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CHILD HEALTH AND DEVELOPMENTAL PROBLEMS AND
CHILD MALTREATMENT AMONG AFDC FAMILIES*

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ABSTRACT

This paper explores the complex interrelationship among the physical health and developmental problems of a child, child abuse and neglect, and poverty. Gaps in agency attention to children's medical needs are identified and recommendations made for reducing these gaps. The analysis is based on interview and agency data for 45 families randomly selected from a group of 365 AFDC recipient families under supervision for child abuse and neglect.

A prominent theme in the child abuse and neglect literature is that certain children have characteristics that increase their vulnerability to abuse and neglect. Characteristics that have been identified are mismatches between the personalities of mother and child (Schaffer and Emerson, 1964; Steele and Pollack, 1968), unattractiveness (Dion, 1974), and the resemblance of a child to a disliked relative of the parent (Helfer, 1970). Exceedingly limited attention has been paid to the way in which the physical health problems and developmental disabilities of a child contribute to parental frustrations and difficulties, thereby increasing the likelihood of child abuse and neglect.

Among the wide range of children's physical health and developmental problems which are potential precipitants of maltreatment, only prematurity of low birth weight of newborns has received much attention. The higher rate of abuse found among these infants has been attributed, in part, to the fact they tend to be less attractive and more difficult to care for than normal babies and consequently, more likely to evoke a negative response from their parents. In addition, such infants often require prolonged hospitalization and special medical care which separates them from their mothers shortly after birth. This separation, to the extent that it interferes with the establishment of emotional bonds between infant and parent, is thought to increase the likelihood of subsequent abusive behavior (Brown and Bakeman, 1974; Elmer and Gregg, 1967; Klein and Stern, 1971; Silver, Dublin, and Lourie, 1971; Skinner and Castle, 1969; and Stern, 1973).

Helfer (1970) observes that a child who imposes special demands upon its parents, such as a handicapped, mentally retarded, or hyperactive child may repre-

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sent an intolerable stress factor, provoking the parent to rejection or abusive behavior. Friedman (1976) in a review of the child abuse and neglect literature, notes that a number of studies reveal that abused children have a higher rate of physical and developmental problems than children in comparison groups. Although there is little evidence to support it, the prevailing interpretation is that these problems are the result rather than the cause of the maltreatment (Helfer, 1976). There is little doubt that severe physical abuse or neglect has the potential to impair a child's physical health and development. There is also little doubt, albeit an interpretation receiving much less attention, that the physical health and developmental problems may contribute significantly to parental maltreatment of a child. Raising a child with an acute or chronic illness, a physical disability, or a developmental problem is an extremely difficult task for any parent. It is even more of a burden for poor parents who live in deprived material circumstances and may, themselves, suffer from some physical or emotional problem. Children's health and developmental problems and the capacity of parents living in poverty to provide adequate care are viewed as closely interrelated, each often the cause and effect of the other. This paper, based on a study which focused upon the total set of physical health and developmental problems of poor children, seeks to demonstrate how these factors, occurring in a context of poverty, are related to parental behavior that comes to be identified as abuse and neglect.

Study Methodology

The analysis is based on a study of 45 families randomly selected from a larger sample of families receiving Aid to Families of Dependent Children (AFDC). All were under the supervision of the public child welfare agency for child abuse and neglect. The small sub-sample, representative of the larger group of maltreating families, afforded a concrete and in-depth picture of the complex interrelationships among children's health and developmental problems, difficulties associated with living in extreme poverty, and parental neglect and abuse of children. Sources of data were interviews with parents, comments and observations of interviewers, and reviews of agency case records of the families interviewed (Wolock and Horowitz, 1979).

Description of the Families

Demographic characteristics. Forty-three of the 45 families were one-parent families headed by women. Fifty-three percent were black (24), forty-two percent white (19), and four percent Puerto Rican (2). The average number of children per family was between 4 and 5 (4.24). Forty-two percent of the families (19) had 5 or more children. Sixty-one percent of the families (28) lived in the most densely populated and socially and economically deprived urban areas of the state. Twenty-two percent (10) lived in urban and suburban communities of somewhat lesser social and economic deprivation, while the remaining families (16%, or 7) resided in suburban and rural communities which were the least socially and economically deprived.

Material living conditions. The sub-sample was drawn from a group of families who lived in severely deprived material circumstances. Overcrowding, often going without heat and hot water, and housing in poor repair were typical of the conditions under which these families lived. Most families reported that their welfare check ran out before the end of the month and many faced frequent financial crises such as evictions and utility shutoffs (Wolock and Horowitz, 1979).

Parent's problems. Fifty-three percent of the parents (24), mostly mothers, had a physical illness or problem including hypertension, anemia, asthma, susceptibility to pneumonia, heart disease, emphysema, various conditions which had been treated by surgery, and complications resulting from surgery.

Thirty-three percent of the caretakers (15) suffered from a serious mental or emotional problem. Severe depression was most common.¹ Sixty percent of the families (27) had an adult member who used alcohol excessively and 20 percent an adult member who had been a heroin user. Two mothers were identified as having limited intellectual capacity. All but 6, or 87 percent of the caretakers had at least one of these problems; many had multiple problems.

The maltreatment. The predominant type of maltreatment was neglect only, found for 69 percent of the families (31). Both neglect and physical abuse occurred in 24 percent of the families (11) and physical abuse only, in 7 percent (3). The main form of physical abuse was severe beatings or other physical acts resulting in an actual or potential physical injury. Sexual abuse, subsumed under physical abuse was found in two families.

The most frequent type of neglect, occurring in 51 percent, or 23, of the study families was the failure to provide adequate physical care of the children in terms of nutritional and regular meals with sufficient amounts of food, adequate clothing, and safe and hygienic living quarters. Next in frequency (in 40% or 18 families) was the failure to provide adequate supervision such as leaving children alone for extended periods of time or leaving them with inappropriate baby-sitters. Inattention to the schooling needs of children was noted in 16 percent (7) of the families and emotional neglect or harassment in 11 percent (5).

The child's medical condition was given as a reason for agency supervision in 18 percent of the families (8). In all but one of these situations the parent had neglected the child's medical problem. For example, a visiting nurse referred one family to the agency because the mother failed to obtain medical care for two children. One child had an acute infection of the subcutaneous tissue, cellulitis, and another had a malformed foot. One family was reported to the agency because an eight-year-old with a seizure disorder and rheumatic heart disease was not being brought to the hospital clinic for medical treatment. In the one case which did not constitute neglect by the parent, the mother herself sought financial help from the agency so that she might obtain medical care for one child who needed open heart surgery and for a second child, described by the mother as a "bleeder."²

The Physical Health and Developmental Problems of Children

The overall picture of the physical health and developmental problems of the children is exceedingly grim. Seventy-eight percent of the 45 families (35) had at least one child and nearly 60 percent (26) more than one child with a physical health or developmental problem. Over a third (16) had three or more children with

¹The caretaker was identified as having a serious emotional problem when the case record indicated that a professional diagnosis of such a problem had been made, the caretaker had been hospitalized for mental illness, the caretaker had made one or more suicide attempts, and/or the caretaker reported extended and extreme feelings of depression.

²The family was included in the study because the mother was not feeding the children properly.

such problems. One large family had nine children with physical health or developmental problems. Many of the children had multiple problems. Thirty-eight percent (17) of the families had a child under five with a physical health and/or developmental problem.

Nearly two-thirds of the 45 families (29) had a child with some chronic illness such as rheumatic heart disease, asthma, high blood pressure, sickle cell anemia, failure to thrive, lead poisoning, and hemophilia. Nearly a fourth (11) had a child who had suffered from an acute illness including pneumonia, colds serious enough to require hospitalization, acute bronchitis, meningitis, chronic diarrhea, gastroenteritis, gonorrhea, severe hemorrhaging as the result of an abortion, and a bladder ulcer. Twenty-nine percent of the families (13) had a physically handicapped child. A speech defect, hearing problem, paralysis, clubbed foot, crippled arm, one leg markedly shorter than another, and a malformed foot were among the conditions noted. Children's neurological disorders such as cerebral palsy, epilepsy, other seizure disorders, and various neurological impairments were found in 18 percent (8) of the families.

Nearly a fourth of the families (11) had a child who was mentally retarded. Compounding the situation, in all but one of these families other children had some physical health problem.

As appalling as this picture is of the health and developmental problems of children, it probably is an underestimate of the actual number of health and developmental conditions. The information is based on what parents reported in interviews and what was recorded in the case record. It has already been amply documented that when interviews are the source of data on illness there tends to be underreporting of conditions (National Center for Health Statistics, 1975). Furthermore, information in the case record about children's health tends to be uneven and reported primarily when it is prominent and extremely serious. In addition, case workers sometimes focus their attention on one or certain children in the family, providing information on these children only.

Comparisons with other studies of children's health problems are difficult because of differences in study populations, time periods, indicators of health status, and methods of assessment. Nevertheless, the findings of this study suggest an even greater prevalence of physical health problems among the children of these families compared with the children of other poor families. Overall, 48 percent of the 191 children (92) had a serious medical condition. Data reported by the National Center for Health Statistics for families earning \$5,000 or less (1973) indicates that examination by a physician showed that 12.6 percent of children aged 6-11 and 28.3 percent of youths 12-17 had significant abnormal findings.³

Children's Health and Developmental Problems as Factors Contributing to Maltreatment

The burden of caring for a sick child and the strain it imposes on parents' energies, family resources and relationships is described in a number of research studies and accounts of individuals working with such children (Breslau, Staruch, and Gortmaker, 1980; Burton, 1974; Burton, 1975; Davis, 1963; McCollum and Gibson, 1970; Moos, 1973; and Travis, 1976). As noted in this literature, much of the physical and emotional strain falls upon the mother. Many medical conditions re-

³Excluded were acute infections, dental caries, defective vision or hearing that would be evident through testing or abnormal laboratory findings.

quire the carrying out of complex and time-consuming treatment regimes which make more difficult the execution of normal household routines and activities. It is not uncommon to find that ill children present greater problems than healthy children in such areas as feeding, sleeping, toilet training, irritability, school adjustment and performance, and social development. Mothers (and fathers too) in addition to constantly worrying about the ill child often feel guilty about having treated the child "badly" prior to the onset of the illness or handicap, and, in the case of a genetically-based medical condition, guilty about having transmitted the condition to their child. Parents who have to watch their child experience pain describe themselves as feeling desperate and helpless. Due to the need for constant surveillance and the uncertainty of the possible occurrence of a medical crisis many mothers fear going out of the home and are deprived of social and recreational outlets.

Difficulties for the mother also stem from the impact of a child's illness on other family members and relationships. Healthy children in the family, resenting the greater attention to the sick sibling, sometimes make greater demands on the mother or are more difficult to manage. The mother, who may have been more lenient with the sick child may also feel she must be equally lenient with the well child, thus, in some instances, compounding the behavioral problems. Under certain circumstances, a sick child in the family has been found to adversely affect the marital relationship. The physical and emotional exhaustion experienced by the parents is thought to limit opportunities for gratifying marital interactions. Husbands and wives who are unable to communicate about the child's illness tend to drift apart.

Caring for a chronically ill or disabled child generally imposes a heavy financial burden on the family's resources. Many chronically ill children need to be periodically hospitalized. Depending on the existence and type of medical insurance or Medicaid eligibility, and the hospital's policy of billing poor families, the financial burden varies but may be devastating. Transportation to emergency medical care, regular office or clinic visits, and trips to distant specialists also pose a serious financial problem for many families. Special and costly equipment and supplies are often needed. While some of these expenses may be paid for by philanthropic organizations or tax-supported programs, only part of the cost or certain items may be covered. Food costs tend to be higher since children with chronic illnesses often require special diets. This is likely to impose a particularly great hardship on the low income family since such diets often require the purchase of more costly food items. In the light of these problems, it is not surprising that a number of studies show that mothers of chronically ill and handicapped children are more likely to have emotional problems than mothers of normal children (Breslau, 1980; Cummings, Bayley, and Rie, 1966; Kulczycki, Robinson, and Berg, 1969).

These pressures, difficulties, and frustrations are likely to contribute to child abuse and neglect in families which are far less vulnerable than the families in this study. Among the study families, beset by numerous other difficulties, a child with a physical or developmental problem is apt to be an even more powerful precipitant of child abuse and neglect. Most of the families, headed by single mothers, lacked the help of a spouse in caring for the family. They were socially isolated and therefore without the emotional and tangible support of friends and family. In all but two of the 35 families in which a child had a medical or developmental problem, the mother herself had a physical condition or illness, a severe

emotional problem, a problem with alcohol or drugs, or was reported to be "slow" or mildly retarded. Seventy-one percent of these families (25 out of 35) had between four and fifteen children. All were living in deprived material circumstances; 19 or 54 percent lived in very crowded or in the most deplorable conditions.

Numerous comments in the case record note that the parent felt overwhelmed by the many pressures she faced. The situation of one family vividly illustrates the stress which is placed upon mothers, who, themselves physically and emotionally handicapped, must care for children with physical health and developmental problems in a context of poverty.

In this family of four children, five to thirteen years of age, three have serious physical problems. The oldest had tubercular meningitis and lead poisoning at the age of two and as a result is now brain damaged. The child was in a coma for six weeks and had to spend six months in an iron lung. He also has had frequent bouts with pneumonia and has had to be hospitalized for the disease five times. Another, younger child is described as bleeding easily. A third child, the youngest, has cystic fibrosis and celiac disease. The mother herself has been physically ill. In recent year she has had an ovarian cyst, a rectal growth, rheumatic heart disease, phlebitis, and anemia. At age 16 she had a heart condition. In addition, she has been emotionally depressed and at one time had a problem with alcohol. The mother is under agency supervision for ignoring, harassing, and berating the children.

Maltreatment as a Contributing Factor to Health and Developmental Problems

The neglectful and abusing behavior of the parent, particularly when it occurs in a context of material deprivation, exacerbates the health and developmental problems of the children and, in some instances, is a major cause of these problems. When the specific types of maltreatment were examined in relation to the particular health and developmental problems of the children, we found that among the families in which a child had a health or developmental problem there were 71 percent, 25 out of the 35 families, in which it seemed highly likely that the maltreating behavior aggravates the child's physical condition. A frequently occurring neglect situation was the failure to adequately supervise children. Yet many of the children who were victims of this type of neglect suffered from conditions which required very close supervision. Examples are asthma, sickle cell anemia, rheumatic heart disease, hemophilia, epilepsy and mental retardation. Similarly, other frequently occurring forms of neglect were failure to provide nutritionally adequate and regular meals, warm enough clothing in the winter time, and homes which were sufficiently clean and safe. A number of the children who failed to receive proper physical care suffered from illnesses and conditions which were likely to become more serious or lead to other illnesses as a result of this type of care. Asthmatic attacks tend to be triggered by conditions such as bronchitis, colds, and pneumonia which occur more frequently when nutrition is not adequate or a child is not dressed warmly enough. Rheumatic fever which can follow an inadequately treated streptococcus infection is more likely to occur in a home in which nutrition is poor, children are not kept warm enough, and unsanitary conditions exist. Nutritional anemia may be the result of a poor diet in the first place and is likely to get worse if the poor diet continues. Cystic fibrosis, a chronic lung condition, requires, among other types of care, excellent nutrition, avoid-

ance of colds, and controlled temperature and humidity.

Moreover, when these types of neglect occur in a context of material deprivation, that is, where there is also overcrowding, insufficient heat and hot water, stopped up plumbing, inadequate garbage removal, poor rodent and roach control, and hazardous housing conditions (peeling paint, unprotected radiators, broken windows, etc.) the ill health of these children is likely to result in major and permanent impairment.

Parents emotionally abused or neglected children who were brain damaged neurologically impaired, had asthma, epilepsy, speech problems or a serious heart condition. The parental behavior is likely to aggravate such conditions which require utmost patience and understanding. Among the victims of physical abuse were children with asthma, high blood pressure, brain damage, mental retardation, rheumatic heart disease, and neurological impairments, problems which need a home climate of stability, trust, and acceptance.

In four of the 35 families it seemed evident that the maltreatment was a major cause of the child's physical problem. In each of these cases the mother had not provided adequate nutrition and as infants the children had failed to gain weight and had been identified as "failure to thrive" babies. In one family the malnourished infant also had a shattered skull, multiple contusions, and a broken arm. Subsequent retardation was thought to be a possible consequence. In another family the "failure to thrive" infant also had a crippled arm as a result of early battering.

Child Health and Developmental Problems and Poverty

The situations of the study families demonstrate how inextricably interwoven are poverty, maltreatment, and the physical health and developmental conditions of children. Many of the children's problems are likely to be a direct consequence of the deprived material circumstances in which they live. Limited food budgets which result in nutritionally inadequate diets, lack of heat during the winter, insufficient clothing, unsanitary conditions, crowded housing, and housing in poor repair increase the susceptibility of the child to a wide range of illnesses and handicaps. The deplorable material conditions, the lack of medical knowledge by the parent, and the lack of adequate care severely limit effective treatment of the physical illnesses and impairments. For example, it would be virtually impossible for the poor parent to provide the asthmatic child with the type of environment and care that is needed. Basic care of this condition requires a dust free, pet free, hypoallergenic, appropriately heated, spotlessly clean apartment or house. The child should be kept away from other children with colds and other respiratory infections which may set off an asthmatic attack. With increased attacks the child becomes sicklier. Constant supervision is essential so that immediate treatment can be given in the event of an attack.

In order to further clarify the impact of poverty upon children's health and developmental problems, the relationship between the material deprivation of the study families and children's health was examined. The families, all of whom represented the poorest of the poor (Wolock and Horowitz, 1979) were divided into those living in average material circumstances for this sub-sample and those in even more deprived material circumstances. Indicators of material level of living included adequacy of space, children's sleeping arrangements, the frequency with which the

family went without heat and hot water, rat infestation, the condition of the building, the amount and condition of the furniture, the frequency of financial crises such as evictions and utility shut-offs, and the extent to which the family went hungry. A rating of "average" often included a certain amount of overcrowding and a problem in one or two other areas such as having been without heat during the winter months or having gone hungry on one or two isolated occasions because of lack of food in the house. The rating of more severe material deprivation was given when the material conditions were poor in most of the areas considered.

Sixty-two percent of the families (28) were living in the less deprived material circumstances and 38 percent (17) in the more deprived. Ninety-four percent, or 16 of the 17 families living in the most severe material deprivation had at least one child with a health or developmental problem, compared with 68 percent (19 out of 28) who were less severely materially deprived. A substantial number of studies, based on comparisons of children in broad socioeconomic groupings, have demonstrated that the health of children and socioeconomic status are inversely related (Keniston, 1977; Health, U.S., 1978; Coles, 1965). The finding that among extremely poor families relatively greater material deprivation is associated with the poor health of children is even more powerful evidence of the crucial role of material deprivation in the onset and exacerbation of medical and developmental problems.

Children's Health and Developmental Problems and Agency Intervention and Services

The underutilization of certain health services by the economically disadvantaged has been well documented. The poor are less inclined to take preventive measures (Rosenstock, 1975), delay longer in seeking medical care (Irelan, 1966), use medical specialists less (Lefcowitz, 1976) and are less likely to have a regular physician for their children (Health, U.S., 1978). The differential utilization has been attributed both to characteristics of the poor (their knowledge and attitudes about health and life style) and to characteristics of the medical care systems which serve the poor (Pratt, 1971; McKinlay, 1975; Keniston, 1977).

Whatever obstacles and barriers interfere with the utilization of health care by the poor, they are likely to be even more prominent for these families. They are representative of a larger group of families who are not only in worse material circumstances but are more socially isolated than other poor families (Wolock and Horowitz, 1979). It is thus expected that they will be even more reluctant to take the initiative in seeking medical care for their children.

In working with child abuse and neglect cases the public child welfare agency is supposed to identify the overall needs and problems of the family and to assist the family in obtaining the necessary services and resources. The agency is thus in a position to encourage and help families obtain appropriate medical care for their children and to provide the support and help which the family is likely to need in carrying out the special care and supervision that the child may require. This may entail, for example, watching for certain behaviors and symptoms which may signal the onset of a medical crisis, the administration of medication, the preparation of special meals and special housekeeping practices. It is essential that the worker not only have full knowledge of special community resources available to children with a particular type of physical or developmental condition but aggress-

sively intervene to obtain them.

An effort was made to determine how well the agency responded to the widespread and serious health and developmental problems of the children. In only three of the 35 families with a child with this type of problem was the agency extensively involved in helping the family obtain proper medical care. Arrangements were made for the necessary physical examinations and treatment and the child and mother taken to the physician. Two families were helped obtain consultation and treatment by specialists in addition to the initial examination by a primary care physician.

At the other extreme were eleven families, nearly one-third, in which there was no indication of any agency attention to the medical or developmental problems of the children, despite the fact that their problems seemed as severe as those of other children. One of the eleven families was specifically referred to the agency for medical neglect, as well as for other types of maltreatment. One of the children had an acute infection of the subcutaneous tissue and another, the baby, had a malformed foot.

For the remaining 21 families with children with health and/or developmental problems there was some but limited agency attention to these problems. The assistance provided was not nearly commensurate with the severity of the problems noted. Mention often was made of arranging for and even taking the child for a medical evaluation but there was no indication of the outcome. Many of the case records merely indicated that the child, or children, had been referred to a medical facility but not whether treatment had been recommended or provided. In many situations the agency helped the family to obtain medical evaluation or treatment for one or two children but not others, even though the case record indicated that other children in the family also had serious health problems.

In no instance was there evidence indicating that the agency had helped the parent carry out medical recommendations regarding the supervision and care of the children. However, homemaker service was provided for variable periods of time to 40 percent, or 14, of the families with children with medical and developmental problems. Even though these problems were not the primary reason for homemaker service, it is likely that the homemaker was of some help in caring for these children.

Some of the children's medical problems may have been correctable had they been detected and treated early enough. Others are the consequence of not having properly treated antecedent illnesses and conditions. Still others are likely to worsen further if not properly cared for, possibly to the point of threatening the life of the child. This is not to imply that the public child welfare agency is to blame. The pattern of services in relation to the physical and developmental problems of children is similar to the patterns of services and interventions provided for other types of problems. The public child welfare agency is overburdened by extremely high caseloads of families with the most difficult problems and has exceedingly limited resources. It seems to be able to do little more than perform a holding operation as a last resort for these extremely deprived families. Given the constraints under which the agency operates, supportive services for children's health problems may be regarded by the agency worker as having lesser priority, the responsibility thought to belong more appropriately to the medical care system. However, medical care services for the poor are largely public and institutionally

based, operating through emergency rooms and outpatient departments of municipal and county hospitals and public health department clinics. These are chronically underfunded and understaffed, resulting in care which tends to be impersonal and lacking in continuity. The supportive services which these families need with respect to their children's health care are not likely to be provided given such conditions. The study showed that the various agencies involved with the family appear to constantly shift among themselves the burden of responsibility for necessary supportive services without having any clear lines of responsibility. Hospitals, visiting nurses, neighborhood health clinics, and physicians referred cases to the public child welfare agency when the parent did not seem to be attending properly to the problem or keeping medical appointments. The public child welfare agency seemed to consider its obligation fulfilled when it referred the child to a medical facility without determining whether the appropriate services were provided. Moreover, the public child welfare agency seems far more attuned to the psychological needs and problems of the family; interventions and services are more oriented toward these problems than to the physical health problems of either the children or the parents. The emphasis seems unwarranted since the state of the art is much further advanced in preventing and alleviating physical health conditions than it is in remedying emotional and mental health disorders.

Summary

An intensive analysis of a sub-sample of 45 families, randomly drawn from a larger group of AFDC recipient families identified as maltreating their children, revealed an appallingly high rate of physical health and developmental problems among the children. Caring for an ill or handicapped youngster and child abuse and neglect were depicted as reciprocally interrelated, each the cause and effect of the other. Among this group of severely economically disadvantaged families greater material deprivation was associated with having a child with a health or developmental problem. In spite of the high rate of children's medical and developmental problems, the agency accorded them only limited attention.

Although the number of families studied was relatively small, they were randomly drawn from a larger group supervised by the public child welfare agency for child abuse and neglect. Consequently, the study families are representative of this group in terms of the high incidence of serious medical and developmental conditions of the children and the patterns of agency interventions.

Implications and Recommendations

Further confirmation of the role of children's health and developmental problems in child maltreatment awaits more rigorous research designed to include a non-maltreating economically disadvantaged comparison group.

The astonishingly high rate of severe physical illness and developmental problems among the children of the 45 poverty families points to the critical need for major reform of the current health care delivery system. A program of universal medical coverage is recommended in order to overcome the inequity of the current system which provides poorer quality care to the poverty patient. However, there is little likelihood that legislation creating such a program will pass in the near future. Therefore, support of a universal health care program for children as outlined by Keniston (1977) and the Children's Defense Fund (1976) is urged. Until a

comprehensive child health care system is in place, efforts must be directed toward the strengthening of the Early and Periodic Screening, Diagnosis, and Treatment program (EPSDT) of 1967. The Child Health Assessment Program (CHAP) bill, a step in this direction, expands coverage and strengthens enforcement by providing bonuses for above-average compliance and penalties for noncompliance based on performance standards such as percentages of children assessed, treated, and immunized.

Finally, it is crucial that the public child welfare agency become more aware of and responsive to the physical health and developmental problems of the children. Recommendations for achieving this include:

1. Training of agency staff in basic health knowledge in order to increase their awareness of health problems generally, to enable them to recognize early signs and symptoms of illness and to increase their understanding of the treatment and care of various illnesses and conditions.
2. Fully informing agency staff, through training sessions and written manuals, of the special community resources and programs which provide financial and other types of tangible assistance to children with certain illnesses and handicapping conditions.
3. The development of collaborative programs with the public health nursing agency to ensure the ready availability of a public health nurse for consultation and for visiting the families.
4. The development of programs which ensure more adequate access to medical services, including the provision of home nursing service, home health aides, and physician assistants with a back up of a physician on call.
5. The provision of homemakers and home service aides who have special training in identifying and caring for individuals with medical and developmental problems. These personnel would provide care and teach parents how to more adequately care for children with medical and developmental problems.
6. The establishment of closer collaboration between the public child welfare agency and the county welfare agency directed toward encouraging parents to participate in the child health assessment and treatment program, whether it be EPSDT or CHAP. Mechanisms should be created which involve the participation of agency staff in critically reviewing these and other medical programs so that health care delivery to their clients is improved.

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