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Poverty, Child Maltreatment, and Foster Care

Teena M. McGuinness and Kristina Schneider

*Child maltreatment occurs at significantly higher rates among those living in poverty. Children in foster care usually come to the attention of child welfare officials because they are neglected by parents who struggle with conditions associated with poverty: homelessness, history of incarceration, HIV seropositivity, and substance abuse. This article reports the disadvantages experienced by young children in foster care (aged 36 months and younger) via a study of records documenting the multiple risks to their health and development. Low birth weight, prenatal substance exposure, and prematurity were commonly encountered risks. Additionally, the child welfare agency had a low rate of documented screening for early intervention (11% of records surveyed) despite multiple risks and mandates for screening. Implications for nurses are offered. *J Am Psychiatr Nurses Assoc*, 2007; 13(5), 296-303. DOI: 10.1177/1078390307308421*

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The cumulative prevalence of psychiatric disorders is 36% by age 16 in American children (Costello, Mustillo, Erkanli, Keeler, & Angold, 2003). Unfortunately, some indicators suggest that the mental health of U.S. children will grow worse: Even as our country's wealth has increased, overall access to mental health care has decreased, and the few existing services for children have declined to a disproportionately greater degree. This sad picture is complicated by the pressures of managed care to be cost effective and legal mandates that require reports concerning children at risk (Silva, Bath, Beer, Minami, & Engel, 2007).

MENTAL DISORDERS IN YOUTH

Mental disorders in children are common. By puberty, 13% of children suffer from psychiatric disorders (Maughan, Iervolino, & Collishaw, 2005). Eight percent of U.S. children younger than 13 years suffer from depression; the proportion of youth with depression increases to 15% by mid-adolescence (Gollan & Pane, 2006; Ramchandani, 2004). Nearly

9% of American children are treated for attentional deficits (Olfson, Gameroff, Marcus, & Jensen, 2003). Twenty percent of youth give serious contemplation to suicide each year, and there has been a marked increase in completed suicides in most industrialized nations during the past 25 years (Maughan et al., 2005). A recent estimate of the prevalence of autistic spectrum disorders found a rate of 116 per 10,000 (Baird et al., 2006), reflecting a 20-fold increase since the early 1980s (Kurita, 2006). The cause or causes of this increase in mental disorders remains unclear. Whether it results from better assessment methods, changing diagnostic criteria, or as yet unidentified factors continues to be a subject for debate (Merrick, Kandel, & Morad, 2004).

Fortunately, there is some mixed good news: On the positive side, the significant economic growth of the 1990s resulted in improvement in material well-being for children. From 1990 to 2000, 8 of 11 material and demographic indicators of child well-being measured improved; these include indicators such as living in poverty, dwelling in a household whose head did not complete high school, and living in a single-parent family (Annie E. Casey Foundation, 2002).

Other news, however, is troubling. Child maltreatment, which is tied to poverty (Drake & Zuravin, 1998), has increased, perhaps because, as the U.S. Census Bureau documented, there has been a continuous rise in the poverty rate at the beginning of the

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21st century (Denavas-Walt, Proctor, & Lee, 2005). In 2000, the poverty rate was 11.3%; by 2004, the rate climbed to 12.7% (Denavas-Walt et al., 2005). More so, the proportion of children who live in severe poverty is also increasing, a trend that will have broad social and health implications (Woolf, Johnson, & Geiger, 2006). Woolf and colleagues warned that the effect of poverty on children “warrants special concern” (p. 332). Indeed, the percentage of children living in poverty rose from 15.7% in 2000 (11.1 million children) to 17.8% in 2004 (13 million children; Dalaker, 2001; Denavas-Walt et al., 2005).

POVERTY AND CHILD MALTREATMENT

There is a large body of literature demonstrating a link between poverty and child abuse and neglect in general. Drake and Zuravin (1998, p. 295) produced a meta-analysis of the issue and concluded that child maltreatment was not evenly dispersed across the socioeconomic spectrum in the United States:

The evidence suggests high levels of child abuse and neglect among the poor and, despite debate on the question, there is no body of empirical data suggesting that the findings are a product of bias predisposing toward overestimates of child maltreatment among the poor.

Several mechanisms have been offered in an attempt to explain the link between poverty and child maltreatment. One mechanism suggests that parents with low socioeconomic status (SES) may be more likely to maltreat their children because they possess fewer resources enabling them to provide adequate levels of care, such as access to health care and basic necessities such as shelter, food, and clothing (Berger, 2004; Rosenfeld et al., 1997). Rutter (2003) proposed that poverty may constitute a distal risk factor for child maltreatment and makes good parenting more difficult. Another proposed mechanism holds that poverty and low SES are factors likely associated with higher overall levels of stress, which result in harsher parenting (Waldfoegel, 2000). Additionally, poverty at the individual and community levels is associated with recurrent child abuse (Drake, Jonson-Reid, Way, & Chung, 2002; Kruttschnitt, McLeod, & Dornfeld, 1994).

Alleviation of poverty (a) decreases the number of one-parent families, (b) increases employment, and (c) enables parents to spend more time with children. Nevertheless, despite three decades of attempts to alleviate poverty in the United States, rates of

child abuse and neglect have continued to grow (McSherry, 2007).

Children in foster care as a group are especially vulnerable to poverty. Of any group of children in the United States, children in foster care have disproportionately experienced the effects of poverty. Each year in America, approximately 550,000 children will spend some portion of the year in out-of-home care (Wulczyn, Barth, Yuan, Harden, & Landsverk, 2005). These children usually come to the attention of child welfare authorities because they are neglected by parents who are battling some combination of poverty, substance abuse, and/or mental illness (Wulczyn et al., 2005). Many children who are entering foster care have already spent their sensitive developmental periods in poverty and have been abused or neglected, resulting in developmental delays, learning disabilities, and compromised brain development (Stahmer et al., 2005; Teicher, Tomoda, & Andersen, 2006).

Conditions associated with removal from parental custody are also conditions associated with poverty: homelessness, history of incarceration, HIV seropositivity, and substance abuse (Lindsey, 1991; Nair, Schuler, Black, Kettinger, & Harrington, 2003). Indeed, low family income is the best predictor of a child's placement into foster care (Lindsey, 1991). This finding has stood the test of time: In 2006, Barth, Wildfire, and Green found that more than half of the children in foster care and a third of the children who receive in-home services are identified by their case workers as having birth families who have difficulty meeting their basic needs at the time of the investigation. Of the families who do not live below poverty level, many suffer financial hardship, as the majority live below 150% of the poverty level (Barth et al., 2006).

Two large studies of child welfare have noted the link between poverty, maltreatment, and neglect. The National Incidence Studies of Child Abuse and Neglect have found that child neglect is 22 times more likely if family income is less than \$15,000 as compared to in families with an income of more than \$30,000 (Sedlak & Broadhurst, 1996). Another system of reporting abuse and neglect (the National Child Abuse and Neglect Data System [NCANDS]) has highlighted the linkage between abuse and neglect of children and its relationship with poverty. Especially in urban populations, family poverty is the strongest predictor of repeat maltreatment (Connell, Bergeron, Katz, Saunders, & Tebes, 2007).

Although child welfare services are driven by state legal systems, they are the de facto mental health care systems for abused and neglected

children. Between 23% and 61% of children in foster care who are younger than 5 years of age are significantly delayed when screened for developmental problems, compared to 10% in the general population (Stahmmer et al., 2005).

In most states, the child welfare system includes child protection services as well as placement services such as foster care, kinship care, and adoption. States define maltreatment by laws and regulations; various statutes prescribe the steps that the agencies must follow once a neglect or abuse report has been filed. Carefully defined terms such as *substantiated*, *founded*, or *indicated* mean that an affirmative finding of child abuse was found (Wulczyn et al., 2005).

MALTREATMENT TYPES AND DEFINITIONS

Four major domains of maltreatment exist: physical abuse, sexual abuse, neglect, and a fourth category, emotional abuse and other types of abuse (Wulczyn et al., 2005).

The most frequent type of maltreatment is neglect, which occurs in approximately 57% of all child case reports (U.S. Department of Health and Human Services, 2003). Neglect is defined as the failure to provide needed, age-appropriate care; additionally, neglect refers to failure to provide food, shelter, supervision, and medical attention. The present rate of neglect in the United States is about 7.4 victims per 1,000 children; this is an increase from the previous 2 years (U.S. Department of Health and Human Services, 2003). But as early as 1981, Polansky, Chalmers, Bittenweiser, and Williams observed, "One would have to be recently arrived from Mars not to think that family income affects the likelihood of child neglect" (p. 22). Despite the common occurrence of neglect, it seems that the topic of neglect has been neglected (McSherry, 2007). Although neglect has a higher incidence rate than abuse, it has been studied much less than abuse and is poorly understood. The problem may be definitional: In the United States, there is no standard definition for neglect, and neglect is defined differently in various states (McSherry, 2007). Additionally, there are differences in the way child welfare authorities define neglect as compared to lay communities' definition of neglect. Different cultures may also have varying definitions of neglect (McSherry, 2007). Establishing a minimal level of care is often in the eye of the beholder. Furthermore, neglect and poverty are intertwined, and the poorest of the poor have the highest rates of neglect (McSherry, 2007). However, a complex relationship exists between poverty and neglect, and this relationship still needs elucidation.

Physical abuse, the second-largest domain of child maltreatment, is defined as the act of causing physical injury, ranging from excessive discipline to beatings and scaldings. Approximately 3.5 victims per 1,000 children sustain physical abuse (Wulczyn et al., 2005).

Sexual abuse refers to sexual acts that provide gratification to the perpetrator; molestation, prostitution, pornography, incest, and sexual exploitation of minors are included in this domain. The rate of substantiated sexual abuse is approximately 1.7 per 1,000 children (Wulczyn et al., 2005).

Sadly, the fourth category of abuse (emotional and other types of abuse and neglect) may not be immediately obvious. Emotional abuse involves extreme thwarting of children's emotional needs, including safety, security, acceptance, and autonomy; witnessing family violence or attempted suicide are examples as well (Barnett, Manly, & Cicchetti, 1993). Educational neglect (De Bellis, 2005) and prenatal exposure to drugs (Doris, Meguid, Thomas, Blatt, & Eckenrode, 2006) are common occurrences among children known to child welfare, both representing significant threats to mental health and later independent living as adults. Yet, the reporting mechanisms for these specific types of maltreatment are quite inconsistent among U.S. states.

PRENATAL SUBSTANCE EXPOSURE

Prenatal substance exposure, defined as exposure to alcohol, tobacco, or illicit drugs during some portion of pregnancy, poses both short- and long-term risks to human development (Floyd, O'Connor, Bertrand, & Sokol, 2006). The earliest investigations of prenatal exposures focused on fetal alcohol syndrome (FAS; Streissguth, 1997). Fetal alcohol syndrome consists of a constellation of findings including profound neurobehavioral disabilities, lower intelligence, impairment in memory and judgment, and attention deficits (Rasmussen, Horne, & Witol, 2006).

Fetal alcohol spectrum disorder (FASD) is a newer term coined to describe a subgroup of children subjected to prenatal alcohol exposure (Caley, Shipkey, Winkelman, Dunlap, & Rivera, 2006). Although not a clinical diagnosis and not as severe as FAS, FASD is indicative of the lifelong implications for a person whose mother drinks while pregnant; FASD is the leading known cause of preventable mental retardation in Western civilization (Caley et al. 2006; Floyd et al., 2006).

The 1980s media coverage of crack (a cheaper form of cocaine) offered some sensationalistic and ominous predictions about "crack babies" (Richardson, Conroy,

& Day, 1996). Fortunately, long-term, well-controlled studies found that the effect of prenatal cocaine exposure was, thankfully, not as dire as originally predicted (Leech, Richardson, Goldschmidt, & Day, 1999; Richardson et al., 1996). Indeed, these children have exhibited a spectrum of difficulties with widely varying outcomes (Lester, LaGasse, & Seifer, 1998). Nevertheless, although the effects might be subtle, there is still risk associated with prenatal cocaine use, and screening for early interventions should be a routine process for children with prenatal substance exposure of all types (Schiller & Allen, 2005).

OTHER RISKS TO THE HEALTH OF FOSTER CHILDREN

In addition to the increased risks for psychiatric and developmental disorders, children in foster care are more likely to suffer from physical problems. These children interact with the health care system on an irregular basis, and basic services such as immunizations are often ignored. In one large study of three states, 12% of foster children had not received routine health care, 34% had not been fully immunized for their age, and only 10% of the children had been evaluated for developmental delays (General Accounting Office, 1995). Alarming, the study further reported that although more than half of the children in the sample were at risk for HIV infection, only 10% had actually been tested (General Accounting Office, 1995).

INFANTS AND TODDLERS ARE ESPECIALLY VULNERABLE

Infants from impoverished backgrounds experience a 2.7-times greater risk of maltreatment (Wulczyn et al., 2005). Because children in infancy are significantly more likely to have experienced maltreatment than any other age, a proposal in the 2004 Child Abuse Prevention and Treatment Act (PL 108-36; CAPTA) suggested that early intervention services for infants and young children would help to mitigate the negative effects of maltreatment. CAPTA is the federal law governing child protective services programs in the United States (Leslie et al., 2005).

The CAPTA legislation stipulates that early intervention screening be made available to all children in out-of-home care via the Program for Infants and Toddlers with Disabilities. The Program for Infants and Toddlers with Disabilities, a component of Part C of IDEA (Individuals with Disabilities Education

Improvement Act), is a federal grant program intended to assist states with comprehensive programs of early intervention services for infants and toddlers with disabilities. Unfortunately, agencies involved in case management focus on safety issues rather than the important link between safety, health, and permanency (limiting time in foster care to prevent foster care "drift"). This lack of attention to the health and developmental status of these children compromises age-appropriate developmental status (Leslie et al., 2005).

Eligibility for early intervention services is granted if the child carries a diagnosis of a condition that will likely result in developmental delay. Services offered under the purview of early intervention include audiologic services, health services, occupational and physical therapy, psychological services, speech and language therapy, and vision services, to name a few. If a child is found to be eligible for early intervention, an individualized family service plan (IFSP) will be initiated for the child's family. The IFSP is intended to serve as a road map for the necessary early intervention services (Leslie et al., 2005).

Regrettably, there is rarely a central database or registry indicating the number of children receiving or eligible for early intervention. Thus, in one county in the southern United States, a psychiatric nursing professor involved in community service with child welfare and an undergraduate nursing honors student undertook a project to review the files of children 3 years of age and younger to determine how many children were receiving early intervention services.

PURPOSE AND METHOD OF THE STUDY

Institutional review board permission for the study was sought, and exempt status was granted. The purpose of the study was to determine (via screening of child welfare records) the extent to which eligible children who reside in foster care or in-home care who were ages birth to 36 months had been screened for early intervention services, and of those children who had been screened, what services they had actually received. The services included audiologic assessment, occupational and physical therapy, psychological services, speech and language therapy, as well as vision screening. Background variables regarding risks to developmental status, such as birth weight, known prenatal exposure to substances, and birth mother health, were also collected. Foster care and in-home division managers via the child welfare agency determined which cases involved children ages 3 and younger. The primary

investigator and undergraduate research assistant signed confidentiality forms provided by the child welfare agency. The researchers reviewed all case files in an office of a child welfare supervisor who was present for review of the files. No identifying information was extracted from the records.

Subjects

At the time of the study in July 2005, the number of children of all ages (newborns to age 18) who were receiving services from county child welfare authorities was 641. The county population was approximately 375,000 and comprised both urban and rural areas in its 1,200 square miles. The number of children 36 months of age and younger known to the child welfare agency at the time of the study was 75. These 75 cases formed the convenience sample that was the basis for this study. The 75 young children represented 11.7% of children who were active cases at the time of the study.

There were 43 girls and 32 boys. Thirty-one children were White, 38 were African American, and 3 were biracial (3 others had missing data for race). With respect to the larger group, which was composed of all active cases, the percentage of African American children was 56%, and the percentage of White children was 43%. There was no biracial category in the profile of children in care. Ages ranged from 2 months to 35 months. Only 34 out of 75 files had recorded birth weights. Of the birth weights available, the average birth weight for the 34 children was 5 pounds. Seventeen children had documented histories of prematurity.

Thirty-six children had documented histories of prenatal substance exposure. The most common substance was cocaine (17), with alcohol (7) and marijuana (6) composing the second- and third-highest number of exposures. Eight children had dual prenatal substance exposure; alcohol and cocaine was the most common dual exposure. One child had Down syndrome.

Birth mother health was sometimes compromised: One mother had pelvic inflammatory disease, two had sexually transmitted diseases at the time of delivery, two had hepatitis C, and two were HIV positive. Three mothers had histories of bipolar disorder, and one had attempted suicide shortly after her child was born. Four birth mothers had IQs of 68 or less. Three birth mothers were incarcerated.

With respect to whether children had been screened for early intervention services, 67 files (89%) had no record of the screening process. Eight children

(11%) received early intervention services, including speech therapy (2), physical therapy (3), and occupational therapy (2); two categories were missing. Of the eight receiving services, one child received two types of services (speech therapy and occupational therapy), whereas five other children received one type of early intervention each. The two additional children had been screened for early intervention services; however, there was no documentation in the chart at the time of the study as to the type of service that would be received (if any).

DISCUSSION

The children in our study faced many risks to their development. Prenatal substance exposure was common in our study (36 out of 75 files had documentation of some form of prenatal substance exposure). It is also common in foster care populations in general (Smith, Johnson, Pears, Fisher, & DeGarmo, 2007). Although difficult to disaggregate from the many risks that foster children face, those with prenatal substance exposure may be challenged with a combination of attention problems, motor control, and perceptual defects, even when they are raised with adequate care after birth (Slinning, 2004). Indeed, prenatal substance exposure is now believed to increase the risk for child maltreatment and predict an increased number of foster care placement transitions (Smith et al., 2007).

Maternal mental and physical health was compromised for some of the children in the sample. Poor mental and physical health is often comorbid with substance use disorders; poor maternal mental health is a risk to child mental health (Steinhausen, Mas, Ledermann, & Metzke, 2006). Prematurity also accompanies prenatal substance use (Sokol et al., 2007). Of the 17 children who were premature, 15 had birth mothers with documented histories of substance use while pregnant.

Clearly, young children in foster care are a vulnerable group by many definitions. Our study supported the presence of many risk factors, such as prematurity, poor material health, maternal mental disorder, maltreatment, and prenatal substance exposure, that set the stage for developmental delay. Additionally, the county child welfare system did not consider screening for early intervention as a priority (based on the paucity of children with documented screenings), despite the magnitude of need. The system designed to protect and care for maltreated children lags behind in promoting the well-being of its children. In view of the great extent of risks, what can nurses do to help children in foster care?

Implications for Practice

Schneiderman has described a public health nursing role in California in assisting children known to child welfare agencies (Schneiderman, 2006). This federally and state funded program employs nurses as an integral part of the team to coordinate health care between the child welfare system and health care providers. The foster care nurse role evolved as a result of the increased recognition of the multiple health and developmental issues seen in child welfare and the lack of timeliness in addressing these problems. Uncoordinated health care plagues many child welfare systems (General Accounting Office, 1995), and this situation has persisted (Stahmer et al., 2005). The nursing role described by Schneiderman (2006) involves reviewing and assessing health needs and following through with recommendations to assess these needs. Inherent to this type of coordination of care is developmental assessment; indeed, this program began with funding from the federally mandated EPSDT (Early Periodic Screening, Diagnosis, and Treatment) program (Schneiderman, 2006). These foster care nurses are forging a powerful new thrust to ensure the health of children.

Indeed, what is needed for children served by child welfare in all counties is a comprehensive continuum of care. This type of system has been described as necessary for older disadvantaged youths in foster care to provide the least restrictive environments for shorter periods of time and fewer placement changes (McKee, Storrs, & Humphrey, 2007). Such an array of services would help to prevent lawsuits against child welfare agencies, which have been brought in several states on behalf of children because of lack of services (Vaughn, Pumariega, & Klaehn, 2003). Such lawsuits result in consent decrees in which the state proposes to improve its services to children based on important principles: (a) Child and family needs drive services, and the services arise from a strengths-based perspective; (b) services are community based, and existing agencies collaborate with one another; and (c) services are delivered in a culturally competent manner (Center for Mental Health Services, 1997). A system with care based on these principles is considered a best-practice standard for children and their families who are living with complex mental health needs.

Psychiatric nurses, by virtue of their education and skills, can advocate for services and policies that will ensure an improvement in child welfare services. One way to act locally is to volunteer on a county quality assurance committee for foster care.

Quality assurance committees have been instituted in many states to work side by side with child welfare case managers in an effort to improve foster care. Typically, these committees exist to improve the performance of the child protection agency. In most states, these quality assurance committees include citizens with an interest in the welfare of foster children and who are willing to invest several hours a month on behalf of the children. The duties of committee members include home visits to evaluate the appropriateness of services rendered, case reviews for oversight of the approaches being offered to the child, and general oversight of the program. Psychiatric nurses make excellent quality assurance committee members and can forge a leadership role on behalf of these children.

There are limitations to our study: The sample was drawn from one county, and although it included all of the cases in the county at that time, the results cannot be generalized beyond the sample. Furthermore, there were many missing data with respect to birth weights. (Interestingly, neither state nor county child welfare authorities collect cohort data on birth weight; indeed, the state birth certificates do not require birth weights as data for birth certificates.)

Valuing the lives of children in foster care means understanding the disadvantages these children have faced and increasing awareness of their plight. Psychiatric nurses are strategically placed to make a difference in their lives. Both our personal and our collective actions will benefit children in foster care.

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