these children may have developmental experiences that are distinct from children who have not been maltreated. Such an understanding helps to identify specific developmental tasks or milestones that should be assessed and/or monitored on a regular basis for children in foster care.

In particular, our understanding of the processes by which the brain develops allows for an increased appreciation of the experiences that nurture positive development and the conditions under which development may be compromised. The most recent generation of brain research offers a more articulated understanding of the mechanisms through which atypical experiences are processed and incorporated into the organizational systems of the maturing brain. Accordingly, this research also offers a more articulated understanding of how experiences of abuse and neglect can influence the ways in which children behave, interpret and respond to the behavior of others. This understanding of critical developmental processes allows parents, professionals and policymakers the opportunity to promote and adopt practices within families, homes, communities and systems that increase the likelihood of positive, healthy early childhood development.

The purpose of this paper is to make a crosswalk between the most recent findings and recommendations on improving the foster care system with the most recent research on the effects of typical and atypical experiences on brain development. This presentation and subsequent analysis will help to identify the ways in which the atypical experiences of children in foster care can negatively influence their development as well as how the foster care experience itself can mitigate or aggravate developmental problems. In support of this goal, the paper draws on literature from a variety of domains including brain research, policy statements and recommendations of professional organizations (e.g., Child Welfare League of America, American Association of Pediatrics), research on developmental psychopathology, and research on the experiences of children in foster care (types of care settings, provision of services). The selected literature offers insights on the foster care experiences, the particular family and developmental experiences of children in foster care, and insights about intervention with

children in foster care. Accordingly, the remainder of this paper will be organized as follows:

- Normative factors associated with positive early child development;
- The intersection of foster care practice and developmental processes;
- Typical brain research: Towards an understanding of how the causes and experiences of out-of-home care can affect development;
- The effects of child abuse and neglect on development; and
- Recommendations for developing a system of supports for foster children to counter the effects of child abuse and neglect

II. NORMATIVE FACTORS ASSOCIATED WITH POSITIVE EARLY CHILD DEVELOPMENT

It is in the context of secure attachment relationships that children receive the physical contact and attention they need, are provided with food and shelter, learn to interact socially and develop expectations about their social interactions with others (Morrison, Frank, Holland & Kates, 1999), develop language skills (Amster, 1999) and are provided with safe opportunities to explore themselves and their environments (Olin, 1999). All such experiences are critical to positive, normative development (National Research Council and Institute of Medicine, 2000).

Parents and other caregivers serve as models of many behaviors including emotional expression and emotional regulation (Morrison, Frank, Holland & Kates, 2000). They help children make sense of themselves and their environments. In particular, they can help children make connections among emotional experiences and emotional expressions and label those experiences. These experiences lay the foundation for language development and emotional regulation.

Specific factors critical to a secure attachment between a child and caregiver include: quantity of time spent together, face-to-face interactions, eye contact, physical proximity, touch and other primary sensory experiences such as smell, sound and taste (Perry, 2001). Securely attached children experience consistent, responsive and supportive relationships to their mothers or primary caregivers even during times of significant stress.

As strategies for intervention are developed for children in foster care, analysis of current practice should be carried out with an understanding of the ways in which the foster care experience can support or hinder positive child development. For instance, when possible, placement decisions should take into account the fit between the respective temperaments of the children and prospective foster parents. While the temperament of a child may have a strong influence on the success of a placement, child's temperament alone is not the best predictor of a successful placement. The goodness of fit between the respective temperaments of the caregiver and child is a better predictor of successful placement. It is guaranteed that there will be a perfect fit between the temperaments of the birth parent and child. Nevertheless, after birth, the birth parent and child have the opportunity to develop their own ways of interacting and communicating based on their individual needs and temperaments (e.g., difficult/ feisty, easy, slow to warm up) (Morrison, Frank, Holland & Kates, 2000). The ways that they interact and communicate are influenced by environmental, social and genetic factors. However, the development of attachment relationships is changed in dramatic ways as a result of out-of-home placement.

By their very nature, out-of-home placements offer less time for the child and caregiver to become attuned to each other (Morrison, Frank, Holland & Kates, 2000). The caregiver has not had the chance to see the child's temperament

unfold gradually. Accordingly, the caregiver has less time to adjust the caregiving style to meet the child's needs. There is even a greater likelihood that the caregiver will misinterpret the child's behavior, because the caregiver and child do not have a shared history of social and emotional development.

If a child is in foster care, his or her ability to develop secure attachment relationships with primary caregivers has already been compromised. Children in foster care may have biological parents who struggle with substance abuse (associated with physical abuse and inconsistent care of the child), experience violence (associated with feelings of threat versus feelings of safety and comfort), and live at or below the poverty level (highly correlated with neglect of children). Such experiences can lead to out-of-home care and often lead to insecure attachment relationships. Insecurely attached children experience inconsistent, punishing, unresponsive emotions from their caregivers and feel threatened during times of stress. Many of the problems that lead to out-of-home placement also lead to insecure (i.e., disorganized/disoriented) attachment relationships. This insecure attachment, in turn, can affect the quality of relationships that foster children develop with caregivers and/or professionals (social workers, physicians, social service providers) while in foster care.

III. THE INTERSECTION OF FOSTER CARE PRACTICE AND DEVELOPMENTAL PROCESSES

Foster care incorporates a wide range of substitute living arrangements for children whose parents are unable to provide adequate care temporarily or permanently (VanBergeijk & McGowan, 1991). *Foster care* is a term commonly used to describe both family-based (relative and non-relative) and congregate care settings. Unlike other types of temporary substitute care for children, such as informal care by relatives or friends, formal foster care involves a change in legal custody and state sponsorship. Further, formal foster care is distinguished from adoption by the fact that adoption involves a permanent change of legal guardianship as well as custody.

Foster care includes a wide range of placement options including emergency shelter, diagnostic center, foster boarding home, kinship foster home, agency-operated boarding home, group home, group residence, child care institution and residential treatment center. [For descriptions see VanBergeijk & McGowan (1991)]. These options differ along a number of dimensions that can have an impact on child development including:

- Duration of out-of-home care (e.g., short-vs. long term);
- Kin versus non-kin care;
- Type of residence (e.g., group residence, family home, agency-operated neighborhood-based home);
- Number of children in residence;
- Support services provided (e.g., clinical evaluations, developmental assessments, educational, medical, recreational and social services); and
- Type of staff in setting (e.g., child care, social work, clinical, interdisciplinary staff).

The problem of developing secure attachments in foster care

Issues such as duration of out-of-home care, kin versus non-kin care and the number of children in residence have an impact on a child's ability to develop secure attachment relationships with caregivers. For instance, the fact that a child must be removed from his or her home often reflects discontinuity in the home, caregiver and community contexts in which a child lives and functions. Children need continuity, consistency, and predictability from their caregivers. [For an example of an effort to reduce discontinuity for children in foster care see Family to Family: Tools for Rebuilding Foster Care: Lessons Learned (AECF, 2001)]. Initiative, for example,

was developed in response to such issues. Accordingly, multiple placements are damaging. (Committee on Early Childhood, Adoption, and Dependent Care, 2000). Likewise, placement in non-kin care decreases the likelihood that there will be continuity in the home, caregiver and community contexts for the child. The number of children in residence may have an effect on the quantity and quality of time that a child spends with a primary caregiver; depending on the amount and quality of time that a caregiver can devote to any one child in the setting.

The problem of identifying and monitoring developmental problems within foster care

Even outside of contact with the foster care system, identifying and monitoring the effects of childhood trauma can be difficult. That is because there may not be a clear and comprehensive history of all the child's traumatic or atypical experiences that would allow for an appropriate diagnosis and treatment. To further complicate the issue, observed problems can be a function of both internal and innate child characteristics (i.e., age, gender) as well as external factors (i.e., previous history of traumatic exposure). Thus different constellations of factors can influence diagnosis and treatment (Perry, 2000):

- Individual adaptive responses can vary based on age, gender and previous trauma. For instance, young children and females may be more likely to dissociate;
- The nature of the traumatic experience can determine the response pattern. As implied in the prior example, dissociation may be more likely if a child does not perceive him or herself to have any control over or means of escape from the trauma;
- Traumatic events of the same nature may elicit different responses in the same child at different developmental periods based on the emerging abilities of the child; and
- Individuals have the adaptive capacity to "learn" from a single experience. They have the capacity to generalize from a single threatening event to other experiences with similar features. Such experiences can be re-experienced or elicited again by similar or associated experiences (Perry, 1999a).
- Individuals may actually experience and exhibit multiple disorders based on multiple experiences (e.g., post-traumatic stress disorder, attention deficit disorder, anxiety or mood disorder). Thus, the likelihood of misdiagnosis is increased (Perry, 1999b)

At the system level, factors such as the support services provided and the type of staff in setting have implications for identification and treatment of problems that may have an impact on a child's development (e.g., Schneiderman, Connors, Fribourg, Gries & Gonzales, 1998). Often the experiences that lead to children being placed in out-of-home care are the same types of experiences that negatively influence development. Yet experiences and processes associated with out-of-home placement often make it difficult to identify developmental problems, consistently monitor developmental problems, and ensure appropriate follow-up or treatment for developmental problems. There are a number of possible reasons. For instance:

- Some providers may work under policies that dictate that they not serve children in foster care without the consent of the biological parent. Thus, decreasing the likelihood of consistent care and monitoring for the child;
- Children may have different health insurance plans and providers based on the particular foster care settings and locations in which they are placed. Thus, there is a lack of continuity in health insurance coverage and care;
- There is insufficient communication among the different people involved in the care and monitoring of children in foster care; resulting in a lack of coordination and/or continuity of care;
- Caregivers and other social service providers

that are in contact with the children on a regular basis may not be adequately trained to identify potential developmental issues. Thus, problems that may compromise development may go unidentified; and

- There is insufficient awareness among caregivers and/or case workers around the resources and supports for children experiencing developmental problems. Thus, problems that may compromise development may go untreated [See Silver, DiLorenzo, Zukoski, Ross, Amster & Schlegel (1999) for further explanation of these problems].

The effect of *age* on the likelihood of experiencing continuity of care once placed in foster care

These issues of care and monitoring of children in foster care are further complicated by the age, race and/or ethnicity of children. For instance, a study of 3,873 children under six years of age found that age at time of placement and race/ethnicity had significant direct effects on outcomes (Barth, 1997). In particular, infant children who enter care are significantly less likely to return to their homes (41%) than toddlers (60%) or preschool children (62%). Among children who entered care as infants and do not return home, significantly more are adopted (32%) than remain in care (19%). Among children who entered care as toddlers and do not return home, more are adopted (18%) than remain in care (12%). Among children who entered care between the ages of three and five and do not return home, more are adopted (22%) than remain in care (8%). Thus, as they increase in age, children in foster care are less likely to return to their homes of origin, remain in contact with their biological parents, experience continuity of physical and mental health care.

The effect of *race and ethnicity* on the likelihood of experiencing continuity of care once placed in foster care

With respect to race and ethnicity, Barth (1997) also found that African American children are far less likely than Caucasian children to be reunified with their families. The decreased likelihood of adoption further reduces the possibility of permanency for African American children. African American children are more than twice as likely to remain in care (33%) as to be adopted. To the contrary, Caucasian children are twice as likely to be adopted (24%) as to remain in care (11%). Latino children are as likely to remain in out-of-home care (17%) as they are to be adopted (17%). Again, as the likelihood of both reunification or adoption decreases, the likelihood of experiencing continuity of physical and mental health care decreases.

These differences in child welfare outcomes based on race are probably a result of a confluence of factors. Racism has been offered as one of those factors. Racism in child welfare services can be manifested in three ways: the kinds of services developed, inequitable treatment based on race within the service delivery system and incomplete efforts to change the system (see Billingsley and Giovannoni, 1972). There is documented evidence of differential experiences of placement and receipt of social services for children of color. A review by Courtney, Barth, Berrick, Brooks, Needell and Park (1996) identified a number of research findings that indicate differential treatment based on race and ethnicity. For instance:

- Data from a comprehensive national survey of child welfare workers reported in 1978 and 1983 indicated that:
    - No services were offered for half the families with children in placement. Native Americans had the least chance of being recommended for services. Caucasians and Asian American families had the greatest chance for service recommendations;
    - oOne-third of children who had a family available for contact had no plan for regular family contact. African American and Latino children were the least likely to have plans for family contact;

- Latino children were less likely to receive day care services than other groups;

- As indicated in a 1982 study of New York City's out-of-home care system, African American and Latino children were less likely than Caucasians to be placed in agencies that had a high activity rates and relatively superior outcome records (regardless of entry-level characteristics);

- In a 1989 study of 1,003 African American children in out-of-home care in five major U.S. cities by the National Black Child Development Institute, researchers found that there were no records of a developmental or psychological assessment for 80% of the children although they had been classified as "healthy" in three out of four cases.

These examples suggest systematic differences in child welfare practice that lead to differential outcomes for children with respect to age, race and ethnicity. In particular, they suggest that children of color are less likely to experience permanency once they have been placed in out-of-home care. Being reunified with their families of origin does not guarantee that these children will receive necessary services and supports. However, the discontinuity of services (health, social services) and supports (formal and informal, social) decreases the likelihood that developmental problems, if any, will be identified as well as the likelihood that foster children will receive needed treatment and follow-up for developmental problems once identified.

IV. TYPICAL BRAIN DEVELOPMENT: TOWARD A BETTER UNDERSTANDING OF THE PROCESSES BY WHICH THE CAUSES AND EXPERIENCES OF OUT-OF-HOME CARE CAN AFFECT DEVELOPMENT

Drawing on other more comprehensive sources on brain development, this section of the paper is devoted to the process by which brain development takes place and is affected. Such an understanding gives insight into the process by which placement in foster care settings and the experiences that lead to placement in foster care can affect early child development. In fact, it has been offered that atypical experiences during early childhood offer special insight into critical periods and experiences that contribute to normal, positive development (Cicchetti, 1996). As researchers begin to isolate the impact of violence, abuse and neglect on areas and systems of the brain related to specific brain functions, there is greater insight into both the processes by which child development is affected as well as the type and nature of intervention necessary.

Normal brain development is a self-constructing, self-organizing phenomenon (Pollak, et al, 1998). That is, as it is stimulated by and responds to sight, smell, touch, and sound, the brain organizes and reorganizes itself to accommodate these experiences. Essentially, the brain organizes itself to make sense of and respond effectively and efficiently to its experiences, both typical and atypical. Some researchers describe brain development as use-dependent (Perry et al, 1998). In simple terms, the areas or systems of the brain that are used undergo further development into more complex areas and systems. For instance, there is rapid and abundant growth during the initial series of discrete developmental stages: Neural tube formation, cell proliferation, migration, aggregation, differentiation, axon out-growth, connection and synaptogenesis. Areas and systems that are not used regularly undergo regression and may even disappear. Such regressive events that can occur in subsequent stages include the selective death of as many as 50% of the neurons in some structures, followed by the selective elimination of a large proportion of axon projections and up to 50% of synapses in some regions (Pollak et al, 1998).

During any one of these stages, the emergence and selection of particular structures or functions (based on use) enable the construction of new structures or functions and the further shaping of those that had previously emerged. In terms of attachment, holding, gazing, smiling, kissing,

singing, laughing all cause specific neurochemical activities that lead to normal organization of brain systems responsible for attachment (Perry, 2001). Unlike a mature system, the developing neural network undergoes continuous, rapid, and profound global change from one of fewer elements, fewer interactions among elements, less stability, and less structural and functional differentiation to one of more elements. This process is key to understanding the pathways by which atypical experiences (e.g., exposure to violence, abuse or neglect) can affect development (Pollak et al, 1998; Courchesne, Chisum & Townsend, 1994).

V. THE EFFECTS OF CHILD ABUSE AND NEGLECT ON BRAIN DEVELOPMENT

As it relates to developing structures and functions, the brain does not distinguish between typical and atypical experiences. That is, the processes that guide and facilitate brain development remain the same whether stimulated by typical or atypical experiences. The extent to which a child experiences typical or atypical events will determine which areas and systems of the brain are further developed, over-developed or under-developed (e.g., DeBellis, Baum, Birmaher, Keshavan, Eccard, Boring, Jenkins & Ryan, 1999; DeBellis, Keshavan, Clark, Casey, Giedd, Boring, Frustaci, K & Ryan, 1999). For instance, research suggests that a child who experiences continued abuse will develop the ability to detect and respond to threat. If a child experiences an inordinate amount of violence or threats of violence, the child's brain will structure itself in ways that increase its ability to detect the threat of violence (i.e., anger, conflict). Accordingly, a child may develop abilities and behaviors that are appropriate for threatening situations yet inappropriate for more normative situations that require other abilities and behaviors (e.g., empathy, ability to accept, nurturing, etc.). Such experiences can have a negative impact on the successful development of other structures related to intellectual development and performance, relationships with adults and peers, etc.).

As Perry and his colleagues (Perry, Pollard, Blakeley, Baker & Vigliante, 1995) explain, a traumatized child may, over the course of time, exhibit motor hyperactivity, anxiety, behavioral impulsivity, sleep problems, tachycardia (an abnormally fast heartbeat), hypertension and a variety of neuroendocrine abnormalities. Essentially the child has become sensitized to the fear response. Consequently, daily stressors that would not normally warrant any response at all may now elicit exaggerated reactivity.

The use-dependent activation and organization just described is related to the fear response of arousal. Yet similar processes can take place related to other abilities or behaviors including dissociation—another typical response to fear among children. A fear response can be thought of as a "state"—a set of circumstances or attributes that characterize a person or thing at a given time. In the developing brain, these states organize neural systems that result in traits—enduring qualities or characteristics— through which subsequent experiences are filtered and which determine responses and behaviors. For instance, maltreated children use fewer emotion-specific language words. In particular, maltreated children make fewer references to physiological states and negative affect. Such difficulties are reflected later in relationships with peers (e.g., the ability to effectively communicate with and respond appropriately to the behavior of peers).

The specific effects of physical and sexual abuse

Negative early experiences can set children on a qualitatively different developmental trajectory than non-maltreated children. For instance, physically abused infants exhibit negative emotional expressions earlier and more frequently than do non-abused children (e.g., Pollak, Cicchetti, Klorman & Brumaghim, 1997). Abused children often have difficulty in

responding to distress, reacting with hostile gestures to other children. Research also suggests that maltreated children appear to respond differently to negative emotional cues and are primed to detect negative affect (e.g., Pollak, Klorman, Thatcher & Cicchetti, 2001). That is, maltreated children will detect emotions such as anger more quickly than children who have not been abused. However, research suggests that maltreated children are also less accurate at recognizing other emotions (e.g., Pollak, Cicchetti, Hornung & Reed, 2000). For example, maltreated children may be so primed to detect negative emotions such as anger that they may wrongly attribute anger to other expressions of emotion.

In their review of research on the developmental impact of abuse and neglect on children, Trickett and McBride-Chang (1995) found limited evidence about the physical and motor development of abused and neglected infants and young children. The research had not been systematic or conclusive. Nevertheless, there is evidence of somatic complaints among sexually abused preschoolers and one study found delays related to physical/motor development among infants.

With respect to social and emotional development, Trickett and McBride-Chang (1995) found that there is consistency in the research on attachment relationships of infants and young children. In particular, maltreated children experience insecure, disorganized/disoriented attachment relationships. As would be expected based on attachment theory, such children also experience disturbed peer relationships when they are older in the form of heightened aggression, inappropriate anger and low prosocial behavior. Their review also suggests that there is a relationship between sexual abuse and internalizing problems as opposed to externalizing problems. However, physically abused and mixed maltreatment groups show both internalizing and externalizing problems. Additionally, sexually abused young children display inappropriate sexual behavior.

Although a consistent, warm, sensitive parent-child relationship is believed to provide the optimal context for language learning, the quality of mother-child attachment does not necessarily predict differences in language development among low-risk infant mother pairs (Amster, 2000). Apparently, mothering in low-risk situations is “good enough” for normative language development even when there is not a secure attachment. However, in high-risk infant-mother pairs (i.e., involving children who have been maltreated), the quality of attachment does play a role in language development. Compared to low-risk pairs, high-risk pairs show less playfulness, reciprocity and verbal interaction.

Maltreated children can exhibit disorders of attachment, mood and behavior. These disorders are often related to language development (Morrison, Frank, Holland & Kates, 2000). For instance, their language development can be so affected by maltreatment that they are not able to use their internal state languages to label and convey their needs or use pretend play to represent their experiences in a meaningful way. Furthermore, children who have difficulty understanding and expressing themselves can become frustrated and are at greater risk of developing behavior disorders.

With respect to cognitive and academic development, Trickett and McBride-Chang (1995) found consistent evidence that physically abused, neglected and mixed maltreated infants and young children show developmental delays cognitively as well as poor early academic progress. The findings on the effects of sexual and physical abuse, in particular, are reported in the Table 1 below.

Table 1:
Findings for research on the impact of abuse and neglect in infancy and early childhood

(I-Infancy, T=Toddlerhood, EC=Early Childhood)

	Physical/motor	Social/emotional	Cognitive/academic
Sexual abuse	Eneuresis (esp. girls) Somatic complaints (esp. boys) (T & EC)	Inappropriate sexual behavior (T & EC) Internalizing problems—anxiety, social withdrawal (EC)	Developmental delays—girls (T & EC)
Physical abuse	No difference in gross or fine motor coordination (EC) No elevated somatic complaints (EC)	Insecure attachment (I) Aggressive, noncompliant, demanding (esp. boys) Withdrawn and wary (esp. girls) Poor social problem solving, less prosocial with peers (EC)	Low cognitive maturity (EC)
Neglect		Peer problems, withdrawn, less prosocial behavior, lack of affect in interaction with peers (EC) Insecure attachment	Developmental delays (I, T & EC) More delayed in language skills than abused (EC)
Mixed maltreatment	Delayed motor development (I) Lower physical competence (mother & teacher ratings) (EC)	Insecure attachment, esp. disorganized/ disoriented (I) Disturbed peer relationships, including heightened verbal and physical aggression, inappropriate anger and hostility, less prosocial behavior, avoidance of interaction, poor social problem solving (EC) No difference in ability to discriminate emotions if IQ controlled	Low Bayley Scores for mental and motor development (I) Low readiness to learn (low cognitive maturity, ability to follow directions, greater dependency, less novelty seeking) (EC) Lower IQ

From Trickett and McBride-Chang (1995)

The specific effects of neglect on development

There is global neglect and chaotic neglect (Perry & Pollard, 1997). Global neglect is indicated when there is a history of relative sensory deprivation in more than one domain (e.g., minimal exposure to language, touch and social interactions). Chaotic neglect— which is far more common—is indicated if there is a history consistent with neglect in at least one domain (i.e., physical, emotional, social or cognitive) at some point or points in time. The impact of neglect on brain development is distinguished from child abuse in that it is related to a lack of attention and sensory stimulation versus negative attention and sensory stimulation.

Children who have experienced neglect only have not been found to display externalizing behavior (Trickett & McBride-Chang, 1995). Neglected children have more significant developmental delays compared with abused and non-maltreated children. For instance, at ages 12, 18, 24 and 36 months, the children who received inadequate psychological care scored lower on measures of IQ than those with adequate psychological care. Furthermore, children who receive inadequate physical or psychological care demonstrate less ability to engage in age-appropriate play at 36 months. During early childhood, in particular, there are significant delays in language skills (compared to abused children) and problems with peers related to neglected children being withdrawn, exhibiting less prosocial behavior, and lack of affect in interaction with peers.

Given our understanding of brain development, the experiences observed among neglected children are probably a reflection of areas and systems of the brain that are under-developed as a result of lack of attention and sensory stimulation. For instance, Perry and Pollard (1997) report that children who have experienced global neglect in the first three years of life experience altered brain growth (i.e., the brain is significantly smaller in size). While the actual size of the brain in chaotically neglected children did not appear to be different from the norms, Perry and Pollard hypothesize that organizational abnormalities exist. Gaudin (1999) reports that older school age victims of neglect experience cognitive deficits that impair their development. Such negative developmental effects have been found to be greater and more enduring for neglect than for any other type of maltreatment (Gaudin, 1999; Trickett & McBride-Chang, 1995).

This is not to say that some forms of abuse cannot be just as detrimental as neglect. Rather, the mechanisms by which child abuse and neglect affect development are different. Accordingly, they may require different types of intervention. For instance, in extreme instances of global neglect, the issue is the under-development of certain areas of the brain as a result of a lack of attention or stimulation. However, in extreme cases of child abuse, the issue is the over-development of certain areas of the brain related to responses to threat and trauma. Accordingly, as opposed to child abuse interventions that may include cognitive therapies to help children to better understand their own thought processes and behaviors (i.e., inappropriate responses in neutral or non-threatening situations), interventions for neglect may include a variety of strategies focused on cognitive stimulation and intensive remediation to stimulate brain growth and functioning.

VI. A SYSTEM OF SUPPORTS TO COUNTER THE EFFECTS OF CHILD ABUSE AND NEGLECT: POLICY AND PRACTICE RECOMMENDATIONS

The current findings of research on the effects of abuse and neglect on early childhood development suggest that foster care policy and practice should explicitly include practices that allow for the ongoing monitoring of a child's developmental progress from a variety of sources including parents, other caregivers, case workers, medical and mental health professionals. The research findings suggest that foster children experiencing developmental delays may exhibit such delays in ways that are

more readily identified as behavior problems rather than as developmental delays. When a developmental problem is not identified correctly and in a timely manner, there is a great chance that development will be further delayed—as the child fails to meet other critical developmental milestones. For instance, ongoing conflicts with peers may be evidence of underdeveloped social cognitive skills. However, the presenting behavior may be treated solely as a disciplinary problem when it really required cognitive intervention based on an understanding of the child's perceptions of threat or motives of others in nonthreatening situations. The various people who raise or otherwise work with or on behalf of children in foster care may recognize problem behavior. Yet they may not understand the developmental implications of the behavior. Thus, there should be training for parents, caregivers and others who come in contact with these children so they can better recognize and monitor development.

The delivery of health and mental health care services to children in family foster care

Even when they are obviously problematic, the behaviors and abilities of children in foster care can still go untreated. Even when the need is recognized, there are potential barriers to children receiving the support necessary for intervention around problems that may compromise development. Accordingly the Child Welfare League of America (CWLA) and AAP, in collaboration, have offered recommendations for the delivery of health and mental health care services to children in family foster care after welfare and health care reform (Simms, M., Freundlich, M., Battistelli, E. S. and Kaufman, N. D., 1999). They suggest that, regardless of the financing mechanisms or organizational structures that are put in place, any system of health care for children in foster care should have the following attributes:

- Comprehensive services with clearly stated standards of care (e.g., CWLA and/or AAP);
- Portable benefits while the child remains in out-of-home care;
- Presumptive eligibility for Medicaid upon removal of the child from the home, regardless of the biological parent's eligibility status;
- Continuous eligibility for a minimum of 12 months and—in an efforts to ensure that treatment and rehabilitative services can continue after placement—extension of eligibility for another 12 months after the child has left the out-of-home care system;
- Social service case coordination and case management services;
- Incentives to encourage participation by health care providers; and
- A local and state governance system that clearly identifies who is responsible for the implementation and enforcement of the standards, procedures, and guidelines.

CWLA and AAP further suggest that the system should work in urban and rural areas with and without managed care plans and with or without a large supply of primary or specialty providers. Additionally, a statewide data system should be established to support the monitoring and follow-up of developmental issues for children in foster care. These suggestions reflect a concern for the continuity of care while a child is in out-ofhome care.

Health coverage for children in foster care

Additionally, specialized developmental and mental health services should be designed for young children in foster care based on current knowledge of the particular developmental challenges and delays encountered by children involved in the child welfare system (Dicker, Gordon & Knitzer, 2001). In particular the American Academy of Pediatrics and the Child Welfare League of America suggest best

practice standards (Committee on Early Childhood, Adoption and Dependent Care, 1994). Among other things, they suggest that:

- Children in foster care should receive a package of health care services including preventive health care, care for acute and chronic illness, developmental and mental health screening and services if indicated, dental car, ongoing evaluation for child abuse and neglect, and referrals to early intervention and early childhood programs;
- One person should be responsible for overseeing the child's care and sharing information about a child's needs across systems including child welfare, early childhood, early intervention, education, medical and mental health;
- Records of a child's health history, services, and health insurance coverage should accompany a child as he or she enters care, changes placement and is discharged from placement; and
- Information about a child's health should be shared with the child's caregivers.

To complement these assessments and services, there should be:

- Monitoring and tracking mechanisms to ensure that needed health, developmental and mental health services are provided [see Dicker, Gordon & Knitzer (2001) for examples]; and
- Oversight authority by the courts to ensure that children in foster care receive needed health, developmental and mental health services as a part of permanency planning [see Dicker, Gordon & Knitzer (2001) for examples].

Comprehensive and periodic assessment for young children in foster care

Decisions about placement, custody and long-term planning should be based, in part, on comprehensive assessments and periodic reassessments of children and families by professionals in pediatrics and child development (e.g., pediatrician, psychiatrist, or psychologist) (Committee on Early Childhood, Adoption, and Dependent Care, 2000). Ongoing relationships between pediatricians, children in foster care and their families can provide valuable insights about children's needs and the ability of a family to meet them. In their policy brief on developmental issues for young children in foster care, the American Academy of Pediatrics (AAP) suggests that pediatricians can play a critical role in supporting the healthy development of children in foster care. In particular they suggest that:

- Pediatricians can play a constructive role in the referral, assessment, and treatment of children who are at risk for being abused, neglected, or abandoned or who are involved in the protective services system.
- Pediatricians need to encourage caregivers to:
    - give the child plenty of love and attention.
    - be consistent with love, stimulation, and discipline.
    - stimulate the child through exposure to developmentally appropriate holding, conversation, reading, music, and toys.
    - expose the child to opportunities to improve language via direct voice and face-to-face contact.
    - match the environment to the child's disposition.

With respect to foster care policy and practice, AAP suggests that

- Parents should be given reasonable assistance and opportunity to maintain their family, while the present and future best

interests of the child should determine what is appropriate.

- A child's attachment history and sense of time should guide the pace of decision-making.
- Foster care placements should always maximize the healing aspects of foster care and be based on the needs of the child.
- Foster care placement with relatives should be based on a careful assessment of the needs of the child and of the ability of the kinship care to meet those needs. As with all foster care placements, kinship care must be supported and supervised adequately.

All these recommendations are based on the assumptions that there needs to be better and more coordinated communication and interaction among all those involved in the care and monitoring of children in foster care. To that end, the needs of foster care systems are not much different from that of other large systems. Accordingly, they are subject to the same barriers faced by other large systems including:

The difficulty in coordinating the policies and practices of the different components and departments within loosely coordinated systems;

The differences in technology employed by the different components and departments within loosely coordinated systems; and

The increased costs associated with establishing and maintaining the appropriate infrastructure to coordinate a stronger system of care and monitoring.

Nevertheless, these recommendations serve to establish a common point of reference for systems that can lay the foundation for coordinated reform.

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