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December 2017

In This Issue

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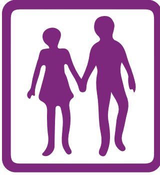
The American Professional Society on the Abuse of Children
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Vol. 29 | No. 2

page 3 **Current Challenges in Addressing the Realities of Poverty and Inequality in Families With Young Children: A Call for Both Policy and Intervention** | *Cary M. Cain and Bethanie S.Van Horne*

This article discusses poverty and inequality in the contexts of both the home and early educational environments, demonstrates the promising results and inherent challenges of early intervention programs, and highlights the need for population-level approaches to truly produce far-reaching and long-lasting changes needed to help all children thrive.

page 14 **The Forgotten Victims: Children of Incarcerated Parents** | *Yen H. Nong and Nancy P. Correa*

The rate of incarceration in the United States has quadrupled in the last four decades and approximately 1.7 million children have a parent incarcerated in a state or federal prison. Parental incarceration is an adverse childhood experience that increases a child's risk for experiencing negative outcomes. The body of literature that examines the impact of parental incarceration is limited, and this uniquely vulnerable population has received less attention and is not well understood. The purpose of this article is to provide an overview of the impact of parental incarceration on children, discuss risk factors that may modify outcomes, and highlight future directions for researchers, policy makers, healthcare providers, schools, and community-based organizations.

page 22 **Understanding Juvenile Probation Officers** | *The National Child Traumatic Stress Network's Justice Consortium*

This article highlights the results of a recent survey of more than 1,700 juvenile probation officers (JPOs) nationwide. The survey was conducted by the National Child Traumatic Stress Network's Justice Consortium for the purposes of better understanding the knowledge level of trauma among JPOs and how mental health professionals can best work with them. The court system is a common entry point for youth who have experienced trauma, and probation is the most common court order for first time juvenile offenders. The Office of Juvenile Justice Delinquency and Prevention refers to juvenile probation as the "work horse of the juvenile justice system." Thus it is crucial to support JPOs using sound trauma-informed practices.

page 24 **At Issue: Rethink the Label *Insular Communities* When Referring to Child Abuse** | *Daniel Pollack*

Accurate terminology and definitions are essential in social science research. It is highly stereotyping, demeaning, and offensive to broadly label communities of color and religious communities as insular when referring to child abuse in those populations. Whether purposely or unwittingly, stereotypes are a shorthand way to overgeneralize and reinforce negative views about particular groups.

page 27 **An Education Agenda for Those Who Need It Most** | *Bill Baccaglini*

One of the most pressing challenges our country faces is the persistently huge disparity in academic achievement between children growing up in poor, underserved communities and children in communities with the resources to meet their educational and developmental needs. That education gap is even wider for children who are also members of our most fragile student population: those in the child welfare system. We believe education is the best path toward a successful future for these children and, after keeping them safe and healthy, education should be our highest priority. Although widespread educational solutions have been a challenge thus far, several programs now offer great promise and, perhaps, a roadmap forward.

page 32 **Threats to the Medically Complex Child** | *Heather C. Moore*

The maltreatment of children in the United States today has reached alarming rates, and estimates range from 1 in 8 children by 18 years old. Specific subpopulations of children are reported to have increased rates of maltreatment. One group is children with special health care needs. Fourteen percent of children in the United States today have a condition with chronic physical, developmental, behavioral, or emotional needs, and 22% of households with children include at least one child with special needs. Medically complex children are the most vulnerable of special-needs children and have the greatest risk for maltreatment. This article describes the prevalence and characteristics of abuse, neglect, and maltreatment in this vulnerable population.

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Current Challenges in Addressing the Realities of Poverty and Inequality in Families With Young Children: A Call for Both Policy and Intervention

Cary M. Cain, MPH, RN
Bethanie S. Van Horne, DrPH, MPH

Background

Over the last decade, there has been a growing acknowledgement of the importance of the first five years of life, and the need to support early education providers and families in optimizing both the home and school environments of our nation's youngest members. At no other time in a person's life does the body and brain develop as rapidly as it does in these first years. In fact, during the first years of life, more than one million new neural connections are formed every second. Critical to the development of these connections in the brain are the quality of the environment, relationships, and early experiences of the young child (Copple, 2012; Shonkoff & Phillips, 2000). These experiences, good or bad, "literally shape the trajectory of brain development" and influence both child and later adult outcomes (Luby et al., 2012; Luby & Rogers, 2013; Horm, Norris, Perry, Chazan Cohen, & Halle, p. 13).

From the adverse childhood experiences (ACE) study, published almost two decades ago, we learned that adversity experienced in childhood is common, and that cumulative exposure to multiple forms of adversity experienced early in life lead to increasingly poor developmental, social, and health outcomes throughout life (Felitti et al., 1998). The ACE study revealed ranked associations (Figure 1) between the number of childhood adversities and adulthood destructive health behaviors and chronic diseases, such as alcoholism, drug abuse, depression, ischemic heart disease, stroke, cancer, diabetes, unintended pregnancy, obesity, and suicide attempts. Additionally, those who experienced six or more adversities during childhood suffered premature death on average twenty years earlier than those without adversity.

Providing an engaging and nurturing environment free of adversity for young children seems, at face value, rather simplistic; however, there are multiple factors that make this challenging. Decades of research and practice have been spent addressing the factors that impact the environments in which children live, grow, learn, sleep, play, and worship. The good news is that certain programs and interventions have been shown to positively influence home and early educational environments as well as child physical, social-emotional, and language development. The bad news is that most of these programs fail to substantially address the root causes of unsupportive environments––namely poverty and inequality––that continue to negatively influence child development and family functioning well after the child and family have completed the program.

This article discusses poverty and inequality in the contexts of the home and early educational environments of young children in the United States, demonstrates the promising results and inherent challenges of early intervention programs, and

highlights the need for population-level approaches to truly produce far-reaching and long-lasting changes needed to help all children thrive.

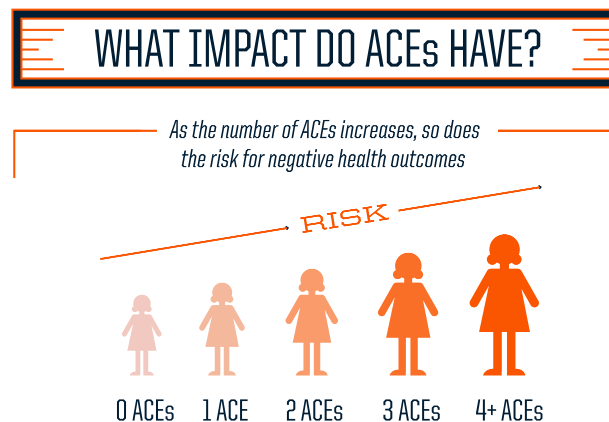
Poverty and Inequality in the Family and Home Environment

Approximately a quarter of the nation's children live in households that are at or below the federal poverty level (Kids Count Data Center, 2017a). These families struggle with the stressors of poverty, including low wage jobs, unemployment, violence, or mental illness (Aber, Bennett, Conley, & Li, 1997; Wood, 2003). Parents that are socioeconomically disadvantaged are also more likely to be socially isolated and receive less social support. Over 70% of families living below the federal poverty level are single-parent households (Kids Count Data Center, 2017b). The burdens on the caregiving environment are substantial because parents with limited access to social and economic support have fewer resources to provide stable home environments with adequate food, housing, health care, and childcare, all of which are needed to help their children thrive (Emerson & Parish, 2010; Mather, 2010; McLoyd, 1990; Schor et al., 2003). Also, compared with two-parent households, single-parent households are not able to invest as much time interacting with his or her child, which is crucial for the child's development (Kalil, Ryan, & Chor, 2014).

Young children spend the majority of their time with their family in the home. Healthy child development is fostered by parents' time and attention toward their child through a supportive and cognitively stimulating home environment (Kalil, Ziol-Guest, Ryan, & Markowitz, 2016). Central to the supportive home environment is the responsive and nurturing care provided by primary caregivers, which moderates the effects of poverty, family stress, and maltreatment (Egeland et al., 1993; Flouri, Midouhas, Joshi, & Tzavidis, 2015). Consistent responsive parenting in early childhood has been associated with cognition, school readiness, and social and emotional regulation later in childhood (Merz et al., 2015; Peterson et al., 2015).

Disparities are noted in the quantity and quality of interactions that children from differing socioeconomic levels are exposed to early in life (Hart & Risley, 1995). Hart and Risely (1995) found that before reaching 4 years old, children from lower-income households heard 32 million fewer words and more negative or harsh language compared with children from households of higher-income levels. A recent study found significant cognitive and language differences among infants from low-income households compared with those from relatively higher-income households, even at 1 year of age (Hurt & Betancourt, 2017). Additionally, a home environment that is chaotic or without nurturing and responsive interaction is associated with changes in the nervous system and brain architecture that can lead to lifelong problems in health, behavior, and learning (Anda et al., 2006; Felitti et al., 1998; Repetti, Taylor, & Seeman, 2002; Shonkoff, 2012; Shonkoff, Garner, & Committee on … Pediatrics, 2012).

Figure 1. Ranked Associations Between the Number of Childhood Adversities and Adulthood Destructive Health Behaviors and Chronic Diseases



Source: Robert Wood Johnson Foundation. (2013). Used with permission from the Robert Wood Johnson Foundation.

Lack of exposure to stimulating interaction early in life leads to higher risk for developmental problems and greater challenges when later learning to read, which can lead to gaps in school readiness and disparities in academic achievement (Halle et al., 2009; Hart & Risley, 1995). Longitudinal studies have shown that children exposed to fewer early language experiences continue to demonstrate low performance in school (Walker, Greenwood, Hart, & Carta, 1994). Evidence

of the associations between socioeconomic disparity and educational achievement have been known for decades (Coleman et al., 1966). Despite understanding this achievement gap, we know that income inequality has been increasing in the United States since the 1970s. As this increase has occurred, the disparity in educational achievement among children from high- and low-income families has widened by 30%–40% (Reardon, 2011; Saez & Zucman, 2014). Gaps in educational attainment place these children at risk for needing special education services and experiencing school dropout, juvenile delinquency, adolescent pregnancy, increased emergency and hospitalization visits, decreased economic productivity, unemployment, dependency on social services, and poor parenting (Doyle, Harmon, Heckman, & Tremblay, 2009; Ramey & Ramey, 1998).

Early Interventions Targeting Families With Young Children

Early interventions targeting economically disadvantaged families with young children can potentially prevent or reduce the adverse effects on brain development and prevent the proliferation of health and social problems in later life (Doyle et al., 2009; Offord & Lipman, 1999). A variety of interventions offered at multiple intensities and with varying delivery methods have shown promising effects; however, the ability to sustain these gains over time has shown mixed results as children who complete such programs continue to live and go to school in disadvantaged environments (Currie & Thomas, 1995).

Childcare Environment

Childcare is one avenue that both researchers and policy makers use to intervene with at-risk populations. Each week, roughly 11 million children under the age of 5 are in some type of childcare. Approximately 42% are with a grandparent or other relative, 35% are in center-based care, 8% in family childcare, 5% with a nanny or other home-based provider, and 5% with a friend or neighbor (Child Care Aware of America, 2016). A large body of research has demonstrated that the early disparities observed in children from low-income families can be prevented or reduced with high-quality, early education. However, the state of our early care and education system is plagued with issues of accessibility, affordability, and quality that have served to exacerbate rather than mitigate the disparities between children living in low-income versus high-income families.

Accessibility and affordability. The ability to access and afford high-quality childcare is challenging for many families in the United States, but particularly for rural and low-income families. Infant care costs vary by location, with state averages ranging from $4,800 in Mississippi to over $22,000 in the District of Columbia. In 33 states and the District of Columbia, infant care costs exceed the average cost of in-state college tuition at 4-year public institutions (Gould & Cooke, 2015). In all 50 states, the cost of center-based infant care averages more than 40% of the median income for single mothers, significantly higher than the federally recommended 10% (Child Care Aware of America, 2016; U.S. Department of Health and Human Services, Administration for Children and Families, 2014). Although low-income families may be eligible for federal childcare subsidies to offset these costs, 2012 data revealed that only 15% of eligible children receive this assistance (Chien, 2015).

In addition to cost, in many areas of the country low-income and rural communities are considered "childcare deserts," with limited to no access to quality care (Child Care Aware of America, 2017). Families in these communities have difficulty just finding licensed childcare options, and do not have the privilege of being able to look for or compare quality. Further, unconventional work hours (e.g., shift work), which many low-income jobs tend to have, also create challenges for families needing childcare because the vast majority of programs do not provide services outside of the typical from 6:00 am to 6:30 pm range.

Quality of childcare. A key to providing a quality service in any industry is the retention of quality staff. This is no different in the early childcare industry. Research examining quality early childhood programs has found the rate of staff turnover to be a strong predictor of program quality, with high turnover associated with lower-quality programs (Cassidy, Lower, Kinter-Duffy, Hedge, & Shim, 2011; Mims, Scott-Little, Lower, Cassidy, & Hestenes, 2008).

In the United States, the turnover rate for childcare professionals is estimated to be between 30% and 40% (Baumgartner, Carson, Apavaloaie, & Tsouloupas, 2009; Whitebook & Sakai, 2003).

Although multiple factors influence retention, low compensation has been found to be the most salient factor leading to high turnover rates in the childcare industry (Cornille, Mullis, Mullis, & Shriner, 2006). In 2016, the median annual salary for a childcare worker in the United States was $21,170 ($10.18/hr), and providers in some states made as little as $17,190 ($8.26/hr) (U.S. Department of Labor, Bureau of Labor Statistics, 2016). These wages are similar and sometimes less than other professions that require less training and education (e.g., median wage for a parking attendant is $10.35/hr and for a fast food cook $10.10/hr) (U.S. Department of Labor, Bureau of Labor Statistics, 2016).

Due to these low wages, highly trained childcare professionals are likely to leave their positions when other job opportunities arise. Results from a longitudinal study demonstrate that when childcare professionals leave a center, only half continue to work in the field while the other half leave the industry entirely (Whitebook & Sakai, 2003). This creates a system in which center owners and directors are using their limited resources to constantly hire and train new staff instead of providing higher wages to staff, hiring additional staff to reduce adult–child ratios, or investing in quality improvement programs.

Beyond staff retention, both structural (e.g., adult–child ratios, group size, provider education and training) and process characteristics (e.g., sensitivity and responsivity of teachers to children's needs, quality of activities and language stimulation) inform the quality of the early educational experience. High-quality childcare promotes children's intellectual, language, and social development through responsive, sensitive, and language-rich stimulation by providers. Children who experience high-quality childcare have high scores on achievement tests, show better social skills, and exhibit fewer behavioral problems (Lamb, 1998; NICHD Early Child Care Research Network, 1998). Unfortunately, research suggests that there is great variability in the quality of programs children participate in and that low-income mothers are more likely than high-income mothers to select childcare based on costs and location instead of quality (Fuller, Kagan, Loeb, & Chang, 2004; Li-Grining & Coley, 2006; Peyton, Jacobs, O'Brien, & Roy, 2001).

Home Visitation Interventions

Home visitation programs offer another option for intervening as these programs do not rely on children attending programs outside of the home, include family members and the home environment, and are able to intervene before the child is even born. These programs have shown promising evidence in promoting early learning in young children, improving parenting competence, and fostering positive parent–child relationships (Johnson, 2009). While these programs are limited in their reach, serving approximately 5% of children living in low-income households, support for such programs has been increasing through federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) funds, state investments, as well as grants from private and nonprofit philanthropic organizations (Innocenti, 2016; University of Pittsburg Office of Child Development, 2010). The MIECHV program provides funds to states to deliver evidence-based home visiting programs to vulnerable families; however, this funding is dependent on legislative action, and as of October 2017, funding for the federal program expired (Adirim & Supplee, 2013; Schochet, 2017). Table 1 includes a list of the MIECHV-eligible home visitation models and their evidence of effectiveness according to eight outcome domains.

Benefits of home visitation programs are that professionals and paraprofessionals provide supportive services in the family's home environment long term, that is, during the critical time of child development beginning prenatally through toddlerhood, which potentially mitigates stress and barriers in access to services and also allows the provider the opportunity to understand the client's interactions with the child and the living conditions in the context of the home and neighborhood (Azzi-Lessing, 2011). Most home visitation programs screen for adversities, such as depression, substance abuse, domestic violence, unemployment, and access to primary health care and housing and food services, though actual connection

to these resources can be difficult in disadvantaged communities due to the lack of provision of these resources (Azzi-Lessing, 2011). Furthermore, barriers are noted in engagement and retention of high-risk families that have complex needs (National Research Council & Institute of Medicine Board on Children, Youth, and Families, 1999). Many economically disadvantaged families may struggle with unstable living conditions, such as moving frequently, causing challenges in engagement and retention (Holland, Christensen, Shone, Kearney, & Kitzman, 2014; National Research Council & Institute of Medicine Board on Children, Youth, and Families, 1999). Other challenges to home visitation programs are similar to those of childcare programs, including staff turnover due to high caseloads and the stressful nature of the work. Retention of staff is vital as the supportive relationship that is fostered between the home visitor and the parent is key for program efficacy.

Early Language Interventions

As language plays a critical role in a child's cognitive and social development by providing a means of communication, methods of obtaining knowledge, and a way to foster future inquiry, specific interventions supporting early language are also utilized to improve outcomes for at-risk children (Song, Spier, & Tamis-Lemonda, 2014). Studies have shown that frequency of reading to a child regularly and often as well as having accessible children's books in the household were associated with positive child outcomes such as early academic success (Pati, Hashim, Brown, Fiks, & Forrest, 2011; Zuckerman & Augustyn, 2011). Research in early language has shown that targeted interventions can significantly increase interactions between the parent and the child, the amount of vocalization response of the child toward the parent, as well as the diversity and breadth of the parents' vocabulary toward the child (Leffel & Suskind, 2013).

Table 1. MIECHV-Eligible Home Visitation Models: Evidence of Effectiveness.

	Eight Outcome Domains							
	Child development and school readiness	Child health	Family economic self-sufficiency	Linkages and referrals	Maternal health	Positive parenting practices	Reductions in child maltreatment	Reductions in juvenile delinquency, family violence, and crime
Attachment and Biobehavioral Catch-Up (ABC) Intervention	YES	YES	NM	NM	NM	YES	NM	NM
Child First	YES	NM	NM	YES	YES	NM	YES	NM
Early Head Start-Home Visiting (EHS-HV)	YES	NO	YES	YES	NO	YES	YES	NM
Early Intervention Program for Adolescent Mothers	NM	YES	YES	NM	NO	NO	NM	NM
Early Start (New Zealand)	YES	YES	NO	NM	NO	YES	YES	NO
Family Check-Up® For Children	YES	NM	NM	NM	YES	YES	NM	NM
Family Connects	NM	YES	NM	YES	YES	YES	NM	NM
Family Spirit®	YES	NM	NM	NM	YES	YES	NM	NM
Health Access Nurturing Development Services (HANDS) Program	NM	YES	YES	NM	YES	NM	YES	NM
Healthy Beginnings	YES	YES	NM	NM	YES	YES	NM	NM
Healthy Families America (HFA)®	YES	YES	YES	YES	YES	YES	YES	YES
Home Instruction for Parents of Preschool Youngsters (HIPPY)	YES	NM	NM	NM	NM	YES	NM	NM
Maternal Early Childhood Sustained Home-Visiting Program (MECSH)	NM	YES	NM	NM	YES	YES	NM	NM
Minding the Baby®	NM	YES	NM	NM	YES	NO	NO	NM
Nurse Family Partnership (NFP)®	YES	YES	YES	NO	YES	YES	YES	YES
Parents as Teachers (PAT)®	YES	NO	YES	NM	NO	YES	YES	NM
Play and Learning Strategies (PALS)	YES	NM	NM	NM	NM	YES	NM	NM
SafeCare®	NM	NM	NO	YES	NO	NM	YES	NO

Note: "YES" indicates that the program has shown favorable effects either confirmed through primary or secondary outcome measures in this domain; "NO" indicates that no statistically significant effects or unfavorable or ambiguous effects were measured through primary or secondary outcomes measures in this domain; "NM" indicates that outcomes were not measured in this domain.

Source: Source: U.S. Department of Health and Human Services, Administration for Children and Families (n.d.).. Retrieved from https://homvee.acf.hhs.gov/outcomes.aspx

Disadvantaged families have fewer resources and may struggle to provide cognitively stimulating books and toys within the home. Additionally these families may struggle with employment and housing security and so may not have the time or ability to invest in their young child's early education (Dickinson, McCabe, & Anastasopoulos, 2003). Programs implemented during primary care well-child visits, such as Reach Out and Read, attempt to address these challenges by modeling reading strategies and giving the family a developmentally appropriate book to take home to engage in shared book reading (Zuckerman, 2009). Reach Out and Read serves approximately 25% of low-income families and has shown evidence for increased shared reading and increased language development in children. Other studies have demonstrated that despite economic difficulty, the frequency of maternal language targeted toward the child is related to significant gains in the child's language ability (Hoff, 2003; Song et al., 2014). Another study found that successful parenting interventions, such as parental engagement in shared book reading, promote the transfer of cognitive skills from parent to child, independent of the parent's cognitive ability, education, and social class (Byford, Kuh, & Richards, 2012).

These demonstrate that despite socioeconomic disadvantage, the importance of promoting consistent and responsive parenting in early childhood cannot be understated for optimal child social and cognitive development. However, providing a rich home language environment is dependent on parental behavior. Studies have shown that parental beliefs and knowledge of child development mediate associations between parental directed speech toward the child and socioeconomic status (Rowe, 2008). As with interventions in the home and in childcare settings, if these interventions do not address adversities and the environments that families are living in, they will be limited in their scope to realize long-term improvements in child outcomes.

Sustained Improvements in Population-Level Child Outcomes

Currently, there is no silver bullet intervention that will promote optimal population-level child development. As noted, gains can be made with socially disadvantaged children through promising home and early education interventions; however, unless improvements are made in the environments in which children live, and in the inequality and adversities they face, significant population-level changes in child outcomes will not be attained. Interventions focused on counseling and education are designed to help individuals rather than populations (Frieden, 2010). Often these interventions are the focus of resources, and even programs that show strong evidence of effectiveness achieve limited population impacts. Interventions that target socioeconomic factors at a population level have the greatest potential to improve outcomes; however, for their success, they need to be supported by the political will.

Policy and partnerships between government and community agencies, including health care providers, churches, and schools, are essential to address poverty and inequality. Focusing on early childhood is vital to begin to decrease inequality in our society. Programs that support families with young children such as paid parental leave and increased subsidies for childcare have been shown to have health and developmental benefits to children (Adema, Clarke, & Frey, 2016). Tied to increased childcare subsidies for children are increased reimbursements for childcare centers serving low-income children receiving subsidies. This increase would allow centers to increase pay for staff, which would help decrease turnover, and invest in quality improvement initiatives. For example, quality rating and improvement systems (QRIS) are assisting states across the country to incentivize and boost quality in early education programs. Although standards vary by state, all QRIS provide financial incentive, with many including increased reimbursement rates, to programs that meet or exceed specific quality standards (National Center on Early Childhood Quality Assurance, 2017). Evaluations of these programs, however, have found that there is a need to increase the reimbursement rates currently provided because the rates are not always enough to support and sustain high-quality programs (e.g., Ashby & Phebus, 2013; Liam & Muenchow, 2009).

Policies to decrease the inequality gap should address

the uneven distribution of wealth and resources across society (Marmot & Bell, 2012). A potential policy to address this would be to increase the federal minimum wage. In the past 40 years, wages for average wage workers have minimally increased compared with massive increases for the top earners wages, causing increasingly greater income inequality (Saez & Zucman, 2014). Another instance of an intervention to reduce inequality is providing supplemental earnings. Morris, Duncan, and Rodrigues (2011) found that supplementing the income of mothers with young children produced higher levels of student achievement compared with students of mothers who received no additional earnings while participating in a welfare to work program. These examples highlight a few population-level policies and programs aimed at reducing poverty and inequality; many others have been proposed and are being discussed in the current landscape.

Conclusion

Research demonstrates that intervening early in childhood is critical to preventing developmental delays, promoting optimal development, and ensuring a healthy and productive future workforce. As discussed, a multitude of challenges may occur when intervening with caregivers of young children in the home and early childcare environments. Some of these challenges can be addressed through policy and societal changes. Even though changing policy will take time, the benefits from these changes will be observed over the long term. While there rightfully is an emphasis on investing in early childhood, most important is the need to fully address the challenges faced by families, educators, and interventionists alike. If not, the benefits will not be realized at a population level. Comprehensive and integrated approaches that include effective interventions to enhance the home and early education environment, supported by policies and investments that mitigate inequality and adversity, are therefore critical to realizing sustained improvements in child outcomes.

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Current Challenges in Addressing the Realities of Poverty and Inequality in Families With Young Children: A Call for Both Policy and Intervention

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The Forgotten Victims: Children of Incarcerated Parents

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Adverse childhood experiences (ACEs) have been well recognized as having a profound impact on the life course of a person. Since the original ACE study in the 1990s, there have been hundreds of research articles and community programs that have addressed ACEs, including child abuse and neglect, intimate partner violence, maternal mental health, family dynamics, and parental substance abuse (Felitti et al., 1998; Green, Browne, & Chou, 2017; Hughes et al., 2017). However, although parental incarceration is recognized as an ACE, it has received less attention and is not as well understood.

Children of incarcerated parents have been described as the "forgotten victims" of crime (Matthews, 1983, title), the "orphans of justice" (Shaw, 1992, p. 41), the "hidden victims of imprisonment" (Cunningham & Baker, 2003, p. 2), and the "unseen victims of the prison boom" (Petersilia, 2005 p. 34). The body of literature that examines the impact of parental incarceration on children is limited, few community programs and resources are directed to this vulnerable population, and policy makers have largely neglected to consider the implications of parental incarcerations on children. This article provides an overview of the impact of incarceration on children, discusses risk factors that may modify outcomes, and highlights future directions for researchers, policy makers, healthcare providers, schools, and community-based organizations.

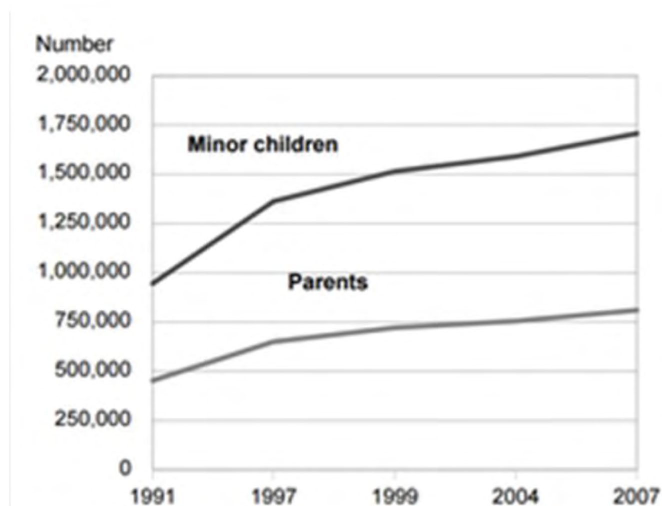
Prevalence and Trends in Parental Incarceration

The rate of incarceration in the United States has more than quadrupled in the last four decades, and the United States has one of the highest incarceration rates in the world (The Sentencing Project, 2017; Walmsley, 2015, p. 15). The American criminal justice system is complex, and as of 2016 it holds more than 2.3 million people in 1,719 state prisons, 102 federal prisons, 942 juvenile correctional facilities, 3,283 local jails, and 79 Indian Country jails (Wagner & Rabuy, 2016). Overall, close to 22% of the world's prisoners are held in the United States (Walmsley, 2015). Incarceration in the United States disproportionately affects males and racial and ethnic minorities. Data from the 2015 Bureau of Justice Statistics report indicate that males account for at least 85% of the jail inmate population (Minton & Zeng, 2016, p. 15). In federal and state prisons, the imprisonment rate of white males is 312 per 100,000 compared with 1,745 per 100,000 black males, and 820 per 100,000 Hispanic males. Similarly, the rate of imprisonment for black females is twice the rate of white females at 103 per 100,000 and 52 per 100,000, respectively (Carson & Anderson, 2016, p. 25).

In a 2010 special report on parents in prison by the Bureau of Justice Statistics, data showed that 51% of males and 62% of females in state prisons report having children under the age of 18, and 63% of males and 59% of females in federal prisons (see Figure 1). Together that means approximately 1.7 million children, 2.3% of the U.S. resident population under the age of 18, have a parent being held in state or federal prisons (Glaze & Maruschak, 2010, p. 25). Hispanic and black children are more likely to experience the incarceration of a parent compared with white children (Gjelsvik, Dumont, Nunn, & Rosen, 2014). An analysis of a 1990 birth cohort found that white children had a 3.6-4.4% cumulative risk of experiencing parental incarceration by age 14, while black children in the same age cohort

had a 25%–28% cumulative risk (Wildeman, 2009).

Figure 1. Estimated Number of Parents in State and Federal Prison and Their Minor Children.



Source: Glaze & Maruschak (2010), p. 25.

Parental Incarceration and Child Well-Being

Parental incarceration is a traumatic experience that is often accompanied with additional ACEs. Research has shown that exposure to multiple ACEs can have a cumulative impact (Anda et al., 2006). Adversities related to parental incarceration may include, but are not limited to, acute and chronic psychological stress, parental separation, changes in living arrangements (possibly foster care), domestic violence, traumatic removal of the parent, and stigmatization (Luther, 2015; Nichols & Loper, 2012; Braman, 2004; Fritsch & Burkhead, 1981).

The exposure to a multitude of adversities when a parent is incarcerated has been considered as both a risk marker and a risk mechanism that may directly or indirectly affect a child's outcomes relating to biological aging, psychosocial development, internalizing and externalizing behavior, criminal justice involvement, drug use, and poor academic performance (Mitchell et al., 2017; Murray & Farrington, 2005; Kopak & Smith-Ruiz, 2016; Wakefield & Wildeman, 2013; Murray, Farrington, & Sekol, 2012; Hanlon et al., 2005; Foster & Hagan, 2009). Women are the fastest-growing prison population, and some studies have shown that maternal incarceration has been linked to increased child adjustment difficulties and higher rates of intergenerational incarceration compared with paternal incarceration (Dallaire, 2007; Huebner & Gustafson, 2007; Phillips, Burns, Wagner, Kramer, & Robbins, 2002).

While studies have found an association between parental incarceration and negative child outcomes, no clear causal paths have been identified. It has been a challenge for researchers to unpack the confounding factors and adversities that were present for families long before the parent was incarcerated. For example, while many studies have reported an association between parental incarceration and negative outcomes, a meta-analysis showed that parental incarceration increases the risk for children's antisocial behavior, but not poor educational performance, drug use, or mental health problems after covariates were controlled (Murray, Farrington, & Sekol, 2012). Nonetheless, many would agree that children of incarcerated parents are a uniquely vulnerable population, and there is a need to better understand this population and how to prevent and mitigate negative outcomes.

Modifiers of Risks

A number of factors may influence how children respond to their parent's incarceration. These factors include family and household dynamics pre-incarceration, witnessing the parent's arrest, social support available during parental incarceration, relationship with the parent while they are incarcerated, and economic and residential instability due to incarceration. The following section highlights how these factors impact a child's response to parental incarceration.

Household Dynamics Prior to the Arrest

The impact of parental incarceration on children is complex and family, household, and community dynamics prior to the arrest contribute to the complexity. A major driver of a child's response to the parental arrest is whether or not the arrested parent was the child's primary care giver, if the arrested parent lived with the child, and the quality of the relationship between the arrested parent and child (Parke & Clarke-

Stewart, 2002; Texas Inmate Families Association, 2016). Approximately half of children affected by incarceration lived with the incarcerated parent prior to arrest (Glaze & Maruschak, 2010). However, more children (64%) lived with their mother than with their father (47%) prior to the parent's arrest. Children who lived with an incarcerated parent and were primarily taken care of by the incarcerated parent are more likely to be affected by the incarceration than children who did not live with the incarcerated parent (Hagan & Dinovitzer, 1999).

While being separated from a loving caregiver can be detrimental to a child, parental incarceration can also alleviate traumatic and toxic household conditions, including exposure to domestic violence, child maltreatment, parental mental illness, drugs and alcohol abuse, and presence of criminal and violent activities (Turanovic, Rodriguez, & Pratt, 2012; Dannerbeck, 2005; Johnson & Waldfogel, 2004; Phillips, Erkanli, Keeler, Costello, & Angold, 2006). Although there is evidence that the net effect of incarceration on children is harmful (Wakefield & Wildeman, 2013), it remains unclear if adverse effects from parental incarceration is due to the loss experienced during parental incarceration or the circumstances that led to the parental incarceration. The pre-existing adversities may heighten risk for maladjustment and thereby either fully or partially contribute to the negative outcomes often observed in children of incarcerated parents (Johnson & Easterling, 2012).

Witnessing Arrest

Some children with an incarcerated parent witness the arrest of their parent. Arrests often occur at night or in the early morning, when parents are likely to be home with their families (Braman, 2004). Estimates of the percentage of children who witness the arrest vary greatly, ranging from 20% to 84% (Arditti, 2012). Witnessing the arrest can be a traumatic experience for children and is associated with an increased risk for posttraumatic stress disorder, maladjustment, and problem behaviors (Arditti, 2012; Phillips & Zhao, 2010). Younger children who witness an arrest are more likely to express internalizing behaviors, such as emotional distress and increased arousal, while older children's behavioral manifestations are more external, such as irritability and immaturity (Roberts et al., 2014).

Additionally, the nature of arrests can vary significantly, which may influence the level of impact on children. Arrests can be accompanied with violence, verbal altercations with the police, presence of firearms and other weapons, and criminal activity. One qualitative study interviewed 30 children who witnessed their mother's arrest and reported that the children experienced nightmares and flashbacks to the arrest (Parke & Clarke-Stewart, 1999).

Social Support and Caregiving During Parental Incarceration

Regardless of where the child resides, the quality of a child's relationship with caring adults during a parent's incarceration influences his or her immediate and long-term well-being. The Bureau of Justice Statistics reports a majority of children with incarcerated fathers live with their mothers during the incarceration period, whereas children with incarcerated mothers are more likely to live with their grandparents, other family members, or in foster care. An estimated 10% of incarcerated mothers have a child in foster or state care (Glaze & Maruschak, 2010).

Developmental research on resilient youth suggests that close relationships with caring adults may help mitigate the negative effects of adversity that children experience (Masten, 1994). Attachment theorists also provide evidence that children can and do form secure attachment relationships with substitute caregivers, especially in a stable environment (Poehlmann, 2005). A recent study conducted with college students who experienced parental incarceration during their childhood demonstrated how caring adults can contribute to their positive adaptation and promote resilience. Examples include the following: (1) providing access to conventional activities (e.g., athletics, day camps, community programs, religious activities, positive everyday childhood activities); (2) supporting a vision of a better life with a strong focus on academic success and exclusion of criminal activity; and (3) encouraging a redirection of their lives to not follow in the same path as their parents who were incarcerated (Luther, 2015).

Overall, social support from a trusted adult such as a caregiver, older sibling, extended family member,

educator, or church member can buffer negative effects of parental incarceration (Cohen & Wills, 1985). An unwavering primary caregiver, even if the relationship is complicated, was identified to be the most significant source of social support because children recognized that those caregivers could provide the stable and supportive home that their incarcerated parents could not (Luther, 2015).

Relationship With Incarcerated Parent While in Confinement

If a child had a strong attachment to and was being primarily cared for by the incarcerated parent, it could be detrimental to the child when that parent is no longer a presence due to incarceration. Disruption to the parent-child attachment with an uncertain future that comes with parental incarceration is traumatizing and may critically increase a child's vulnerability to later life adversities (Arditti, 2012). Studies have generally found that maintaining parent-child contact through communication and visitations during parental incarceration is beneficial to both the child and the parent (Poehlmann, Dallaire, Loper, & Shear, 2010). Some of those benefits include lower rates of recidivism (for mothers in a nursery program during confinement), paternal involvement post release, improved inmate behavior while incarcerated, decreased feelings of alienation felt by children, and enhanced attachment and self-esteem for children (Byrne, Goshin, & Joestl, 2010; Carlson, 1998; La Vigne, Naser, Brooks, & Castro, 2005; Bales & Mears, 2008; Shlafer & Poehlmann, 2010; Landreth & Lobaugh, 1998). Additionally, children of incarcerated parents have shared how the emotional and social support from their incarcerated or formerly incarcerated parents was a source of motivation that helped them stay on course toward college (Luther, 2015).

However, concerns regarding the condition and quality of visitation have been raised. It is not uncommon for prisons to restrict inmates to their seat, which is often bolted to the floor during visitation thus causing limitations for children to move freely and feel comfortable (Arditti, 2012). Also noted are the lack of privacy, tedious and lengthy waits, humiliation, rude treatment by correctional officers, and an environment that can be crowded, noisy, and dirty (Arditti, 2003; Comfort, 2008; Hairston, 2001). These conditions during visitations could create difficulties for offenders and their families, not to mention be a traumatic experience itself that could lend to the arousal of painful emotions associated with the incarceration.

There is a delicate balance in maintaining the parent-child relationship during parental incarceration that promotes positive effects and minimizes further trauma. In one study, visitations that did not include family-friendly interventions to promote parent-child relationship as part of the visit resulted in negative outcomes such as insecure attachment and child attention problems (Dallaire, Ciccone, & Wilson, 2012; Poehlmann, 2005). In contrast, studies that included family-friendly interventions during visitations, such as a prison nursery program for mothers and infants or enhanced prison visitation for fathers and their school-aged children, have yielded positive child outcomes including enhanced attachment and increased self-esteem (Byrne Goshin, & Joestl, 2010; Landreth & Lobaugh, 1998). Studies have also suggested that mail correspondence is beneficial with no negative effects (Poehlmann, Dallaire, Loper, & Shear, 2010). A 2007 survey of state and federal inmates revealed that mail correspondence is the most convenient and likely form of communication (70% state and 84% federal) for incarcerated parents and their children.

Economic and Residential Instability

Parental incarceration is often coupled with economic disadvantage and inconsistent living arrangements. The removal of a working adult parent from the home usually involves a loss of monetary contributions from that individual. In addition, incarceration may lead to additional expenses for the family, such as travel costs and days taken off work to visit the inmate, phone calls through expensive collect call rates, and mailing packages to supplement food and hygiene needs lacking in the incarcerated facilities (Braman, 2004; Comfort, 2008; Grinstead, Faigeles, Bancroft, & Zack, 2001).

After being released, there is a string of additional economic hardships involved as the offender seeks to re-enter society. Analysis using population-based sampling of 20 large cities in the Fragile Families and Child Wellbeing Study showed a strong and significant relationship between parental incarceration and a number of economic and family instability outcomes

post release. Fathers who have spent time in jail or prison are significantly less likely to be employed, less likely to work consistently, and less likely to have earnings comparable to their counterparts with no history of incarceration (Geller, Garfinkel, Cooper, & Mincy, 2009). As such, contributions to the household may diminish and lead to considerable hardships and difficulty in meeting basic material and residential needs, such as food, rent, utility bills, and medical expenses that last beyond the period of incarceration. In addition, any legal fees or debt that has incurred during incarceration can compound these difficulties (Harris, Evans, & Beckett, 2010).

Discussion

Parental incarceration is a dynamic and complex phenomenon that affects approximately 1.7 million children in the United States. Children of incarcerated parents are a vulnerable population that often experience multiple adversities, yet are often overlooked and do not receive the attention or support of other vulnerable populations. Academia, policy makers, healthcare providers, schools, and community-based organizations need to address this vulnerable and often overlooked population.

Given that over 50% of inmates have children, policy makers and government officials need to consider the needs of children from the time of a parent's arrest through post release. For example, could visitation procedures be modified to create a less traumatic environment for children visiting their parents while maintaining a safe environment? What policies and programs can be put in place to ensure that children of incarcerated parents have safe, stable, and nurturing relationships with caregivers and other adults during the incarceration? What parent education or family support programs can be provided to parents while in confinement or after release?

Community-based organizations and social service agencies need to ensure services are continually available to support the children of incarcerated parents and their caregivers. Many of these children are exposed to multiple adversities in addition to parental incarceration and appropriate interventions may be beneficial. In addition to more programs and policies that support children of incarcerated parents, more research is needed to understand the unique needs of children of incarcerated parents and the most effective way to support this vulnerable population. Research suggests that parental incarceration is harmful for children, but more research is needed with stronger designs including prospective longitudinal studies that address confounding and pre-existing factors. Future areas of research may include how children in different circumstances respond to parental incarceration, such as children who are separated from their primary care giver compared with children who are not separated from their primary caregiver, or children who are not exposed to multiple adversities compared with children who are exposed only to parental incarceration.

In addition to the need for research, we need to collect more data from jails and prisons on the children of incarcerated parents. Many jails do not collect any information on the children of inmates, so communities do not know the prevalence of children of incarcerated parents or how to reach these children for interventions and programs.

Academia, policy makers, health care providers, schools, and community-based organizations continue to make strides toward recognizing the impact of childhood adversity and the need for trauma-informed care. However, more attention needs to be directed to the children of incarcerated parents and how to prevent and mitigate negative outcomes for this vulnerable population.

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The Forgotten Victims: Children of Incarcerated Parents

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Understanding Juvenile Probation Officers

The National Child Traumatic Stress Network's Justice Consortium

The court system is a common entry point for youth who have experienced trauma, and probation is the most common court order for first-time juvenile offenders. The U.S. Office of Juvenile Justice Delinquency and Prevention refers to juvenile probation as the "work horse of the juvenile justice system." Thus, it is crucial to support juvenile probation officers (JPOs) using sound trauma-informed practices.

To best support our JPOs, we need to understand what they already know about trauma, how we can best work with them, and what tools would be most useful to them.

Recently the National Child Traumatic Stress Network's Justice Consortium Juvenile Probation Officer Subcommittee developed a survey and delivered it to more than 1700 JPOs nationwide. There were a number of interesting and useful findings, including the following:

- Reducing recidivism and improving youth functioning were the most frequently endorsed goals of probation as reported by JPOs, reflecting that JPOs view their roles as both protecting the public and addressing the needs of the youth.
- Though a majority of officers indicated having received formal training in trauma through a workshop and other informal means, many respondents indicated wanting more training on specific trauma topics, including identifying trauma-related needs, survival strategies of traumatized youth, the impact of trauma on youth, developing an effective case plan, and how to engage in self-care.
- Self-care was identified as an important training element; about half of the sample identified one or more job stressors related to managing their caseloads.
- While more than half of the respondents indicated that their office routinely screens for trauma, fewer than 40% indicated that this screening occurs through a standard trauma screening tool. Instead, a variety of structured and unstructured methods are used to identify traumatic stress with youth on their caseloads.

Juvenile probation officers have widespread interest in understanding the impact of trauma on the youth they supervise. Those who work with children can support JPOs by helping them access information about trauma and youth in formats they use.

To read the full survey summary results, see: http://www.nctsn.org/sites/default/files/assets/pdfs/po_survey.pdf

About the Author

The National Child Traumatic Stress Network's Justice Consortium strives to work with judges, attorneys, probation officers, and other professionals in the family, dependency, and juvenile justice court systems, and with staff of juvenile correctional facilities and programs, to improve assessment practices, create more trauma-informed court environments, inform decision making, and help create more trauma-informed treatment and placement options for children, adolescents, and their caregivers. Contact: Learn more at http://nctsn.org.

Rethink the Label *Insular Communities* When Referring to Child Abuse

Daniel Pollack, MSSA (MSW), JD

"The beginning of wisdom is the definition of terms." Socrates

The Child Welfare League of America (CWLA) recently issued a "Call for Essays on Child Maltreatment in Insular and Isolated Communities" (2017). The announcement states, in part, the following:

> A growing body of research over the past 20 years has illuminated why some groups—such as Native-born Latino, African American, and Native American children and families—are overrepresented in the child welfare system. There are other individuals, groups, and communities, however, that may experience maltreatment, but remain unknown, isolated, and insular to researchers and policy-makers alike…. In a broader sense, there are many communities that are insular not only due to geography, but also to religious, cultural, language and other sources of isolation.

Although the origin of the word *insular* comes from the Latin *insula*, meaning "island," the actual definition of the word has such pejorative overtones that, when the subject is child abuse, it should not be used in conjunction with the word *community*.

Among other synonyms, the online Oxford Living Dictionary (2017) suggests the following synonyms for the word *insular*: "narrow-minded, parochial, provincial, small-town, petty, myopic, inflexible, dogmatic, rigid, entrenched, intolerant, prejudiced, bigoted, biased, xenophobic, discriminatory." All the other words listed have similar negative connotations.

The same thesaurus suggests the following synonyms for the word *insular* as applied to the word *community*: "isolated, inaccessible, cut off, closed, separate, segregated, detached, solitary, self-contained, self-sufficient." On the whole, this list is more neutral.

Search for the phrase *insular community* AND *child abuse* on the Internet and find that 19 out of the first 20 entries describe abuse that took place in a religious community. Thus, it seems that *insular community*, when used in the child abuse context, is a code name for religious community, even though that may not be the explicit intent.

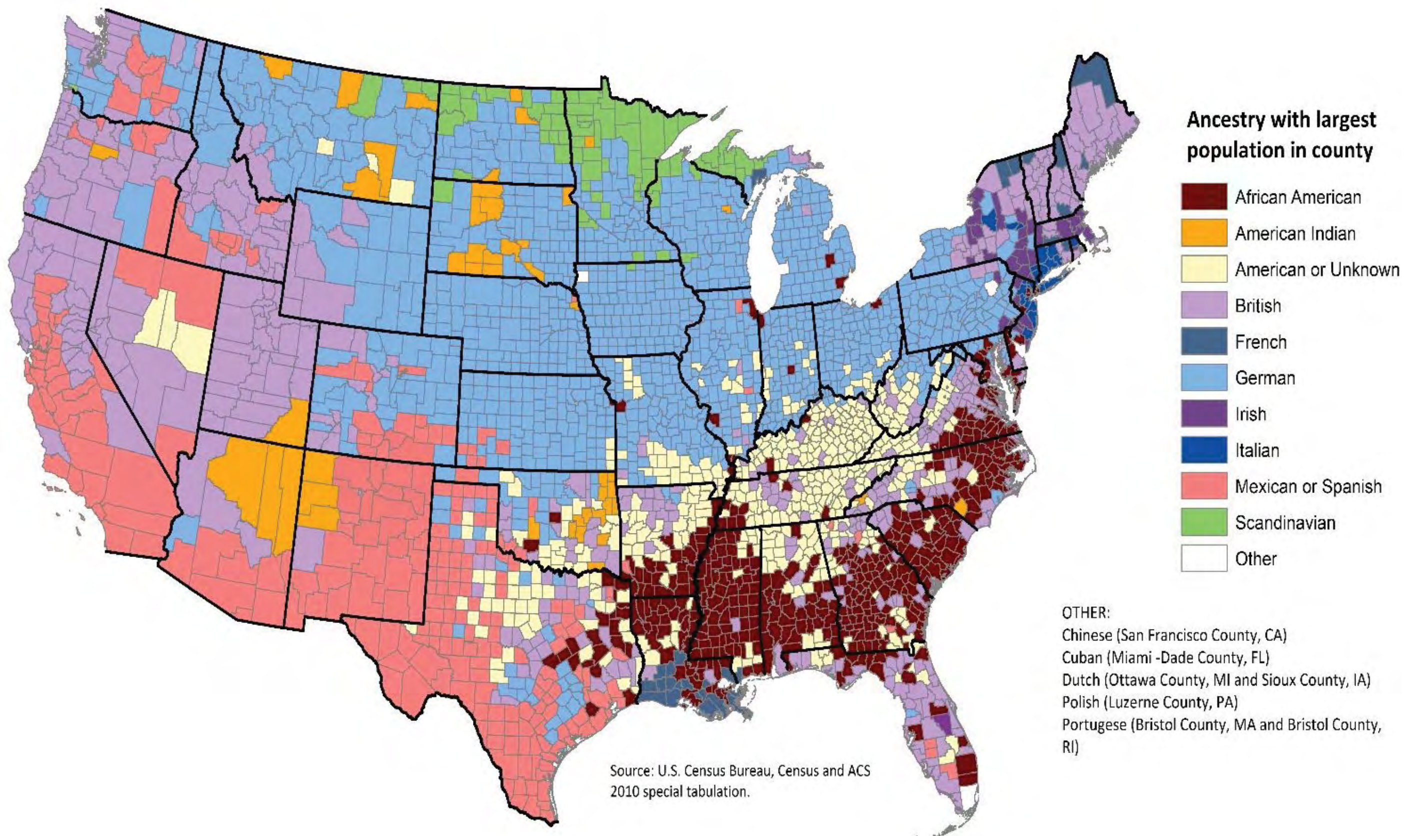
The spate of clergy who have abused their positions and engaged in unspeakable predatory behavior is inexcusable. No amount of monetary compensation or therapy will ever make their victims whole. And, without a doubt, all religious communities have their fair share of child abuse. But to label wholesale those communities as *insular* expresses subtle animosity and condemnation.

Similarly, it is highly stereotypical to refer to all communities of color as *insular*. As of July 2014 (U.S. Census Bureau, 2016), there were 45.7 million African Americans either alone or in combination with one or more other races. As of July 2016, the Hispanic population was 57.5 million (U.S. Census Bureau, 2017). As of 2011, there were more than five million Native Americans and Alaska Natives in the U.S. (U.S. Census Bureau, 2012). To designate each one as *insular* is a gross mischaracterization.

Consider the latest (2010) U.S. Census Bureau ancestry map in Illustration 1 (next page).

Certainly not all African Americans, American

Illustration l. Ancestry With the Largest Population in County.



Indians, and Latinos, whose concentrated population stretches thousands of miles over multiple states, could be considered insular.

Accurate terminology and definitions are essential in social science research. Words always matter. Perhaps the word *tight-knit*—"a group of people united or bound together by strong relationships and common interests"—might be a better choice for social scientists to use when speaking about these types of communities. Even if it is done inadvertently, mislabeling can spawn unintended hostility.

About the Author

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Rethink the Label *Insular Communities* When Referring to Child Abuse

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An Education Agenda for Those Who Need It Most

Bill Baccaglini, MA

One of the most pressing challenges our country faces is the persistently huge disparity in academic achievement between children growing up in poor, underserved communities and children in communities with the resources to meet their educational and developmental needs. That education gap is even wider for children who are also members of our most fragile student population: those in the child welfare system, which includes children who have been victims of abuse or neglect, are living in foster homes, or whose families are receiving supervision and support from child protective agencies.

As these children grow up, they lack the kinds of supports many of us take for granted: a good education; a reliable network of family, friends, and community; and the presence of stable adult role models in their lives. On any given day, there are over 400,000 children in the foster care system in America (Child Welfare Information Gateway, 2017). A variety of reasons exist for removing them from their homes, but all of the children have been victims of neglect or abuse. They are often the latest link in a multi-generational chain characterized by poverty, dependency, and sometimes, crime.

More often than not, they will enter adulthood without the tools to live independently. As a result, just under one in four transition-age foster youth will be incarcerated within two years. Twenty-seven percent will experience homelessness (Child Trends, 2017). Only half will graduate from high school and of the 10% who eventually attend college, only 3% will graduate (Tzawa-Hayden, 2004).

For years, the child welfare system has focused on the most urgent needs of the children it served, making sure they are safe, have enough food to eat, and have clean clothes to wear, while striving to achieve permanency. Although those are crucial first steps, they are not enough and never have been.

We believe education is the best path toward a successful future for these children, and after we keep them safe and healthy, education should be our highest priority. Thus far, widespread educational solutions have been a challenge, but several programs and ideas now offer great promise and, perhaps, a roadmap forward.

Why This Matters

The foster care population is less than 1% of the total number of children in America. Why focus attention on them when our education system needs improvement in so many other ways that affect so many more young people? Because the cost of maintaining the status quo is enormous. The human toll of failing to educate a segment of our population is obvious, but we also incur a significant cost in terms of the tax dollars needed to respond to the consequences of that failure.

Without an adequate education, many of these children will spend at least some of their adult lives either in the justice system or dependent on various service systems, or both. Even putting aside the tragedy of having lost these individuals as productive members of society, the costs to taxpayers alone can be staggering, with government having to spend tens

of thousands of dollars each year for every person who is homeless or incarcerated. Add to that the multiplier effect of inter-generational poverty and dependency, in which one generation cannot count on the prior one when "times get tough."

The New York Foundling is one of the oldest and largest child welfare organizations in the country, and in recent years, we have adopted several evidence-based programs that have proven to be effective at keeping families together, diverting young people from the criminal justice system, getting the young on a positive track in life, and protecting children from the physical abuse and psychological trauma that characterize so many of their lives.

We have concluded that education is the final piece of the puzzle and should be the current and future focus of our energies. Our experience in developing educational programs has taught us some valuable lessons, which we believe can serve as models for other organizations and for governmental entities around the country. And, what these programs have in common is that they are all scalable.

Elementary Education

Traditional public education systems are built to educate the majority of students. Teachers, out of necessity, teach to the "middle of the room." They aren't equipped to address the special needs and circumstances of students in the child welfare system––all of whom have experienced trauma, often the result of having been physically or sexually abused or seriously neglected. As a result, foster children tend to be the most marginal students attending the most marginal schools.

Creating a model that reaches these children is crucial. Without an exemplar, they are far more likely to struggle with mental illness, unplanned pregnancies, drug abuse, incarceration, and long-term dependence on government-funded services for food, healthcare, and housing.

Ten years ago, The Foundling launched Mott Haven Academy, a PreK–5 charter school in one of the nation's most disadvantaged communities. Two thirds of our students are in the child welfare system, and the remaining third come from the surrounding community. We created this model as the best way of assessing what subgroups, if any, benefit from our integrated approach. The Foundling has no intention of growing as a charter management organization. It wants only to build a base of knowledge and experience that others can use to potentially serve thousands of these children across the country. Despite all our experience, however, we initially found progress elusive. It was only after more fully appreciating the consequences of trauma for the learning process, and incorporating these into our curriculum, that real achievement occurred. Having gone through this process, we now have strong evidence that our approach is working.
Last year, we achieved the following:

- Overall, in both English and math, the percentage of students with passing scores at Haven Academy was triple the percentage in the surrounding community school district.
- Our students' performance also exceeded the averages for public and charter schools in New York City and New York State.
- Child welfare-involved children at Haven Academy outperformed students in the general community school district.
- In English, the percentage of child welfare students at Haven who passed the exam was double the percentage in the community school district as a whole.
- In math, the percentage of Haven child welfare students passing was 2.5 times greater than the community school district and exceeded the overall city and state averages.

What are the keys to these results? What tactics are we using that are replicable and scalable?

Educators and child welfare professionals work together so that, for example, when a student is absent, the teacher notifies the school social worker who can reach out to the family and follow up, if necessary,

with home visits including school personnel and case workers.

We offer health and dental services on the premises so we can integrate the visits into the school day, and the student doesn't need to miss a day of school for an appointment––or miss the appointment because scheduling is too much of a challenge.

Because so many of these children have experienced trauma in their young lives, we provide teachers and staff with specific training in this area. In fact, trauma sensitivity is integrated into every aspect of school life. For instance, if a student recoils when a teacher touches him on the shoulder, it is likely a result of a history of abuse and an indication that the student needs to be engaged without physical contact. Teachers and staff are very intentional about the language, habits, routines, and interactions they exhibit. All school staff members understand the "triggers" of student behaviors.

And because of these children's often chaotic lives, they need stability and predictability. If they accidentally spill a drink, for example, will someone hit them or will someone simply help them clean it up and remind them to be careful? If they intentionally break rules, they need to know exactly what will happen as a result––predictable accountability and the knowledge that while they must respect authority figures, they need not live in fear of them.

We believe that in supporting educators with some of the tools and training usually employed by child welfare professionals, and increasing the integration between the two to create trauma-sensitive schools, we can bridge the education gap between at-risk youth and students in the general population nationwide. Our experience at Haven Academy shows that this outcome is within our reach.

The results to date have been so positive that, this year, in recognition of the need to continue working with children beyond 5th grade, we opened a new middle school.

The Path to Higher Education

For older children in foster care, The Foundling developed Road to Success, a program that provides tutors and mentors trained specifically to work with foster care students. They meet weekly in a location of the students' choosing, lowering the chances of "no shows." Often, these tutors and mentors, who may not be much older than the students themselves, become one of the most stable and important relationships these children have.

This relationship is about more than passing the next exam; it's about preparing young people to cope with academic life as part of their lives overall––something most of us spend a lifetime teaching our own children, but that has been completely missing in the lives of this population. In fact, the most important part of this relationship involves developing trust at the outset. These tutors and mentors often spend considerable time learning about the lives of the young people they work with, teaching them to cope, working with them on life skills, and building a genuine bond before they can shift the focus to academics.

It sounds so simple, and for most people, it seems like an obvious step. Children aren't doing well in school––get them a tutor. But, first, that would be unlikely to happen for most children in the child welfare program. And, these are more than mere tutors; they are

carefully selected, undergo a rigorous vetting process, and receive extensive training before they begin work. Does so simple an intervention really make a difference in the lives of children who already face so many other challenges? With the right tutors and mentors, the answer is "yes" in our experience. Nevertheless, we reinforce the fact that while the intervention may seem simple from a distance, it is being conducted by professionals who are carefully selected and trained.

Among children in our care overall, the high school graduation rate has increased from 34% to 55%. Those who were in tutoring in grades 7–11 were promoted to the next grade 91% of the time. The number of high school graduates enrolling in four-year colleges has quadrupled over the last four years. Eighty-eight percent have continued working with their tutors after aging out of foster care. The cost: a little more than $5,000 per year per child.

Clearly, in addition to the human benefits, the long-term cost savings and overall economic impact of a program like this, if scaled up to connect with a much larger percentage of foster children across the country, could be staggering.

Success in College

Last year, The Foundling began a partnership with the City University of New York and New York's Administration for Children's Services to provide support for children under the supervision of the child welfare system who enroll in one of three CUNY campuses.

These young people lack the types of support systems and life experiences available to many of their peers. They may not be prepared to live on their own in a college dorm, manage their expenses or their time, or navigate the college landscape.

We have just completed the first year of this program and are in the process of scaling it up from 40 students to 200. Even though, in the first year, the initial students were not as prepared to begin as subsequent classes will be, we have seen signs of success. Compared with the overall foster care population, which sees approximately 3% graduating from college, we have noted the following:

- Several students have GPAs above 3.0 and about one third have GPAs above 2.6.
- 33 out of 40 initial students are still in our program.
- GPA is clearly connected to the number of tutoring hours students received, but the amount of tutoring needed was not overwhelming. The students with GPAs above 2.6 received at least 17 hours of tutoring over the course of the entire school year.

The programs are staffed by Residence Assistants (RAs) and Tutors. Unlike traditional RAs, ours are full-time employees, not students, and all have backgrounds in education or social work, or both. Living among the students, the RAs focus on helping each one learn how to navigate the college environment. Because RAs are assigned only 10 students, they are able to get to know the students very well and advise on the full range of social and academic issues and challenges they may encounter.

Like in our Road to Success program, tutors help the students stay current in their coursework and provide whatever remediation may be required. Working with a caseload of just 12 students, the tutors, all full-time employees, are able to provide the one-on-one attention necessary for our students to develop and adhere to an academic plan.

The Time Is Now

Our country clearly is looking for new ideas to effect transformative change in areas where problems have long seemed intractable. Our program has the potential to improve the lives of countless children and break the cycle of poverty and, at the same time, can be accomplished through the use of proven techniques that will provide enormous budgetary savings, over the near term and for generations to come. Educating children who have been left behind (generation

after generation) certainly meets that definition, and it could well be an area where broad consensus is possible.

The Foundling is not alone in this effort and is proud to be on the front lines. The evidence-based models that we, and others, are developing and refining continue to yield measurable results that show a clear path forward. If others replicate and expand on them, we can make progress on one of the most intractable challenges we have faced in the past 50 years. Both the financial and moral costs of doing otherwise are unacceptable.

About the Author

Bill Baccaglini, MA, is President and CEO of The New York Foundling. He has overseen expansion of the charity to reduce the operating deficit by $7.5 million, to implement policies and procedures resulting in national accreditation, and to expand the charity's foster boarding and prevention programs. He has led the push toward evidenced-based practices, increasing the effectiveness of service delivery and enhancing The Foundling's role as an industry leader.

Bill previously spent more than twenty years in New York State government, where he was instrumental in the creation of the NYS Office of Children and Family Services (OFCS) in Albany; served as Director of the OFCS Office of Strategic Planning, and Policy Development; and worked to develop a new model for funding foster care services in New York State. He also led the agency's initiative to expand mental health services in child welfare and juvenile justice systems. Contact: bill.baccaglini@nyfoundling.org or by phone at 212-886-4005.

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Threats to the Medically Complex Child

Heather C. Moore, MD, FAAP

The maltreatment of children in the United States today has reached alarming rates, and estimates range from 1 in 8 children by 18 years old to 25% of surveyed children reporting caregiver maltreatment (Jackson, Kisson, & Greene, 2015; Wildeman et al., 2014). This is a public health crisis that affects those at the intersection of medicine, law, social welfare, and child advocacy. One of the most vulnerable groups of children subjected to maltreatment comprises pediatric patients with special heath care needs. It is estimated that from 13% to 19% of children in the U.S. currently qualify as having special needs—children at increased risk for chronic physical, developmental, behavioral, or emotional conditions—as designated by the Maternal and Child Health Bureau in 1988 (U.S. Department of Health and Human Services [USDHHS], 2008). A 2005-2006 survey sponsored by the U.S. Maternal and Child Health Bureau and conducted by the National Center for Health Statistics (within the CDC) revealed that almost 14% of U.S. children met the definition for children with special health care needs (CSHCN) (USDHHS, 2008). Twenty-two percent of family households with children include at least one child with special needs (USDHHS, 2008). There is considerable variability in the specific needs of CSHCN—variation in medical complexity, functional limitations, and required resources (Cohen et al., 2011).

Children with medical complexity (CMC) are a distinct subpopulation of special-needs patients. Requiring the highest degree of medical intervention, CMC accrue the majority of health care resources and costs. CMC are patients with significant chronic conditions, including multisystem disease, severe functional limitations from a neurologic disorder, cancer, sequelae in multiple organ systems, and organ transplants with ongoing effects (Cohen et al., 2011). Advances in medicine have allowed survival of these children far beyond past expectations, albeit with considerable disability. Subsequently, interventions such as medical technology, home nursing care, intensive therapy services, and high utilization of health care resources (Cohen et al., 2011) are common. Estimates of CMC prevalence range from 1% to 5% of the U.S. pediatric population, depending on definitions of health care needs and the number of medical diagnoses (Petska, Gordon, Jablonski, & Sheets, 2017; Berry et al., 2014).

CMC are set apart as specifically vulnerable, even within the context of special-needs patients. Severe limitations in activities of daily living and almost complete dependence on caregivers place these patients in precarious situations. The majority of CMC are unable to accomplish any independent tasks. They are entirely reliant on a multitude of others to carry out the basics of existence—nutrition, dressing, bathing, movement changes, medication administration, and hygiene. Without individuals to attend to these needs, such children would be unable to survive, let alone thrive. Many CMC are technology-dependent, relying on feeding tubes, tracheostomy tubes, respiratory machinery, wheelchairs, and other life-sustaining devices. Polypharmacy, the use of multiple daily medications, is frequently encountered with these patients. Caregivers, including in-home medical personnel, are necessary for medication administration. These factors combined create considerable vulnerability for the medically complex child.

Maltreatment and special needs, especially in the lives of the young, often intrinsically coexist. Maltreated children have increased risk of developing a disability, and CSHCN are more frequently abused and neglected (Corr & Santos, 2017). One study that focused on the prevalence of maltreatment occurring in CSHCN found this population to be 1.8 times more likely to be neglected, 1.6 times more likely to be physically abused,

and 2.2 times more likely to be sexually abused than children without special health care needs (Hibbard, Desch, & the American Academy of Pediatrics [AAP], 2007). A study of more than 4,500 maltreated children, conducted by Sullivan and Knutson (2000), described rates approximately 2 to 3 times higher. CSHCN were 3.76 times more often neglected, 3.79 times more often physically abused, and 3.14 times more likely to be sexually assaulted compared to non-CSHCN (Sullivan & Knutson, 2000). Within the health care sphere, maltreatment of the patient with special health care needs is repeatedly not recognized and diagnosed. The more medically complex the patient is, the more elusive the diagnosis of maltreatment may be. Characteristics of maltreatment in CSHCN as outlined by Sullivan, Knutson, and Ashford (2010) include the following:

1. Types of maltreatment––types in descending order of frequency are neglect, physical abuse, sexual abuse, and emotional abuse. Many children are victims of multiple types.
2. Victim gender––boys were identified to be more commonly neglected and abused in all forms of maltreatment.
3. Types of disabilities¬¬––behavior disorders, speech and language disorders, intellectual disability, and hearing impairments are the most frequently described disorders.
4. Disability and abuse associations––children with behavioral issues, speech and language disorders, and intellectual disability are all at increased risk for neglect and physical abuse. These groups, along with children diagnosed with attention deficit hyperactivity disorder (ADHD), are higher-risk targets for sexual abuse.
5. Age at first maltreatment––53% of abused children in the Sullivan and Knutson (2000) study were <4 years old when maltreatment was first identified.
6. Severity of maltreatment––children with multiple medical disabilities endured the most severe forms of abuse and neglect.
7. Duration of maltreatment––medically complex children endure longer (often years' worth) periods of maltreatment.
8. Perpetrators––generally, children with medical complexity were abused or neglected by known and trusted individuals. In cases of sexual abuse, a perpetrator outside the family committed the acts 40% of the time.
9. Chronic illness or disability––20% of maltreated medically complex children have a parent with a chronic illness or disability, compared with 10% of nonspecial-needs children.
10. Single-parent families––a large portion of maltreated CSHCN (61%) lived in households with a single parent.
11. Site of abuse––the majority of abuse or neglect of a medically complex child occurs in the home or home of a perpetrator.

Medically complex children, the most vulnerable pediatric patients, convene in the center of child maltreatment risk. Their inherent susceptibility resides in the nature of their disability. Severe functional limitations, such as limited or no mobility and technology dependence, incapacitate the child to physically escape from a perpetrator. Limited or no communication prevents disclosure of the maltreatment, and intellectual disability impairs insight into another's abusive or neglectful actions (Nowak, 2015). Specifically, with respect to sexual abuse, children with medical complexity may be targeted owing to their high need of dependency on others. This high dependency may propagate excessive compliance and diminished understanding of offender motives (Nowak, 2015).

Children with medical complexity often place the highest burden of care onto caretakers. The demands are multifactorial and encompass emotional, physical, economic, and social factors. In particular, caregivers with limited social and community support feel overwhelmed and may lack healthy coping strategies, elevating the risk to abuse or neglect a child with medical complexity (Hibbard, Desch, & AAP). Among neonatal intensive care unit graduates, higher caregiving burden is associated with an increased risk for reports to child welfare (Nandyal et al., 2013). Parents and caregivers may suffer sleep deprivation, given the medical demands of the child (Sullivan, Knutson, & Ashford, 2010). Economic demands because of the child's needs may surpass the family's financial resources, especially for the poor. Transportation may be affected, and thus medical appointment adherence declines. Unemployment, particularly if a caregiver loses a job due to missed work from medical care for the child, lends secondary stress to

the fragile home life.

Children with medical complexity frequently have impaired cognition, developmental immaturities, and severe behavioral problems. Given these impairments, formation of the child-parent attachment is insecure, and negativity defines the dyad. Negative parental attitudes weaken the bond, and maltreatment is more apt to result (Corr & Santos, 2017). Noncommunicative children and children with behavioral concerns tend to not respond positively to traditional means of reinforcement. Discipline of such a child can be frustrating, and with a limited repertoire of behavioral control, parents often resort to physical measures (Hibbard, Desch, & AAP, 2007).

Various caregivers in the life of a medically complex child may expand the potential risk for abuse or neglect. Care from other adults exposes the child to more opportunities for harm; these care providers have not often formed any attachment to the child as a protective measure. If the child ventures beyond the home, risk for abuse or neglect rises with exposure to unfamiliar adults. CMC are often perceived, by community members, to have a higher tolerance for pain or to be unaware of pain and, therefore, are subjected to painful physical actions (Taraisman, 2016). Communal attitudes may exist that no one would victimize a child with medical complexity and, as a result, insufficient monitoring for abuse/neglect transpires (Taraisman, 2016).

Physical Abuse and the Medically Complex Child

Noted previously, childhood maltreatment, a pervasive trend in the United States, affects an estimated 1 in 8 children by 18 years old (Jackson, Kisson, & Greene, 2015). Maltreatment comes in many forms: physical, sexual, or neglect (Jackson, Kisson, & Greene, 2015). In 2010, the Child Abuse and Preventive Treatment Act (CAPTA) defined the term maltreatment as "child abuse and neglect," which means, at a minimum, any recent act or failure to act on the part of a parent or caretaker, that results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm." A select group of children may experience multiple forms of maltreatment, while others only one. Child abuse is the physical act of an adult upon a child, causing harm or potential harm. Actions such as hitting, biting, kicking, punching, slapping, shoving, throwing, shaking, smothering, burning, and other are examples of intentional physical abuse. Physical abuse may present with varying injuries, from mild to severe (Jackson, Kisson, & Greene, 2015). Frequently, an inconsistent history or no history at all may accompany the discovery of the corporeal injury. This is especially prevalent in nonverbal children or children with limited intellectual functioning. Diminished or lack of verbal communication from the child prevents first-person knowledge of the abuse.

Several factors of medical complexity intensify the physical abuse risk. Speech and language impairments present a 5 times risk for excessive physical force, while behavior disorders increase the likelihood by 7 times. For the child with intellectual disability, the risk is 4 times higher for all forms of risk and is 2 times greater in children with visual or orthopedic impairments (Sullivan & Knutson, 2000). Referring again the defining factors for children with medical complexity, the majority of CMC reside in these categories simultaneously. This serves to foster scenarios predisposed for caregiver frustration and forceful physical interactions. A severely

autistic child with a gastrostomy tube may repeatedly pull out the tube, requiring caretakers to replace it each time. Exasperation ensues and the caregiver forcibly inserts the tube, injuring the child. This scenario may repeat itself with a multitude of technology–– replacement of a tracheostomy tube, insertion of a urethral catheter, cleaning and care of wounds. Attendants can use excessive force with a nonambulatory child, fracturing or dislocating bones. The nature of the medical conditions may inherently lead to physical trauma. Children with cerebral palsy often develop osteopenia (weakened bone strength), and any movement other than done with excessive care, may hurt them.

Case 1—Physical Abuse:

A 12-year-old male with Kallman syndrome (delayed or no puberty, no sense of smell), hearing loss, mutism, severe autism, intellectual disability, failure to thrive, short stature, and gastrostomy tube feeds presented to the special-needs clinic with human bite marks on multiple parts of his body. Prior to the abusive injuries, the child had been placed in a group home, with three other patients. These patients were all grown men with intellectual disability and inability to live independently. The patient visited the clinic that day to meet with his child psychiatrist and adjust his behavior medications. The group home staff member noted the patient had new "bruises" on his back, legs, and upper posterior thighs. Upon examination, the bruises were determined to be consistent with adult-sized human bite marks and in locations the child would be unable to reach with his own mouth. A full investigation ensued with Children Protective Services (CPS) and Adult Protective Services (APS), but the perpetrator was not discovered, and the child returned to the home.

The patient was followed, and it was documented that the bruising from the bite marks had mostly resolved, until return to the clinic 2.5 months later. At this visit, new adult-sized human bite marks were noted on bodily areas the patient would be unable to reach on his own. Referrals were again sent to CPS and APS. The child currently remains in the group home without positive identification of the offender.

Sexual Abuse and the Medically Complex Child

Sexual abuse of minors, according to the Child Abuse Prevention and Treatment Act (CAPTA), is defined as "the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct; or the rape, and in cases of caretaker or inter-familial relationships, statutory rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children" (CAPTA, 2010). Again, cases of sexual abuse in the nonverbal or limited verbal child present an added degree of difficulty with lack of first-person reporting.

As with physical abuse, specific disorders raise the probability of sexual abuse. In descending order of magnitude, these disorders are behavior disorder (5.5 times more risk), mental retardation or intellectual disability (4 times more risk), speech and language condition (3 times risk), and all others being equal at twice the risk (Sullivan & Knutson, 2000). Predators will target medically complex children specifically because the children have neuromuscular conditions that alter or cease physical movement. Children with limited to no expression communication are preyed upon not only because they cannot alert someone at the time but also will not subsequently disclose. Early pubertal developmental is well documented in children with central nervous disruption or insult. Consequently, these children will develop secondary sexual traits, such as breast development and pubic hair, quite early. Findings such as this can give the appearance that the child may be older than the actual age. Younger patients can be targeted as well. If the patient has mild impaired intellectual disability, persuasion and grooming may be tactics leading to sexual abuse.

Case 2 – Sexual Abuse:

A 15-year-old female with mild intellectual disability, quadriplegic cerebral palsy, dependency on a wheelchair, bladder and bowel incontinence, and seizure disorder presented to a special-needs clinic and during part of the visit disclosed to the physician that she had been touched on her breast and inner thigh by a male PE teacher at her high school. The patient reported the touching had

occurred on the outside of her clothes, and it was not the first incident. The coach had touched her legs in a way on various occasions that made her feel uncomfortable. The mother noted that her daughter had stated the coach made her feel uncomfortable, but she did not disclose the fondling. A report was made to CPS and the patient was removed from the school. Subsequently, the PE teacher was fired from the high school.

During a later therapy session, the adolescent revealed that the coach had paid extra attention to her for months, calling her his "special girl," and would stroke and fondle her. Reportedly, the coach would whisper "special things" into the patient's ear, telling her how important she was to him. Given her quadriplegia, the patient was unable to move herself and completely dependent on the teacher to move her during this time. It was assessed that the teacher had groomed this adolescent to accept the abuse as special attention, and the abuse continued for many months before disclosure.

> *" Medically complex children are the most vulnerable of special-needs children and have the greatest risk for maltreatment."*

Medical Child Abuse and the Medically Complex Child

Medical child abuse (MCA), a complex form of maltreatment, most commonly involves the exaggeration, fabrication, and/or the induction of the signs or symptoms of illness by external methods. Medical child abuse results in overutilization of medical care, intervention, and resources (Berry et al., 2014) at the instigation and often insistence of the principal caregiver. Physically, the child is subjected to excessive medical examinations, blood draws, diagnostic imaging (often invasive), unnecessary surgical procedures, and administration of medication with potentially harmful side effects (Petska et al., 2017). In addition to the physical aspect of the maltreatment, emotional abuse and neglect can be present as well. The abnormal child-caregiver dyad in a case of caregiver-fabricated illness produces extreme emotional distress for a child (Petska et al., 2017). The discrepancy of harmful actions by the caretaker in medical child abuse and the expected care-taking role of a loved one to a child creates internal emotional turmoil for the child. This may be heightened in a child with intellectual disability, complex medical needs, or multiorgan disease.

Children with medical complexity and medical child abuse victims frequently present with similar clinical presentations (Petska et al., 2017). Situations may transpire that lead to an inaccurate diagnosis of medical child abuse when not present or a missed diagnosis of MCA, coexisting in a child with medical complexity (Petska et al., 2017). There is significant enough overlap between medical complexity and medical child abuse that up to 30% of MCA victims have an actual underlying medical condition (Petska et al., 2017). As with other forms of abuse, the medically complex child suffering from medical child abuse is often unable to describe the maltreatment, due to speech and language disorders and intellectual disability. As opposed to children without medical complexity, a special-needs patient may have genuine symptoms present that are exaggerated by the MCA perpetrator or manipulated by intentional actions to worsen. A health care provider in this circumstance may escalate therapeutic inventions in an effort to help, thus unsuspectingly perpetuating the abuse.

Case 3 – Medical Child Abuse:

A 2-year-old female followed closely in the special-needs clinic was diagnosed as a victim of medical child abuse after at least 1 year of suspicion by the primary medical provider. The child was a former extreme premature infant who had a prolonged NICU stay and had diagnoses of subglottic laryngeal clefts, ventriculomegaly, bronchopulmonary dysplasia (BPD), and reflux. Medical child abuse was initially suspected at 10 months of age, due to more than seven hospitalizations for apneic episodes. The child abuse physician followed the child for

1 year as the primary care pediatrician, and it was noted that the mother repeatedly notified the on-call providers in the practice of apneic episodes so severe that CPR was required. Upon further inquiry, the child always returned to baseline, and the mother was the only witness, despite having home nursing training. Seventeen office visits to the special-needs clinic alone are documented over a 1-years period of time. The mother maintained the use of supportive respiratory equipment and convinced multiple subspecialists to prescribe inappropriate medications, based on symptom report only; the lab testing was normal in these instances. The infant was admitted for a therapeutic separation from the mother, after it was determined that the mother repeatedly exaggerated symptoms, likely falsified symptoms, and maintained inappropriate treatments for the child.

While hospitalized and removed from the mother's care, the patient was weaned off her seizure medication after it was determined she did not have seizure activity. Her respiratory support machines were discontinued after studies indicated no need and the child required only one medication for her mild chronic lung disease. She is currently in the father's custody and has supervised visitation with the mother.

Neglect and the Medically Complex Child

Child neglect is the most common substantiated form of maltreatment reported to child welfare agencies (Jackson, Kisson, & Greene, 2015). The Children's Bureau, in 2004, reported that 60% of child victims suffered from a form of neglect (USDHHS, 2008)). Neglect subtypes include educational neglect, nutritional neglect, physical neglect, supervision neglect, and medical neglect. When a child's medical needs are not met and the child is harmed or at risk of harm, the parent has medically neglected the patient. Boos & Fortin (2014) describe the various dimensions of medical neglect:

1. Temporality: neglect can be an isolated rare event, a recurrent but intermittent situation, or a chronic and ongoing issue.
2. Potentiality of harm: mistreatment may be remote, imminent, or actual.
3. Probability: when harm is not yet actualized, its likelihood and severity are subject to probability.
4. Severity of harm: harms vary from mild discomfort to fatalities.
5. Etiology: Rarely, ongoing medical neglect is the consequence of a single person's action or inaction. Medical neglect occurs at the intersection of the family's life and the medical system.

Neglect in the child with medical complexity manifests in various forms. The child requiring gastrostomy tube feeds may present with failure to thrive because nutrition is not being supplied. Pressure wounds and ensuing complications may develop in a nonambulatory child who is dependent on others to adjust positioning of bodily pressure points. A child needing multiple medications for a variety of chronic conditions may fail to receive these in a timely manner, or at all. Accordingly, the child may suffer worsening of physical symptoms such as seizures, muscular spasms, dystonic posturing, pain, or mental and emotional symptoms, including mood lability, depression, mania, or exaggeration of aggression.

Medical neglect is the failure to attain or a significant delay in attaining recommended health care services. It can also include noncompliance with medically prescribed treatments. Chronic illnesses place a higher demand on caregivers and families. More routine contact with the medical systems is necessary and families may miss appointments due to employment concerns. Medical fragility with multiorgan involvement raises the likelihood of poor outcomes, even with small departures from prescribed care (Boos & Fortin, 2014). The American Academy of Pediatrics has outlined criteria for the diagnosis of child medical neglect (Jenny & AAP, 2007):

1. A child is harmed or is at risk of harm because of lack of health care.
2. The recommended health care offers significant net benefit to the child.
3. The anticipated benefit of the treatment is significantly greater than morbidity, so that reasonable caregivers would choose treatment over nontreatment.
4. It can be demonstrated that access to health care is available and not used.
5. The caregiver understands the medical advice given.

Misperceptions of medical information, derived from family members, social medial Internet sites, and self-directed Internet searches can foster an environment of distrust with the established medical system. Families may choose to opt for nontraditional interventions for their child's disorders and symptoms. Medical neglect still exists in such situations, if the above criteria are fulfilled.

Case 4 – Neglect:

A 2-month-old female infant presented to the special-needs clinic to establish care. The child had a severe upper airway anomaly requiring placement of a tracheostomy tube and use of a ventilator to maintain normal breathing. Along with her tracheostomy tube, a gastrostomy tube was also placed to ensure the child received adequate nutrition, as eating by mouth was difficult and potentially harmful for the infant. At the second clinic visit, it was noted the mother refused to have the patient weighed (had been weighed in another clinic earlier that day), and when mother's inappropriate feeding of the child was broached by provider, the mother reportedly became agitated and refused to heed the provider's advice. This occurred despite noted weight loss in the infant. Recommendations were again made to the mother, but the mother stated, "The babies in the NICU are too fat, and I will not let my daughter become fat." She also conceded that she had discontinued any gastrostomy tube feeds, giving only oral nutrition.

At each subsequent visit, the infant's weight gain was deemed inadequate, and every attempt to engage the mother was fraught with hostility. The mother refused feeding increases, despite stagnant weight gain. The mother had the patient's gastrostomy tube removed against medical advice. Upon further investigation, it was revealed the child was receiving no therapy interventions and not attaining any developmental gains. After multiple clinic visits, psychiatry was brought in to evaluate mother, but she refused. The mother then fired the special-needs clinic and the infant's pulmonologist, who both had discussed Child Protective Services involvement. The infant was evaluated by a community pediatrician who documented weight loss on two separate visits and subsequently hospitalized the child. During this hospitalization, the diagnosis of neglect was documented, the gastrostomy tube was replaced, and the child was removed from the mother's custody. She has since been placed in medical foster care and is growing appropriately and gaining developmental milestones with therapy intervention.

Conclusion

The medically complex child lives in a sphere of vulnerability and fragility, a sphere fraught with diseases, disease complications, medications, therapies, technology and equipment, medical personnel, and caregivers. Within this sphere lies the hidden risk of maltreatment. This maltreatment comes in many forms: human bites in a defenseless, autistic mute child; the grooming and sexual abuse of a wheelchair-bound adolescent female yearning to feel special; a medically complex patient whose mother refuses to permit improved health; and an infant allowed to starve by a mother whose mental health obscures her own perception of appropriate growth of her infant. Individuals entering into the sphere of the medically complex child should remain vigilant in monitoring for and recognizing maltreatment. Caregiver education, caregiver respite, and other prevention strategies must be at the forefront of maltreatment intervention, particularly pertaining to children with medical complexity. Caregivers and families require respite time away from attending to the child's medical needs. The health care provider proactively should evaluate for and order appropriate in-home services, such as private duty nursing or paid personal attendant care. Medical treatments in conjunction with therapeutic behavioral counseling can address aggression or other problem behaviors. Consistent care provided by a pediatrician helps establish a trustful relationship within the medical system and allows for health literacy education. These are a few examples of proactive measures the health care system can adopt. Other fields intersecting with child abuse prevention must also design and implement protective practices within the scope focused on medically complex children.

About the Author

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News of the Organization

Janet F. Rosenzweig PhD, MPA

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- ***Challenges in the Evaluation of Child Neglect*** (Published 2008)
- ***Psychosocial Evaluation of Suspected Sexual Abuse in Children*** (Published 1997)
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APSAC needs your financial support; as you consider your end-of-year charitable gifts, please consider APSAC; find some options for giving here.

Best wishes for a lovely holiday season and New Year!

Join or start a State Chapter

APSAC state chapters provide a great opportunity for networking to share information and resources of all kinds. Currently APSAC has chapters in California, Florida, Iowa, Michigan, New York, North Carolina, South Carolina, and Wisconsin. Results of our last

member poll indicated strong interest among APSAC members to start chapters in Georgia and Virginia. When a state initiates a chapter, APSAC offers a small startup grant. Thereafter, state chapters receive an annual stipend of $15 per member to support statewide activities, such as a conference, newsletter, website, or other resource to further the goal of "strengthening practice through knowledge" in each state. For a list of active chapters and their contact information, check here; for information on starting a new chapter, contact apsac@apsac.org

Let APSAC help you plan your conferences

APSAC has access to some of the best trainers and foremost researchers in child maltreatment in the country. If you are part of any organization planning a conference for 2018, contact us and let us help!

Support for court cases

The APSAC amicus committee can prove to be an invaluable resource when a high-profile court case is being heard in your state. We can quickly gather leading experts to work under the guidance of the attorneys on our amicus committee to prepare an amicus brief, written to ensure that the most current research findings are available to the court. To contact the amicus committee about a potential case, email info@apsac.org.

Join us, June 13-16 for the 25th Anniversary Colloquia in New Orleans!

Excitement is growing for the APSAC 25th Anniversary Colloquia; more abstracts were submitted for consideration as presentations than ever before! A vibrant educational program is being assembled, promising thought-provoking and informative days; New Orleans style anniversary celebrations are in the works, promising exciting evenings! Watch our website for updates and registration information; this is certain to fill up quickly!

An Update on the National Summit to End Corporal Punishment in The United States

On October 12 and 13, 2017, the Vincent J. Fontana Center for Child Protection of the New York Foundling and APSAC co-sponsored the National Summit to End Corporal Punishment in the United States. The science is now unequivocal; corporal punishment is harmful to children. Recognizing the need to impact social policy and cultural norms, this Summit brought together the leading national experts and researchers in violence to children, representatives from national professional organizations, and social change experts. The goals of the Summit were to develop a national strategy to end corporal punishment, create the framework for a national public health campaign, and conceptualize the framework for a coordinating body to train professional staff, educate parents, and disseminate information about evidence-based parent programs. The summit proceedings will be published, and an implementation plan is under development. Please follow the progress of this important initiative at www.apsac.org.

It's not too late to join us for Advanced Training Institutes at the San Diego International Conference on Child and Family Maltreatment, January 29, 2018!

Option 1: ADVANCED ISSUES IN CHILD SEXUAL ABUSE

Presenters: Debra Esernio-Jenssen, MD; Barbara L. Knox, MD

Taught by experienced physicians, this one-day advanced training shares valuable information for members of any profession interested in medical evaluation and evidence, sex trafficking and sexualization of children in the media and how it relates to child sexual abuse.

Option 2: CHILD MALTREATMENT PREVENTION STRATEGIES ACROSS THE SOCIAL ECOLOGY

Presenters: Randell Alexander, MD, PhD, Sandra Alexander, MEd, J. Bart Klika, PhD, MSW; Paul Lanier, MSW, PhD; Stacie Schrieffer LeBlanc, JD, MEd; Janet Rosenzweig MS, PhD, MPA; Deborah Sendek, MS

Experts will present one major prevention strategy directed at each level of the social ecology, e.g. individuals, families, communities and society, offering topical presentations on what is known about preventing different forms of child abuse and neglect.

Register here!

Thank you to our 2017 Corporal Punishment Summit Attendees!

Mel Schneiderman, PhD, *The New York Foundling*
David Corwin, MD, *Chair, Academy on Violence and Abuse and Director of Forensic Services in Pediatric at the U. of Utah*
George Holden, PhD, *Southern Methodist University and President of U.S.A. Alliance Against Hitting Children*
Stacie LeBlanc, MEd, JD, *New Orleans Children's Advocacy Center & Audrey Hepburn CARE Center of Children's Hospital*
Cathy Taylor, PhD, *Tulane University*
Liz Gershoff, PhD, *The University of Texas at Austin*
Viola Vaughan-Eden, PhD, *Norfolk State U. and President, National Association to End Interpersonal Violence*
Randell Alexander, MD, PhD, *Academy on Violence and Abuse University of Florida*
Victor Vieth, JD, *Gunderson Health*
Mary Pulido, PhD, *New York Society on the Prevention of Cruelty to Children*
Shawna Lee, PhD, *University of Michigan*
Vincent Palusci, MD, *NYU Lagone Medical Center*
Robert Block, MD, *Past President American Academy of Pediatrics; The University of Oklahoma*
Janet Rosenzweig, PhD, MPA,
American Professional Society on the Abuse of Children
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George Carey, *The Family Room in Norfolk*
Stuart Hart, PhD, *International Institute for Child Rights and Development*
Gail Horner, PhD, *National Association of Nurse Practitioners*
Jennifer Hahn, *Fenton Social Service Agency*
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Lauren Caldwell, PhD, JD, *American Psychological Association*
Ismael Ozanne, JD, *District Attorney, Wisconsin*
Teresa Rafael, MSW, *National Alliance of Children's Trust and Prevention Funds*
Debra Esernio-Jenssen, MD, *Lehigh Valley Physician Group*
Rosemary Chalk, *Institute of Medicine, Keck Center*
Jeff Linkenbach, PhD, *The Montana Institute*
Robert Sege, MD, *American Academy of Pediatricians*
Robert David Cohen, *Rain Barrel Communications*

Washington Update

Ruth Friedman, PhD

Tax Legislation

Congressional Republicans are using the reconciliation process, which requires only 50 votes for Senate passage, to enact a very large tax cut. The House of Representatives passed their bill on November 16th, and the Senate passed their bill December 2nd. They are working to resolve differences between the two bills and pass a final bill into law before December 25th. Both bills are centrally focused on cutting the corporate tax rate and in fact will lead to tax increases for many low- and middle-income families. In addition, both bills involve changes that would impact college students, graduate students, and universities, including changes that would greatly increase taxes for graduate students. In addition, the Senate tax bill repeals the individual mandate in the Affordable Care Act, which is expected to increase health care premiums and lead to 13 million fewer insured Americans.

Though there are a number of tax-specific provisions that differ between the two bills, their impact on domestic spending programs are very similar. The cost of the tax legislation will add at least 1 trillion dollars to the deficit. Most child, family, and other stakeholders believe Congressional Republicans will use the trillion-dollar deficit increase to justify drastic cuts to domestic spending.

No Progress on Funding for CHIP or MIECHV

Funding to states for the Children's Health Insurance Program (CHIP) and the Maternal Infant Early Childhood Home Visiting program (MIECHV) expired on September 30, 2017 and the programs remain unfunded. A list of when states will run out of CHIP funding can be found here. Congress has not found bipartisan funding offsets to pay for the reauthorization of these programs. Stakeholders remain hopeful this will be addressed by the end of 2017.

Annual Appropriations

The federal government is currently being funded under a short-term Continuing Resolution (CR) that expires on December 22, 2017. This means Congress will have to pass another CR or final bill in order to keep the government funded and running past the 22nd. It is probable that Congress will have to pass another short-term CR, perhaps into mid-January, before trying to pass a final appropriations bill to carry funding through the entire fiscal year.

Future Federal Action on the Safety Net

Children and family stakeholders are very concerned about possible federal action in 2018 that would dramatically reconfigure and cut the social safety net, including programs such as Medicaid, TANF, SNAP (formerly known as food stamps), and low income housing. The President and Republican Leaders have recently repeated stated their intention to soon pursue drastic changes to restructure and reduce the federal support for social safety net programs (e.g., see here, here, and here). Blueprints for some of these proposals were previously put forth in Speaker Ryan's *A Better Way* plan. In addition to action in Congress on these programs in 2018, the Trump Administration is also expected to act shortly. Health advocates are anticipating the Trump Administration will approve numerous state waiver requests that were denied under the Obama Administration that would allow states to change their Medicaid program to include new restrictions such as work requirements or time limits. In addition, the Administration has been considering issuing an Executive Order that would require federal

agencies to review low-income assistance programs and propose new rules to conform to new program principles.

HHS Releases FY16 AFCARS Data

On November 30, the Children's Bureau, an office of HHS's Administration for Children and Families released the FY2016 report with the new data from the Adoption and Foster Care Analysis and Reporting System (AFCARS) for FY2016. The data show an increase in the number of children in foster care as well as an increase in the number of adoption from the child welfare system. Of the 15 categories states can report for the circumstances associated with a child's removal from home and placement into care, drug abuse by a parent had the largest percentage point increase, from 32 percent in FY2015 to 34 percent in FY2016.

Staying Informed

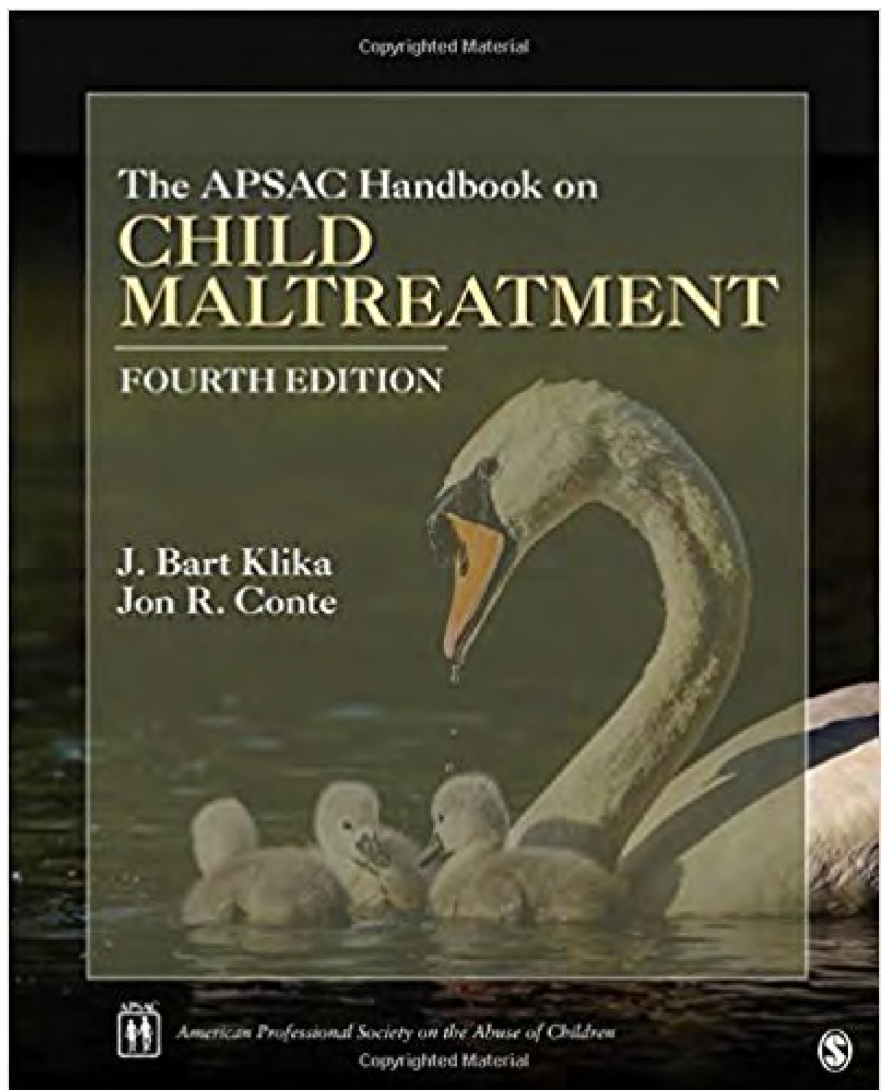
Interested in staying informed and up to date on a regular basis? One way to stay informed about federal happenings impacting children and families is the Coalition for Human Needs, which produces a bimonthly legislative newsletter as well as action alerts. You can find it here.

About the Author

Ruth Friedman, Ph.D., is the Executive Director of the National Child Abuse Coalition. She is an independent child and family policy consultant and national expert on early education, child welfare, and juvenile justice. She spent 12 years working for Democratic staff of the U.S. House Committee on Education and the Workforce, helping spearhead early learning, child safety, and anti-poverty initiatives. Dr. Friedman has a Ph.D. in clinical psychology and an M.A. in public policy. Prior to working for Congress, she was a researcher and therapist, focusing on resiliency in children and families living in high poverty neighborhoods.

Need a last-minute holiday gift for a colleague? The Fourth Edition of the *APSAC Handbook of Child Maltreatment* is here!

The Fourth Edition of this best-selling handbook provides readers with the most up-to-date theory, research, and best practices in the field of child abuse and neglect. Edited by leading experts, the book covers all aspects of child maltreatment, from physical abuse to sexual abuse and neglect, focusing on etiology, consequences, investigation, and treatment and systems.



Updates include new content on assessment and mental health interventions, prevention, as well as global perspectives. Comprehensive and easy to read, the handbook will serve as an invaluable resource for students and professionals—both emerging and seasoned—across disciplines, but part of the same movement dedicated to improving the lives of maltreated children. Proceeds from the Handbook help support APSAC operations.

Help your colleagues strengthen practice through knowledge in 2018—order the Handbook today!

Conference Calendar

March

March 9–13, 2018
National CASA/GAL Annual Conference
Boston, MA
800-628-3233
www.casaforchildren.com

March 18-21, 2018
National Council of Juvenile and Family Court Judges
National Conference on Juvenile Justice
San Diego, CA
775-507-4777
www.ncjfcj.org

March 19–22, 2018
34th International Symposium on Child Abuse
Huntsville, AL
256-533-5437
www.nationalcac.org

April

April 26–29, 2018
Child Welfare League of America
Building Resilience in Challenging Times
Washington, DC
202-688-4200
www.cwla.org

June

June 6-9, 2018
AFCC 55th Annual Conference
Compassionate Family Court Systems:
Trauma-Informed Jurisprudence
Washington, DC
608-664-3750
afcc@afccnet.org

June 13-16, 2018
American Professional Society
on the Abuse of Children
25th Anniversary Colloquium
877-402-7722
apsac@apsac.org
www.apsac.org

July

July 9-13, 2018
APSAC Forensic Training Clinic
Seattle, WA
614-827-1321
apsac@apsac.org
www.apsac.org

September

September 5-9, 2018
22nd International Summit and Training
on Violence, Abuse and Trauma
San Diego, CA
858-527-1860, x 4031
http://www.ivatcenters.org

October

October 22-26, 2018
APSAC Forensic Training Clinic
Norfolk, VA
614-827-1321
apsac@apsac.org
www.apsac.org

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