Foster Care = Chronic Care: In the Medical Home

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Children in Foster Care - Outcomes

- Significant mental health problems – 54%
- Chronic medical illness - 30%
- Unemployment – 20%- 40%
- Live at or below the poverty level - 33%
- Lack health insurance - 33%–50%
- Homelessness within 1 year of emancipation – 22%–36%
- High school completion – markedly reduced and delayed
- Postsecondary education - 16%
- Bachelor's degree - 1.8%
- PTSD 2 x that of combat veterans

Significant improvements in a child's health status, development, intelligence, school attendance, and academic achievement after foster care

Children in NYC Foster Care >= 2 years

- 2009 Children's Rights report, The Long Road Home
- 46% developmental disorder
  - Communication
  - Learning disorder
- 60% Psych disorder
  - ADHD
  - ODD, PTSD, depression, adjustment disorder
- 37% psychotropic medication
- 14% psych hospitalization in one year review period

TABLE 1 Health Problems at Entry to Foster Care[41]

Problem or Condition	%
Chronic or untreated physical health condition	35–45
Birth defect	15
Mental health problem	40–95
Developmental/educational:	
Developmental delay in child <5 y	60
Special education placement/academic underachievement	45
Significant dental conditions[a]	20
Family problems[b]	100
Reproductive health issue risks (eg, pregnancy and sexually transmitted infections)	100

[a] Data are from Starlight Pediatrics, personal communication. Sangeeta Gajendra, DDS, MPH, Eastman School of Dentistry, Clinical Chief of Community Dentistry, Rochester NY, 2002.

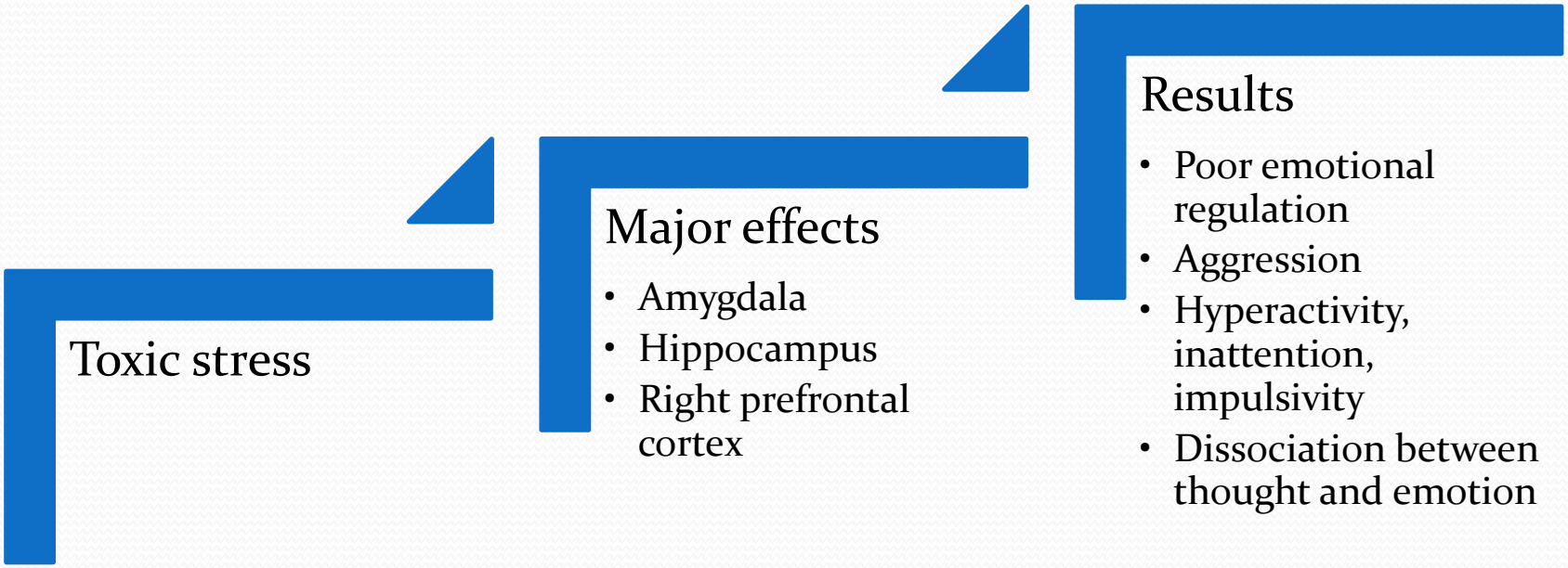
[b] By definition, because that is why they are in foster care.

Foster care	**18,000**	NYS OFC
Sickle cell	3400	CDC
Type 1 Diabetes	7800	NYS DOH
Childhood cancers	1000	NYS DOH

- More children in foster care in NY than children with sickle cell, diabetes and cancers COMBINED!

9500 new admissions in 2014
1000 children in Nassau and Suffolk Counties

AAP – Young Children- ACEs



- Attachment, trust, self-esteem, conscience, empathy, problem solving, focused learning, and impulse control

OFS – Children under 5 Years

- Extensive childhood trauma (maternal/parental mental illness, physical and sexual abuse, parental substance abuse, parental incarceration and neglect)
- Devastating effects on brain development and cause significant developmental, behavioral and social-emotional difficulties
- 45% new admissions
- 35% of children in foster care – 6000+
- 60% of children in NYC
- 54% planned to go home
- 27% planned for adoption

Loss of Family and/or Siblings

Loss of stability and certainty – incompatible placement

Loss, rejection, and unworthiness - birth family visitation unpredictable

Multiple caseworkers

Loss of school or child care

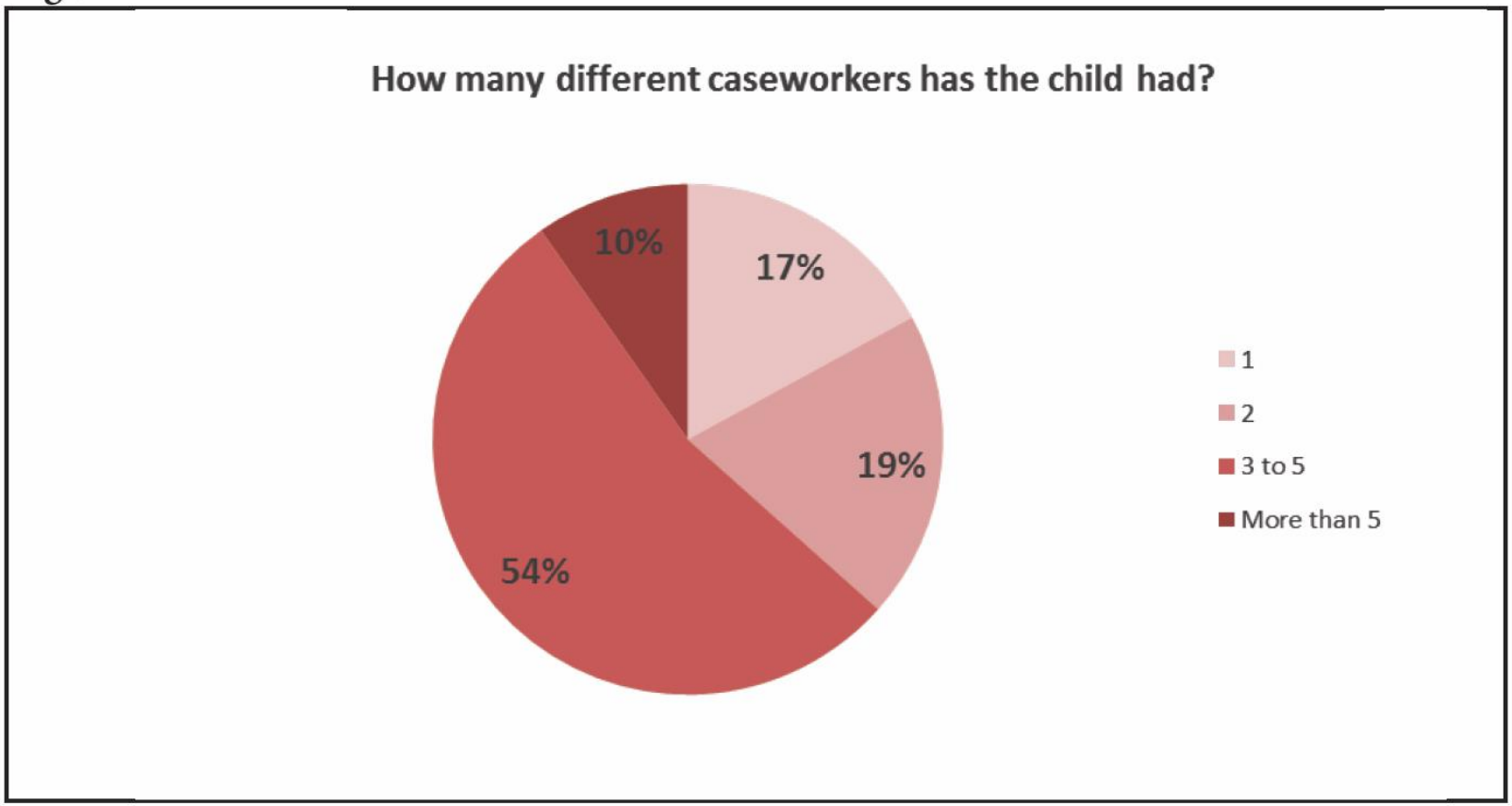
Friends

Teasing or bullying by peers

Significant increase in behavioral/emotional problems =more transitions among placements

Multiple case workers

Figure 10

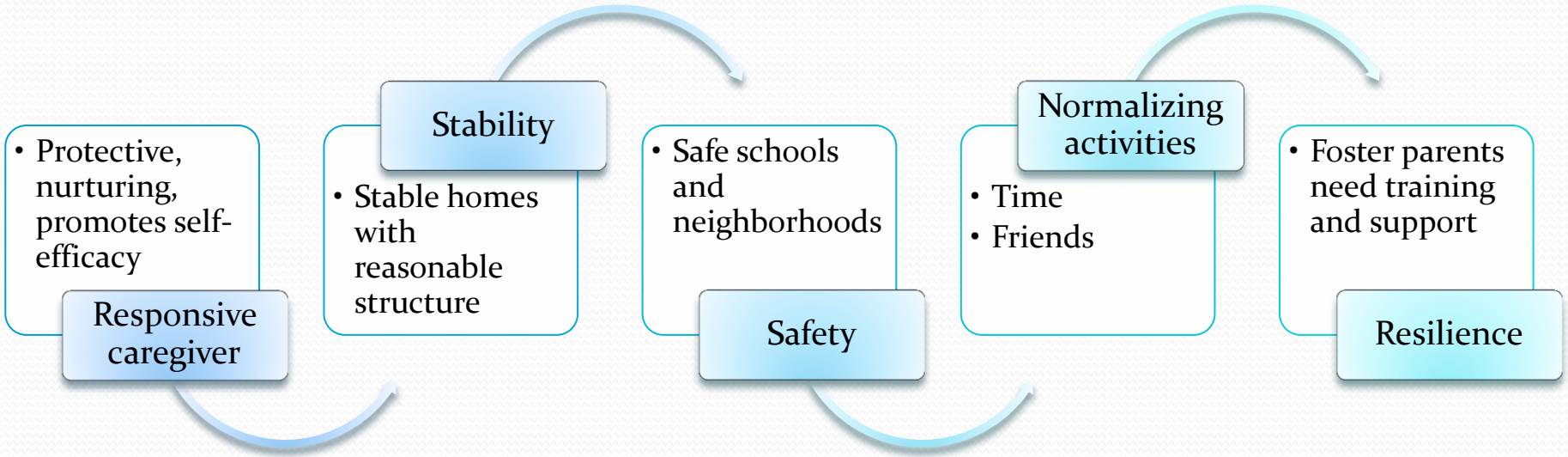


Bigger

Stronger

Wiser and Kind

Foster care = Opportunity



Health Care Delivery

- Contract with a foster agency
- Providers based in the community (esp. downstate)
- Combination of both
- Little communication and coordination with mental health providers, courts, child welfare, foster care agencies or insurance providers
- Lack of health information
- Confidentiality and consent
- Payment and coverage

Foster Care = CSHCN

TABLE 2 Qualities of the Medical Home for the Child in Foster Care

Qualities of the pediatric medical home (http://www.medicalhomeinfo.org)

1. Accessible
2. Comprehensive health care
3. Compassionate care
4. Care that is continuous over time
5. Care that is coordinated
6. Culturally competent health care
7. Family focused

Additional features of foster care medical home

1. Competency in heightened surveillance for child abuse and neglect
2. Understanding of the effects of child abuse and neglect, childhood trauma, and removal from family on child, birth family, and foster/kinship family
3. Collaborative relationship with child welfare and legal system on behalf of child
4. Coordination of care with other community-based resources, including Early Intervention, mental and dental health professionals, Head Start, schools, child care providers
5. Team-based care that ideally would include a child welfare liaison, mental health expert, and health care monitoring manager
6. Mental health integration into the medical home or a referral network of trauma-informed mental health providers

- Child abuse and neglect
- Understand effects of early trauma and removal on child, birth and foster family
- Work with child welfare and legal systems
- Coordinated care with community agencies
- Team based care
- Mental health integration

Pediatric Visits

- Screen for signs of abuse and neglect
- Assess quality of the parent-child relationship
  - Parents may need training and support to care for severe trauma
- Share concerns with the child's caseworker
  - Poor weight gain
  - Lack of warmth between the child and the foster parent
  - Caregiver who is overly rigid and speaks harshly to the child
  - Frequent missed/canceled appointments
  - Failure to comply with health recommendations

TABLE 3 Initial Health Screening Visit

Health Visit Type	Time After Entry to Foster/Kinship Care	Purpose	Components	Actions
Initial health screening visit	Within 72 h[a]	1. Identify health conditions requiring prompt attention: acute/chronic illness, child abuse/neglect, mental health disturbance, pregnancy 2. Identify health conditions important in making placement decisions 3. Identify significant behavior issues important in making placement decisions	1. Review of health information 2. Review of trauma history 3. Review of systems 4. Symptom-targeted examination 5. Child abuse screen: growth parameters, vitals, skin, joints/extremities, external genitalia 6. Developmental surveillance or screen 7. Mental health screen: suicidality, homicidality, violent behaviors, trauma exposures 8. Adolescent health screen: pregnancy screen for sexually mature girls and sexually transmitted infection testing for all adolescents	1. Appropriate treatment and referral 2. Communication with caseworker 3. Anticipatory guidance related to transition into foster care, parenting the traumatized child, specific health issues

[a] Some children should have their initial health screen within 24 hours: children younger than 3 years; any child with a complex chronic health condition or significant developmental delays, or on medication, or with an acute illness or infestation; any child with known mental health or behavioral problems; or any child for whom a more immediate examination for suspected child abuse and neglect is indicated.

TABLE 4 Comprehensive Health Assessment

Health Visit Type	Time After Entry to Foster/Kinship Care	Purpose	Components	Actions
Comprehensive health assessment	Within 30 d	1. Review available health information	1. Review of available health information including trauma history 2. Review of systems 3. Complete physical examination	1. Appropriate treatment and referral (mental health, developmental, educational, dental)
		2. Identify acute and chronic health conditions	4. Child abuse and neglect screen (See Table 3) 5. Family planning and sexual safety counseling for adolescents	2. Communication with caseworker
		3. Identify developmental and mental health conditions	6. Developmental screen and referral for evaluation 7. Mental health screen and referral for evaluation	3. Anticipatory guidance particularly around parenting traumatized child
		4. Trauma assessment	8. Adolescent health survey 9. Review of school performance	
		5. Develop an individualized treatment plan	10. Immunization review 11. Dental screen and referral 12. Hearing and vision screening 13. HIV risk assessment 14. Laboratory studies[a] 15. Anticipatory guidance[a]	4. Schedule follow-up visit

[a] See recommendations in text.

TABLE 5 Follow-up to Comprehensive Health Assessment

Health Visit Type	Time After Entry to Foster/Kinship Care	Purpose	Components	Actions
Follow-up health assessment	Within 90 d	1. Identify acute and chronic health conditions 2. Assess for ongoing stressors 3. Assess "goodness of fit" in home/monitor for abuse and neglect 4. Update immunizations 5. Provide health education 6. Review findings from developmental and mental health evaluations 7. Assess school adaptation and performance 8. Update and reinforce treatment plan	1. Physical examination as indicated: weight check imperative <3 y; child abuse and neglect screen 2. Observation of parent-child interaction 3. Foster parent/patient education[a] 4. Immunization update 5. Review of referrals/reports 6. Review of treatment plan	1. Appropriate treatment and referral 2. Anticipatory guidance especially around parenting traumatized child 3. Communication with caseworker 4. Schedule follow-up appointment

[a] See text for details.

- What Happened to You?

- NOT ALWAYS
- What's Wrong with You?

http://s59.photobucket.com/user/felicia916/library/

Response to Trauma: Bodily Functions

FUNCTION	CENTRAL CAUSE	SYMPTOM(S)
Sleep	Stimulation of reticular activating system	1. Difficulty falling asleep 2. Difficulty staying asleep 3. Nightmares
Eating	Inhibition of satiety center, anxiety	1. Rapid eating 2. Lack of satiety 3. Food hoarding 4. Loss of appetite
Toileting	Increased sympathetic tone, increased catecholamines	1. Constipation 2. Encopresis 3. Enuresis 4. Regression of toileting skills

Response to Trauma: Behaviors[15,16]

CATEGORY	MORE COMMON WITH	RESPONSE	MISIDENTIFIED AS AND/OR COMORBID WITH
Dissociation (Dopaminergic)	• Females • Young children • Ongoing trauma/pain • Inability to defend self	• Detachment • Numbing • Compliance • Fantasy	• Depression • ADHD inattentive type • Developmental delay
Arousal (Adrenergic)	• Males • Older children • Witness to violence • Inability to fight or flee	• Hypervigilance • Aggression • Anxiety • Exaggerated response	• ADHD • ODD • Conduct disorder • Bipolar disorder • Anger management difficulties

Response to Trauma: Development and Learning[15,16]			
AGE	**IMPACT ON WORKING MEMORY**	**IMPACT ON INHIBITORY CONTROL**	**IMPACT ON COGNITIVE FLEXIBILITY**
Infant / toddler / pre-schooler	Difficulty acquiring developmental milestones	Frequent severe tantrums Aggressive with other children Attachment may be impacted	Easily frustrated
School-aged child	Difficulty with school skill acquisition Losing details can lead to confabulation, viewed by others as lying	Frequently in trouble at school and with peers for fighting and disrupting	Organizational difficulties Can look like learning problems or ADHD
Adolescent	Difficulty keeping up with material as academics advance Trouble keeping school work and home life organized Confabulation increasingly interpreted by others as integrity issue	Impulsive actions which can threaten health and well-being Actions can lead to involvement with law enforcement and increasingly serious consequences	Difficulty assuming tasks of young adulthood which require rapid interpretation of information: ie, driving, functioning in workforce

Therapies for the Traumatized Child

AGE	THERAPY	GOALS
Young child 0-5 years	• PCIT – Parent Child Interactive Therapy • CPP – Child Parent Psychotherapy	Works with caregivers and children to address child behaviors observed during play. A dyadic intervention that targets the impact of trauma on the child-parent relationship and how the parent can provide emotional safety for the child.
Older children	• TF-CBT – Trauma Focused Cognitive Behavioral Therapy (for children 5 and older) • CBITS – Cognitive Behavioral Intervention for Trauma In Schools (for high school-aged youth)	Trains children and families in: • relaxation techniques • skills and language to access emotion • psychoeducation Then, child is guided to create a trauma narrative. Child develops/writes a story about what happened to him or her. When the child is able to tell or read this story to the caregiver, it indicates the trauma no longer defines the child, but is instead a story of what happened, having lost its power to continue to harm.
Both older and younger children with complex trauma/ attachment concerns	• ARC – Attachment, Self-Regulation, and Competency	To support healthy relationships between children and their caregiving systems to: • support resources and safety for adult members of the family • build all family members' ability to manage feelings, body sensations, and behaviors • improve problem solving skills • support healthy development of identity • support the child in processing/integrating stressful life experiences

Psychotropic Medication

- 3x more than other Medicaid-enrolled children for longer time
- Higher rates of polypharmacy
- Why?
  - Caregiver demand for medication to manage disruptive behaviors
  - Lack of understanding of childhood trauma
  - Lack of pediatric mental health resources
  - Misdiagnosis of trauma symptoms - ADHD
- Full evaluation – can treat depression/anxiety
- Short-term to manage severe sleep problems or emotional distress symptoms or when foster care placement is at risk
- May not address the underlying trauma and attachment issues at the root of challenging behaviors
- Parenting skills

Advocacy

- Babies Can't Wait – Institute for Parenting
  - Trauma informed care
  - Collaboration with Courts
- CWCIP
  - Family court changes
- AAP Chapter 2 – 35% of all children removed from homes
  - Grant
- Education

Questions?