CONNECTICUT VOICES FOR CHILDREN

Testimony Supporting:
S.B. 981, An Act Concerning the Placement of Young Children in Congregate Care Facilities
H.B. 6340, An Act Concerning the Placement of Children in Out-of-State Treatment Facilities
H.B. 6336, An Act Concerning Kinship Care

Jamey Bell, J.D., Jake Siegel, and Alexandra Dufresne, J.D.
Select Committee on Children
February 22, 2011

We testify today on behalf of Connecticut Voices for Children, a research-based public education and advocacy organization that works statewide to promote the well-being of Connecticut's children, youth, and families. We ask for your support for three bills before you today that would greatly improve the lives of children in the child welfare system.

1) **Connecticut Voices for Children *strongly supports* S.B. 981, which reflects the widespread consensus among experts and advocates that children—especially children under age 6— should be cared for in families, rather than in congregate care facilities.**[1]

   a) Congregate care is **developmentally inappropriate** for young children.

Extensive research shows that children – particularly young children -- need the presence of a consistent caregiver to develop properly.[2] Even high-quality institutional or congregate (group) care by necessity involves shift workers, undermining young children's ability to attach to a primary caregiver.[3] As Victor Groza, Grace F. Brody Professor of Parent-Child Studies at Case Western Reserve University, writes, "The insecurities that result from lack of a primary caregiver can interfere with a child's ability to adjust to life changes, succeed in school, make friends, connect with other people, or to become connected to a parent when reunified or placed for adoption."[4] Indeed, in light of this research, many developing countries are moving away from group care to foster care systems.[5]

Yet in Connecticut, as of August 2010, 978 of the children in DCF care — including 223 children under the age of 12 — were placed in congregate care settings.[6] A much smaller number of these children are under the age of six,[7] but each year dozens and sometimes hundreds of Connecticut children under six are placed in congregate care in "SAFE Homes" for some length of time.[8,9]

   b) Despite the good intentions behind the development of the SAFE Home model, a comprehensive study led by Yale University researchers concluded that **children placed at SAFE Homes achieved outcomes that were no better (and in many cases worse) than those of children initially placed in family foster care**.[10]

The SAFE Home model was designed to allow children to be evaluated while an appropriate placement was being located. However, these settings have turned into short to moderate-term "placements of last resort" when DCF has been unable to locate an appropriate family placement.

Furthermore, while proponents of SAFE Homes justify their use as a means to avoid separating sibling groups, the Yale study showed that while children initially placed in SAFE Homes were more likely to begin their time in care with their siblings, by the 1-year follow-up they were no more likely to be living with siblings than children who were initially placed in family foster care.[11] Young children who are members of sibling groups still have a developmental need for attachment to a primary caregiver. Rather than resorting to congregate care for very young children, DCF should work towards accommodating these young children and their siblings in family foster care.

c) Not only are these congregate care settings developmentally harmful to young children, they are also **more expensive than alternative family placements.**

On a per-day basis, the average cost of a SAFE home is many times the foster care reimbursement rate.[12] Furthermore, the SAFE home evaluation unambiguously concluded that total placement costs for children initially placed in SAFE homes were greater than the total costs for children initially placed in family foster care.[13]

The Commission on Enhancing Agency Outcomes has also commented on the potential for significant financial savings by shifting children to family settings. In February 2010, it reported, "Short-term savings result because foster care board and care payments should be less than per child costs for congregate care. And there should be longer-term savings because kids are far more likely to get adopted out of foster homes than congregate care."[14]

d) This bill contains a **medical needs exemption** that allows young children to be placed in congregate care facilities in the rare case that their behavioral health or other medical needs necessitate such a placement.

In all other cases, the use of congregate care settings for children under six is not clinically justifiable. As Dr. Deborah A. Frank, a developmental behavioral pediatrician and Professor of Pediatrics at Boston University School of Medicine writes in support of this bill, "Simply put, infants, toddlers, or preschoolers without severe behavioral health needs do not belong in institutions."[15]

e) Several **other states have already taken positive action** toward limiting the use of congregate care for children under the age of six.

Nevada has passed legislation which, as of January 1, 2009, forbids the state from placing a child under six in a non-family placement that utilizes shift-workers unless no appropriate foster home is available in the child's county of residence.[16] Several other states limit the amount of time or the circumstances under which young children can be placed in congregate care.[17]

We most respectfully ask the committee to report favorably on S.B. 981. The time has come for Connecticut to eliminate the unnecessary use of congregate care for very young children, in light of evidence regarding the developmental harms that it can cause.

2) **Connecticut Voices for Children also *strongly supports* H.B. 6340, An Act Concerning the Placement of Children in Out-of-State Treatment Facilities.**

First, we would like to reiterate how encouraging it is that Commissioner Katz has indicated that reducing the utilization of out-of-state residential treatment facilities will be a priority for DCF under her leadership. While in certain situations an out-of-state residential placement is the most appropriate choice given the specific needs of a child, Connecticut Voices for Children believes that children are best served in their communities of origin whenever possible. We recognize that, in certain cases, "out-of-state" residential treatment facilities (in Massachusetts, for instance) are closer to the community of origin than comparable facilities within the state of Connecticut. However, the Court Monitor's September 2010 Ad Hoc Review of Out of State Children revealed that children are still being placed as far away as Texas. [18]

When children are placed hundreds or thousands of miles away from their communities of origin, this prevents them from developing and sustaining the bonds necessary to achieve permanence after returning from out-of-state. Furthermore, it creates strains on the entire system, as caseworkers must make face-to-face visits, potentially negatively impacting other cases on their caseloads. In sum, any step to reduce the use of out-of-state residential facilities is welcome, assuming that youth are able to receive appropriate services in-state.

H.B. 6340 creates a rebuttable presumption that placement in Connecticut is in a child or youth's best interest, ensuring that children will only be sent out of state when there is a compelling justification for such a placement. We believe that this change in law, coupled with increased attention to and funding for in-state services (including, to the extent possible, community-based services), will meaningfully reduce the need to rely on out-of-state residential treatment facilities.

3) **Connecticut Voices for Children also *strongly supports* H.B. 6336, An Act Concerning Kinship Care.**

Connecticut could do a much better job of placing children in the child welfare system with relatives. Not only is this consistent with federal law,[19] it is also consistent with best practices in child welfare. Studies have found that, among other things, children in kinship care experience less placement instability[20] and children in kinship care experience fewer behavioral and social problems.[21]

Unfortunately, only 13% of Connecticut children in the child welfare system are placed with kin, much below the national average of 21%.[22] There are seven states that have at least 35% of children in kinship care, showing that much higher rates of such placements are achievable.[23]

This bill would establish a working group to study how to eliminate barriers to kinship care placements. In addition, the bill would eliminate one such barrier, by providing that a requirement that a foster parent must provide a separate bedroom for a child should not prevent placement with a relative when such a placement is otherwise in the child's best interest.

By beginning to address barriers to kinship care, Connecticut can move towards increased kinship placements, and, ultimately, to better outcomes for children and youth in care.

Thank you for the opportunity to submit testimony.

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[1] See, e.g., Duerr Berrick, J., Barth, R., Needell, B., & Jonson-Reid, M.. "Group Care and Young Children." *The Social Science Review* 71:2 (1997), 257-273 (concluding that "given that placement into group care costs much more, provides less stability of caregiving, and does not increase the likelihood of adoption, very young children should not be placed in group care") and Frank, D., Klass, P., Earls, F., and Eisenberg, L, "Infants and Young Children in Orphanages: One View from Pediatrics and Child Psychiatry." *Pediatrics* 97:4 (1996), 569-578 (summarizing that "infants and young children are uniquely vulnerable to the medical and psychosocial hazards of institutional care, negative effects that cannot be reduced to a tolerable level even with massive expenditures").

[2] See, e.g., Rosenblum, K., Dayton, C., & Muzik, M.. "Infant social and emotional development: Emerging competence in a relational context." In C. Zeanah (Ed.) *Handbook of Infant Mental Health, 3rd Edition*. New York: Guilford Press, p. 80-103.

[3] For a review of the research concerning the impact of congregate care, see Barth, Richard P. (2002). *Institutions vs. Foster Homes: The Empirical Base for the Second Century of Debate*. Chapel Hill, NC: UNC, School of Social Work, Jordan Institute for Families. Available online at http://ssw.unc.edu/jif/events/GroupCare.pdf.

[4] Testimony of Victor Groza, Ph.D., LISWS in Support of S.B. 981. (Attachment A).

[5] In a study of a group of Romanian foster children in congregate care settings, those children that had experienced any period of time--no matter how limited--in institutional setting were significantly more likely to experience psychiatric disorders than children who had never been in these settings. *See* Zeanah, C., Egger, H., Smyke, A., Nelson, C., Fox, N., Marhsall, P., & Gunthrie, D.. "Institutional Rearing and Psychological Disorders in Romanian Preschool Children." *American Journal of Psychiatry* 166 (2009), 777-785.

[6] Court Monitor's Report, p. 33.

[7] According to the Office of the Child Advocate, as of December 2010, there were 25 children under the age of six in safe homes. Email from Jeanne Milstein, Child Advocate, December 10, 2010.

[8] In 2009, 248 children under the age of six were placed in SAFE homes. March 10, 2010 Letter to DCF, from the Office of the Child Advocate, Center for Children's Advocacy, Voices for Children, Child Protection Commission, and Connecticut Legal Services citing data collected by Joan Kaufman, Ph.D. at the Zigler Center for Child Development and Social Policy at Yale University.

[9] Although breakdowns of length of stay by age are not publicly available, as of November 2010, 59 of the 99 children in SAFE homes had been there longer than 60 days. *Juan F. v. Rell* Exit Plan Quarterly Report July 1, 2010 – September 30, 2010. Report of the DCF Court Monitor's Office, p. 34. Furthermore, while the bulk of published research focuses on the harm caused by extended placements in congregate care, there are reasons to believe that even short stays are harmful to young children. See expert testimony of Victor Groza, Ph.D. LISWS and Deborah A. Frank, M.D. in support of S.B. 981 (Attachments A and B, respectively.) Indeed, what seems like a short time to an adult can be a long time in a child's life, particularly in certain developmental windows. See expert testimony of Katherine Rosenblum, Ph.D. in support of S.B. 981 (Attachment C, stating that "particularly at a time of emotional need even a few days in congregate care is likely to represent added hardship at a time of marked vulnerability").

[10] DeSena, A., Murphy, R., Douglas-Plumberi, H., Blau, G., Kelly, B., Horwitz, S., & Kaufman, J. (2005). Safe Homes: Is it worth the cost? An evaluation of group home permanency planning program for children who first enter out-of-home-care. *Child Abuse & Neglect, 29*, 627-643.

[11] *Ibid.*

[12] The per diem foster care reimbursement rate for a child under the age of six is $24.84. See DCF Policy Manual 36-55-25.2, "Financial Information: Reimbursement Rates" (available at http://www.ct.gov/dcf/cwp/view.asp?a=2639&Q=394382). Although there are higher rates for medically complex and therapeutic foster homes, by any estimation SAFE homes are significantly more expensive than the average foster care placement. A decade ago, DeSena et al. conservatively estimated the cost of a SAFE home placement (including only child care and custodial staffing costs) to be $85.00 per day.

[13] *Ibid* 8.
[14] State of Connecticut Commission on Enhancing Agency Outcomes, Initial Report to the Governor, President Pro Tempore of the Senate, and the Speaker of the House, February 1, 2010.
[15] Testimony of Deborah A. Frank, M.D. Supporting S.B. 981 (Attachment B).
[16]Nevada Revised Statute 432B.3905 **(**"An employee of an agency which provides child welfare services…shall not transfer a child who is under the age of 6 years to, or place such a child in, a child care institution unless appropriate foster care is not available at the time of placement in the county in which the child resides…A child under the age of 6 years may be placed in a child care institution…if the child requires medical services and such medical services could not be provided at any other placement…or if necessary to avoid separating siblings.")
[17] See, *e.g.*, Michigan Department of Consumer and Industry Services, Division of Child Welfare Licensing Rule R 400.4133 ("A child under 6 years of age shall not remain in an institution for more than 30 days, unless this stay is documented to be in the best interest of the child."); Florida Department of Children and Family Services Rule 65C-14.040(4) ("No child under the age of 6 years, or the age of enrollment in the first grade of school, shall be admitted to a residential child caring agency except under emergency circumstances or to prevent the separation of a family. An emergency placement of a child under 6 years shall be documented in the child's case record, verifying that no alternate plan for care was available at the time of admission. Continued diligent effort shall be made, including referral to the department to place a child under age 6 in foster care or other appropriate care. Such plans shall be made within 30 days of the child's admission. Residential care for children under 6 who are part of a sibling group may be continued, as appropriate.")
[18] *Juan F. v. Rell* Exit Plan, Quarterly Report, April 1, 2010-June 30, 2010. Civil Action No. 2:89 CV 859 (CFD), p. 79.
[19] The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) establishes that the states "shall consider giving preference to an adult relative over a non-related caregiver when determining a placement for a child, provided that the relative caregiver meets all relevant State child protection standards."
[20] Chamberlain, P., Price, J., Reid, J., Landsverk, J. Fisher, P., & Stoolmiller, M.. "Who disrupts from placement in foster and kinship care?" *Child Abuse & Neglect* 30:4 (2006), p. 409-424.
[21] Sakai, C., Lin, H., & Flores, G. "Health Outcomes and Family Services in Kinship Care." *Archives of Pediatrics & Adolescent Medicine* 165:2 (2011), p. 159-165. Rubin, D., Downes, K., O'Reilly, A., Mekonnen, R., Luan, X., Localio, R.. "Impact of Kinship Care on Behavioral Well-being for Children in Out-of-Home Care." *Archives of Pediatrics & Adolescent Medicine* 162:6 (2008), p. 550-556.
[22] Email from Joan Kaufman, Ph.D., Zigler Center for Child Development and Social Policy at Yale University, February 18, 2011, citing her analysis of Adoption and Foster Care Analysis and Reporting System data from the Administration of Children and Families, U.S. Department of Health and Human Services.
[23] *Ibid.* The seven states are Arizona, Illinois, Michigan, New Jersey, and Washington(35%), Florida (42%) and Hawaii (44%).

CASE WESTERN RESERVE
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17 February 2011

RE: Testimony in Support of S.B. 981, An Act Concerning the Placement of Youth Children in Congregate Care

Representative Urban, Senator Musto, and Distinguished Members of the Select Committee on Children:

I was asked to provide written testimony in favor of S.B. 981, a **bill in Connecticut that would prohibit congregate care of children under 6.** This letter is based on my research, training and technical assistance experiences throughout the US, Romania, Ukraine, Ethiopia, Belize, Guatemala and India.

Babies are biologically prepared to depend upon primary caregivers. A mom, a dad, a grandma, an adopted parent, a foster parent– it doesn't really matter who--but babies are designed to become attached to a primary parent or caregiver. Congregate care, by its very nature, provides constantly changing caregivers – nurses, volunteers or other direct care staff work on shifts and caregivers change frequently. Most children cannot bond because they don't have a consistent person caring for them. Even the best care provided, where all physical needs are swiftly met and cuddling is frequent, still results in problematic outcomes for many children. This is particularly true for the most at-risk children who bring genetic, prenatal and post-natal vulnerabilities to these interactions.

When children don't have primary caregivers, serious consequences can follow them throughout life. Some children become unable to form specific attachments – they can't connect. Others never manage to regulate their stress and emotions, and may be more at risk for developing a serious psychiatric disorder. Many develop developmental trajectories not consistent with optimal growth. In all these situation, the insecurities that result from lack of a primary caregiver can interfere with a child's ability to adjust to life changes, succeed in school, make friends, connect with other people, or to become connected to a parent when reunified or placed for adoption. Not every child will suffer all of these problems, but it is likely that far more will be than children who are placed in family-based care, and it is difficult to predict which children those will be.

It is important to remember that children do not differentiate between good and bad, only familiar and unfamiliar. Every time a child is removed from his or her birth family, the experience is traumatic, and compounds the maltreatment these children have already suffered. Trauma can compromise a child's development in a number of ways. Several studies in the US and Europe have showed how substitute caregivers can learn parenting techniques to reduce the stress babies and young children experience on being removed from their homes and that encourage healthy attachment.

For more than 60 years, studies of English wartime evacuation sites, eastern European orphanages and American congregate care facilities have found long-term damage to children subjected to group care, even if that care is temporary. It is time to use this research to inform public policy and child welfare practice. Legislation that would make congregate care a rare event will benefit the children both short term and long term. I encourage you to enact the legislation.

Sincerely,

Victor Groza, Ph.D., LISWS
Grace F. Brody Professor of Parent-Child Studies

Attachment A

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DEBORAH A. FRANK, MD
Professor of Pediatrics
Boston University School of Medicine
Boston Medical Center
Director, Grow Team for Children
Boston Medical Center

Testimony Supporting S.B. 981: An Act Concerning the Placement of Young Children in Congregate Care Facilities

Deborah A. Frank, M.D.
Select Committee on Children
February 22, 2011

Senator Musto, Representative Urban, and Distinguished Members of the Select Committee on Children:

I am a Developmental Behavioral Pediatrician, trained by Dr. T Berry Brazelton and currently Professor of Pediatrics at the Boston University School of Medicine and Director of the Grow Clinic for Children at Boston Medical Center. In addition, I am Founding Principal Investigator of Children's HealthWatch, a non-partisan research center that works to improve child health by bringing evidence and analysis from pediatric care to policy makers and members of the public. My work over the past three decades has focused on the health and development of at-risk children. I write today in support of S.B. 981, An Act Concerning the Placement of Young Children in Congregate Care Facilities.

In 1996, with Dr. Perri Klass, a specialist in infectious disease, and two eminent Harvard Professors of Child Psychiatry Dr. Felton J. Earls, and Dr. Leon Eisenberg, I co-authored an article in *Pediatrics* titled "Infants and Young Children in Orphanages: One View from Pediatrics and Child Psychiatry." Though the article focused in particular on the harms of long-term placement in institutional care, I believe that our findings can inform the current debate in your state over the placement of young children in congregate care in cases of abuse or neglect.

The conclusion among medical and child welfare professionals since the first White House Conference on Children in 1909 is clear: When removal from relatives is unavoidable because of serious maltreatment, infants and young children should be provided with long-term, family-based care. Housing infants and young children in institutions instead of with families goes against over a hundred years of consensus among physicians and child welfare specialists.

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Even the best institutional settings are inherently unsuitable for the developmental needs of infants and very young children, exposing them to concurrent risks of serious infection disease and sustained risks to their socioemotional development. As we concluded in our paper, "from a developmental perspective, infants and young children are uniquely vulnerable to the medical and psychosocial risks intrinsic to institutional care."

I do recognize that some preschoolers (age 4 and up) may be so disturbed behaviorally that they need temporary therapeutic congregate care settings. The proposed legislation contains an exemption to allow such placements for children with severe health needs who cannot be served in any other setting.

Simply put, infants, toddlers, or preschoolers without severe behavioral health needs do not belong in institutions. S.B. 981 makes sure that such children would be placed instead with families, a tremendously positive step in improving care for Connecticut's youngest and most vulnerable children. Along with this, I would stress to the Committee the importance of investing the resources to provide adequate supervision and support to foster parents to make sure that the children in their care can thrive.

Sincerely,

Deborah A. Frank, M.D.
Director, Grow Clinic
Boston Medical Center

Founding Principal Investigator
Children's HealthWatch

Professor of Pediatrics
Boston University School of Medicine

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Testimony Supporting S.B. 981: An Act Concerning the Placement of Young Children in Congregate Care Facilities

Katherine Rosenblum, Ph.D.
Select Committee on Children
February 22, 2011

Senator Musto, Representative Urban, and distinguished Members of the Select Committee on Children:

I am a clinical and developmental psychologist and am currently an Assistant Research Scientist at the University of Michigan's Center for Human Growth and Development and Adjunct Clinical Professor in the Department of Psychiatry. In Psychiatry I direct the Parent-Child Relational Clinic, the specialty clinic that serves children under 6 years old and their families. In addition, I am the Psychologist Consultant to the Child Advocacy Law Clinic at the University of Michigan School of Law, where I lecture and offer consultation regarding developmental issues pertaining to child welfare. The testimony I am submitting today reflects my professional opinion based on my clinical and developmental expertise, and does not necessarily reflect the opinion of the University of Michigan.

My research and clinical work focus on relationship disruptions in early childhood, interventions to support parent-child relationships, and the special needs of young children in the context of adoption and foster care. My own research, consistent with the abundance of current evidence, underscores the critical role of an emotionally available caregiver for infant and young child social and emotional wellbeing (see Rosenblum et al., 2006; Rosenblum et al., 2009). My work has demonstrated that even very young children are attuned to the presence and emotional availability of their primary caregiver. Young children are biologically hardwired to expect an environment that provides a committed, stable primary caregiver. Indeed, the commitment of a foster parent to his or her child has been identified as a critical feature of the foster caregiving environment, and reflects the degree to which the caregiver is emotionally and psychologically committed to, and invested in, their child (e.g., Dozier & Lindhiem, 2006). An important recent study using a rigorous experimental design demonstrated that children previously placed in congregate care settings who were subsequently moved to foster homes showed significant improvements across a number of important developmental domains (e.g., Smyke et al, 2010). It is likely that one of the reasons young children in the congregate care setting fared poorly relative to children in foster homes was that shift care workers, no matter how well intentioned, were understandably and inherently less likely to commit and emotionally invest *as a parent* to the young child, and thus failed to meet critical child needs. Given the heightened emotional needs of young children who enter foster care, the availability of a caregiver who can meet these needs is most critical. Infants and young children experience a different sense of time, and particularly at a time of heightened emotional need even a few days in congregate care is likely to represent added hardship at a time of marked vulnerability.

I therefore strongly support S.B. 981, which prohibits the Department of Children and Families from placing children under the age of six in congregate care facilities except in a few unusual circumstances**.** Young children are developmentally hardwired to bond to a primary caregiver. Congregate care, by its very nature, does not involve a consistent caregiver and therefore is inappropriate for the developmental needs of young children. Even short-term placements in congregate care facilities can have long-lasting social and emotional effects.

Although DCF acknowledges that family care is almost always better for very young children, the Department continues to put children under 6 - including infants and toddlers - in temporary congregate care facilities with some regularity; overstays are not uncommon. In 2009, 248 children under 6 were placed in congregate care settings in Connecticut. There are reasons to believe that DCF will continue to institutionalize abused and neglected children unless the practice is expressly prohibited. This legislation follows the model of several states that are beginning to codify prohibitions on congregate care for very young children, bringing their laws in-line with a century of knowledge about developmental psychology.

S.B. 981 reflects the consensus among experts in child development, which is that children under the age of six should be cared for in families, not in institutions. I therefore respectfully ask that you support this important piece of legislation, which would improve the lives of Connecticut's most vulnerable young children.

Respectfully submitted,

Sincerely,

Kate Rosenblum
Clinical Assistant Professor of Psychiatry
Assistant Research Scientist, Human Growth and Development

References Cited

Dozier, M. & Lindheim, O. (2006). This Is My Child: Differences Among Foster Parents in Commitment to Their Young Children. Child Maltreatment, 11, 338-345.

Rosenblum, K.L., Dayton, C., & McDonough, S.C. (2006). Communicating feelings: Links between mothers' representations of their infants, parenting, and infant emotional development. In O. Mayseless (Ed.), Parenting Representations: Theory, Research, and Clinical Implications. New York: Cambridge University Press, pp. 109-148.

Rosenblum, K.L., Dayton, C., & Muzik, M. (2009). Infant social and emotional development: Emerging competence in a relational context. In C. Zeanah (Ed.) Handbook of Infant Mental Health, 3rd Edition. New York: Guilford Press, pp. 80-103.

Smyke, A. T., Zeanah, C.H., Fox, N.A., Nelson, C.A., Guthrie, D. (2010). Placement in Foster Care Enhances Quality of Attachment Among Young Institutionalized Children, Child Development, 212–223.

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Child and Adolescent Psychiatry

February 21, 2011

Group Care for Children Less Than 6 Years Old

I am a child and adolescent psychiatrist and developmental researcher who has worked with maltreated young children for more than 30 years. For the past 16 years, together with my colleagues at Tulane, I have directed a community based intervention for young children in foster care. I have conducted research with these young children during this same time. Together with Charles Nelson of Harvard Medical School and Nathan Fox at the University of Maryland, for the past 10 years I have led a research project in Romania (the Bucharest Early Intervention Project) which is the first ever randomized clinical trial of foster care as an alternative to congregate care for young children. My colleagues and I have published more than 50 scientific papers demonstrating that congregate care has toxic effects on young children's development and that children in foster care develop more favorably than children in group settings.

These findings are in keeping with other scientific literature. Every previous study that compared children in foster care to children in group care demonstrated that children in foster care had fewer problemns and more favorable development. What the Bucharest Project added was the clear demonstration that the differences were not due to pre-placement characteristics of the children but were due to the actual settings in which the children were raised. There can no longer be any question about family care be always preferable to congregate care.

The reasons why group care is so harmful to young children is because they need loving care from a relative small number of caregiving adults. Only through substantial and regular (daily) interactions with caregivers can young children form attachments to adult caregivers. The rotating shifts of congregate care staff limit children's opportunities to form healthy and robust attachments. We have demonstrated this conclusively in our work in Romania.

In June of 2009, a group of investigators from 8 different countries who have studied young children raised in congregate care settings met to review the world's literature. Results of the conference, which will be published as a forthcoming Monograph of the Society for Research In Child Development later this year, concluded unambiguously that younbg children belong in families rather than congregate care and that the sooner they are placed in these settings the more likely they will escape long term harm. There are many vexing questions in the child development literature—whether young children should be placed in congregate care is NOT one of them. The question has been settled.

I urge you to support the legislation entitled, AN ACT CONCERNING THE PLACEMENT OF YOUNG CHILDREN IN CONGREGATE CARE FACILITIES, which will amend Subsection

(j) of Connecticut General Statute § 46b-129 to ensure that young children will be placed in families rather than in congregate settings unless they are with their parents in the congregate care or unless they are too ill to be cared for in a family.

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