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The Long View: Has Anything Really Improved for Children and Families Involved with Child Welfare over 3 Decades?

Moira Szilagyi
UCLA Health, MSzilagyi@mednet.ucla.edu

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The overall poor health status and outcomes of children and youth in foster care have been documented in multiple studies over the last 3 decades.[1] During this time, knowledge about brain development, positive parenting, resilience, traumatic stress, and epigenetics has exploded, resulting in demands for child welfare to become trauma-informed, child-centered, and developmentally focused.[2] This special issue affords us the opportunity to reflect on: what's better or not after 30 years; whether legislation and financing are aligned with child welfare's goals of safety, permanency and well-being; and what remains to be done to improve the outcomes of children and youth in foster care or otherwise involved with child welfare.

On the Threshold of Foster Care

Child welfare's role begins when families are reported because of concern about potential child abuse or neglect. For the 3.5 million children whose circumstances child welfare chooses to investigate annually out of the 7.2 million referred, workers must decide whether each family is in such crisis that child safety is under imminent threat. The reasons for family involvement with child welfare and removal of children have been relatively stable over time.[1] Neglect remains the major indication of maltreatment, accounting for 70% of removals, and usually occurs in the context of impaired caregiving that results from parental substance use disorder and mental health problems. Children who are removed from their families have high rates of exposure to domestic violence and may also experience other forms of child maltreatment. Their families have high rates of stressors that can impact parenting, including poverty, homelessness, food insecurity, and limited social supports. Thus, children brought to the attention of child welfare often lack the typical nurturing environment that promotes healthy development. They carry with them their histories of trauma and adversity, the impact that has had on their health and well-being, and their unique personalities, strengths, and temperaments. They also carry with them their former attachment patterns, which may be secure, avoidant, ambivalent, or disorganized, depending on the nature of their prior relationships and their trauma histories.[3-6] When child welfare involvement results in family disruption, the grief and loss experienced is no less painful for children and parents

today than it was 30 years ago, although there is greater recognition by child welfare of how profoundly devastating this experience can be.

How Trauma Aborts Resilience

In the last 20 years, scientists have developed a deep understanding of how chronic, frequent or intense stressors, in the relative absence of buffering by protective caregivers, lead to poor physical, emotional, behavioral, and developmental outcomes. Science can now explain how stress becomes biologically embedded.[5] Neuro-hormonal stress responses that were designed to activate rapidly in response to danger and then return quickly to baseline once danger has passed can remain activated and become dysregulated when a person, especially a child, lives with ongoing stressors with limited buffering. This has been variously termed the toxic stress response, childhood complex trauma, traumatic stress, or developmental trauma disorder.[5,7]

We now know that dysregulation of the neuro-hormonal stress pathways at the cellular level alters gene expression, which ultimately impacts neuronal connections, brain architecture and function, the immune system, and inflammatory pathways. The distribution of glucocorticoid receptors in the brain is altered, partially explaining the ongoing dysregulation of the physiologic stress response. In very young children whose brains are rapidly growing and developing, changes can be significant. Simplistically, the amygdala, the brain's danger alert system, may become larger while the hippocampus and other structures that enable regulation of emotional and behavioral responses may be underdeveloped. Cumulative childhood stressors leading to altered gene expression may also suppress humoral immunity and increase inflammatory markers accounting for the higher prevalence of short- and long-term poor health outcomes.

The Adverse Childhood Experiences described by Felitti nearly 20 years ago are particularly dangerous for children as they occur within the family and are thus a breach of the child's primary attachment relationship. Maltreated children not only lack the typical protective caregiving that promotes healthy development, they experience neglect or danger from the very person who should be their buffer. And the symptoms (disordered sleep, poor affect and emotional self-regulation, elevated startle response, learning difficulties, poor attention, etc.) that we commonly observe in traumatized children correlate with the changes in brain architecture and function described by biology. Thus, the science of

traumatic stress has profound implications for children, their parents, substitute caregivers, child welfare professionals and all child-serving systems (health care, mental health care, education, childcare, court, etc.). It also has profound implications for policymakers and the health of our society, present and future.[6]

Foster Care and Resilience Promotion

Foster care is mandated to protect children, to promote their well-being, and to help them achieve timely permanency. Secure attachment to a nurturing, attentive, and attuned caregiver over time is the fundamental foundation upon which healthy child development and human resilience are built over time. The earliest relationships with our parents/caregivers become the template for all future relationships and are the venues in which we develop the brain structures we need to learn and think, to regulate our emotions and behaviors, and to pay attention. It is where we begin to form our concept of self and master the skills that promote self-efficacy. In short, it is through attachment relationships that we develop into caring, competent, rational, creative, and healthy human beings. Simply put, resilience is the typical outcome when a child thrives in a secure attachment relationship with an attuned attentive caregiver.

Child welfare professionals in responding to families in crisis have a clear mandate to remove children when their safety is at imminent risk. But they are often confronted with situations where the safety concerns may be insufficient to justify removal. Whether children are removed or remain at home, child welfare is obligated to provide services that support family reunification or maintenance. Some families may have been doing relatively well until a crisis or series of crises overwhelmed parental caregiving capacities. Identifying family strengths and challenges and determining what is needed and whether it is possible to help a family heal in ways sufficient to promote child safety and well-being is a complex, demanding, time-consuming, intense and sometimes heart-wrenching job. This job is made more difficult when there are insufficient resources to support child and family healing.

When children are removed, foster/kinship caregivers are the major therapeutic intervention that child welfare offers. The new caregiver must, over a brief time, become the new attachment figure for a child because healing and recovery from trauma can only occur for children in the context of a secure attachment relationship. This is particularly true after a child has experienced the most significant trauma any child can suffer—

the loss of their parent. The individual child's experience of foster care thus remains highly dependent on the knowledge, skills, and dedication of their new caregivers. But this care is also deeply impacted by their caseworkers, judges, attorneys, and other professionals who serve them. Caregivers come with a range of skills and experiences, attitudes about parenting, individual strengths, social supports, and their own histories of trauma and loss. Professionals serving these children and families also bring a range of professional competencies, attitudes, and beliefs to their work. Child welfare professionals in particular have a complex job rife with competing demands on behalf of vulnerable children and families. Thus, child welfare is a complex, often imperfect system, deeply dependent on the skills and dedication of a workforce tasked with the care and healing of society's most vulnerable and needy children and families.

What Has Improved

Our knowledge about what works for children and families has grown dramatically in three decades and has been accompanied by the development of evidence-based prevention, parenting, and treatment programs that can improve the experiences and outcomes of children and adolescents in terms of family maintenance, placement stability, permanency, and well-being.[1,4,8-11] The American Academy of Pediatrics has published guidelines for the health care of children and adolescents in foster care.[12] There are reliable, open-access, centralized resources (the Child Welfare Information Gateway, the California Evidence-Based Clearinghouse for Child Welfare, and the National Child Traumatic Stress Network) that review, rate, and disseminate information and evidence about best practices for child welfare and trauma treatment. And many child welfare professionals have received at least some training in childhood trauma.

Other good news arises from what has changed for the better in terms of policy, legislation, and regulation as they have begun to reflect the science about the impact of childhood trauma over the life-course.[6] A short summary of key pieces of federal legislation that have changed the landscape over the last several decades includes:

- The Adoption and Safe Families Act of 1997 (P.L.105-89): set timelines to promote earlier permanency through reunification, guardianship, and adoption; provided funding for evidence-based interventions aimed at family preservation and the prevention of child maltreatment; and increased adoption subsidies.

- The Foster Care Independence Act of 1999 (P.L. 106-169): provided states incentives to maintain youth in foster care past their 18th birthday.
- The Child Abuse Prevention and Treatment Act (P.L.93-247) and multiple re-authorizations: makes young children < 3 years old with substantiated maltreatment automatically eligible for evaluation by Early Intervention.
- The Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351): supports keeping siblings together and children in their communities and schools of origin when feasible; formally addressed the responsibility of the states to oversee the health care and coordination of services for children in foster care.
- The Patient Protection and Affordable Care Act of 2010 (P.L. 111-148, amended): effective January 2014, youth emancipating from foster care can retain Medicaid eligibility until age 26 years.
- Family First Prevention Services Act of 2018 (P.L. 115-123): fundamentally alters child welfare funding by: enabling states to shift federal funds (Title IV-E) from foster care to family preservation services regardless of family income; funds placement of children with their mothers in inpatient treatment settings; increases supports to families who have reunified; improves resources for adoption and guardianship; expedites interstate placement of children with extended family members; and includes the first federal guidelines for congregate care.

Legislative changes have impacted the numbers of children, the relative prevalence of minority children, adoption rates, and the length of stay in foster care. The downward trend in removals reduced the average daily census of children in foster care from 567,000 in 1999 to a nadir of 396,966 in 2012. Despite the recent uptick in entries, the overall trend in admissions remains downward over 2 decades.[13] Recognition that disparities in reporting and investigation led to an overrepresentation of minority children in foster care led many child welfare agencies to address these issues, resulting in a relatively larger reduction in the numbers of minority children entering foster care compared with white children.[14] Efforts at earlier reunification and increased adoptions out of foster care have shortened the average length of stay so that 25% of children now spend under 6 months in foster care and only 5% are in care for more than 5 years.

Changing societal attitudes and antidiscrimination laws have led to an increase in the numbers of same-sex and unmarried couples who choose foster parenting and adoption.[15] The recognized importance of family connections has led to increased placement with relatives or kinship caregivers, enabling children to remain in their extended families, cultures, and/or communities.

Major Areas for Improvement Remain

Unfortunately, despite greater knowledge about what children need for healthy development and evidence about what promotes healing for parents and children, there remains much room for improvement in implementing that knowledge and evidence into practice. Implementation is challenging for many reasons. Lack of awareness about specific interventions, inadequate foster parent and caseworker training, and limited financial resources, appropriately trained mental health professionals, and care coordination across systems are commonly cited barriers.

Training about childhood trauma has expanded but is merely the first step in systems change. In many communities, the systems (child welfare, courts, mental health, pediatrics, schools, early childhood education and care) involved in caring for children in foster care have not yet effectively educated their staff about childhood trauma or integrated their services. Training for caregivers about childhood trauma, caring for the traumatized child, positive parenting strategies, and co-parenting are not widespread or reinforced with ongoing support from well-qualified professionals.

The implementation and dissemination of trauma-informed care and evidence-based and best-practice interventions remain limited. Merely learning about Adverse Childhood Experiences[16] and Complex Childhood Trauma[5] does not provide child welfare and mental health professionals with the practical skills and tools they need to help children, birth parents, and foster/kinship caregivers. As an example, ample evidence exists that Multi-dimensional Treatment Foster Care promotes secure attachment to the foster caregiver, normalizes the dysregulation of the child's neuro-hormonal stress responses, and nurtures child emotional regulation,[8,17] but it has not been widely replicated. Incorporation of effective evidence-based dyadic mental health therapies, such as Parent-child Interaction Therapy or Child Parent Psychotherapy, into parent-child visitation remains scarce. Yet, quality visitation remains one of the best predictors of reunification.[18] While visitation schedules have been slightly liberalized

in the last 2 decades, almost all agencies still rely on traditional monitored or supervised visitation models rather than on mentored or therapeutic visitation models that promote positive parenting skills, parent attunement, understanding of child development, and secure attachment.[19]

Supports for Transition-age Youth (TAY) have increased but are insufficient to meet the need.[20] Data about the abysmal outcomes of foster care youth and the impact of childhood trauma on the delayed maturation of executive function have contributed to changing expectations about child welfare's responsibilities for this population. Research has shown that youths with mentors fare better than their peers,[21] but funding seldom exists for mentoring programs or for youth to engage in normalizing activities through which they might find mentors. Independent living training is, by federal law, supposed to begin at age 14 years and should include engaging youth in identifying a group of responsible adults in their communities with whom they can maintain connections after emancipation. Emerging evidence also indicates that half of adolescents who are insecurely attached to their birth parent can form a secure attachment with a stable foster caregiver[11] and that specific interventions can improve stability and outcomes for youth,[17] but these programs are not widely replicated.

Sadly, despite the relatively larger reduction in the numbers of minority children in care, African-American children in particular continue to be overrepresented. Certain sub populations of children have longer lengths of stay, including children with major behavioral issues, members of large sibling groups, and children of color. Particular subpopulations require specialized services that are often in short supply, and these include children with disabilities, children dually diagnosed with intellectual disabilities and behavioral issues, sexually exploited children, youth with juvenile justice involvement, children with major mental health problems, pregnant and parenting teens, LGBTQ youth, unaccompanied refugee minors and children with complex medical problems.

Many other issues also persist despite decades of advocacy to change them. Financing streams and information systems for child welfare, health, and mental health services exist in discrete buckets and do not support the integration of services and training across systems necessary for system redesign. Despite legislation supporting care coordination, medical home care, and evidence-based trauma-informed mental health services, the federally mandated state-level health care oversight that

might encourage these outcomes remains largely primitive in its infrastructure for a population that is transient and complex. Mental health and other services are often not available urgently at the time of removal and placement, or at other times of transition, for children and families. Despite modern technology that enables remote access to a variety of education and health programs, many localities continue to lack key services such as trauma training and pediatric trauma-informed mental health services due to lack of awareness, funding, or availability.

Recruitment and retention of foster parents have emerged as critical issues as their overall numbers have declined. While the drop in foster parent numbers paralleled requirements that they have another source of income outside of foster care in order to be licensed, societal norms and cultural shifts may have also played a role. Most foster parents work outside the home, but federal and state laws do not support parental leave for caregivers when a new child is placed in their home, although this would likely promote attachment, bonding, and placement stability, and result in more families able to accept infants too young for childcare. Agencies particularly struggle with recruiting families to care for their highest risk children, including adolescents and those groups who remain longer in care and have less stable placements. Adolescents and other high-risk children may end up in congregate care because of the dearth of family-based settings.

Despite some major advances, the child welfare system largely remains a crisis-driven system. This is not surprising. Child welfare is the intensive care unit of the social welfare system, dealing daily with families and children in crisis. Caseloads remain higher than recommended and caseworkers are expected to work simultaneously on the conflicting goals of family reunification and an alternative permanency plan, such as adoption or guardianship. The crisis orientation also reflects the demands created by emerging national crises such as the opioid epidemic or the recent surge in unaccompanied refugee minors. When such events occur, child welfare has to contend with them by urgently refocusing its limited staff and financial resources.

Child welfare education (and pay) is inadequate for the complexity of a job that requires caseworkers to be part legal expert, trauma-informed mental health professional, social worker, parenting skills educator, child development and attachment specialist, navigator, and advocate. Court, which is by its nature an adversarial process, remains the venue in which

decisions about placement, services, and permanency are made, but court personnel are inadequately trained in child development, childhood trauma, attachment and parenting, and mental health--knowledge basic to appropriately adjudicate cases. Children still miss too much school, losing an average of 4 months of academics each time they change schools.[22] Schools and childcare settings may suspend or expel a child who has unpredictable behavioral outbursts because they do not recognize or know how to manage trauma symptoms. Placement changes, which disrupt yet another attachment relationship, often occur as a result of administrative decisions instead of consideration of a child's needs, and without appropriate planning, whether the child is moving to a new foster placement or returning home. Many events in foster care can re-traumatize children: court hearings, separation from siblings, inconsistent or poor-quality visitation, being bullied by peers, and witnessing other children entering or leaving the home. A change in school or childcare is stressful for any child, but potentially traumatizing for a child in foster care.

Ideally, interventions to stabilize children and their families should ensue quickly and to a high standard when the family of origin is disrupted for purposes of child protection. However, resources are limited and often inaccessible, fragmented, or inadequate, leaving child welfare to patch together a safety net that may not match child and family needs and may fail those it is intended to protect and help.

Potential Future Opportunities

What we know about systems is that they are designed to achieve the results they get, and what gets measured is what gets done. Moving forward, policies need to be designed with the ends in mind, with clear measures of the outcomes we want to achieve, clear steps of how to get to those ends and outcomes, frequent reassessment of whether we are achieving intended outcomes, and financing that supports those goals, steps, and outcomes. Despite its imperfections, the Families First legislation provides a potentially transformative opportunity for states to align financing with the goals of safety, permanency, and well-being, to improve caregiver and professional education to support those goals, and to implement evidence-based, informed, or promising practices that have been shown to reduce family disruption and be healing for children and families at all stages of child welfare involvement.

Realistically and sadly, we will probably never achieve a world in which there is no need for substitute care, so we should try to make out-of-home

care for children, who are after all our future, as healing for them and their families as we can. We can begin by keeping the child at the center of all that we do, much as we are learning to keep the patient at the center in health care. Child welfare leadership and staff, health and mental health professionals, judges, and all the other professionals who assist child welfare in its work need to become proficient in childhood trauma and its impact, so they have the knowledge and skills to undertake their work in a way that promotes healing for children and families. We need to professionalize the child welfare workforce by designing and implementing a national child welfare educational curriculum so that child welfare workers receive the right training for the complex nature of the work they do and earn postgraduate credits leading to a master's degree and pay raises in accordance with credits earned. Resource and birth parents need similar intensive training and supports and access to resources that will help them help children. As localities and states move funding to develop and implement evidence-based preventive services, we need to be sure that those children and families already involved with child welfare, especially those in foster care, have access to evidence-based/informed care that begins with the first encounter with child welfare. Strategies to recruit and educate resource caregivers, both foster and kinship, need to be developed as do the supports to retain them. Evidence-based/informed family preservation efforts and resources that can stabilize families need to be used early and liberally to reduce family disruption. Since child welfare is our emergency service for families in crisis, we need to make sure that staff is well-educated and that evidence-based protocols and interventions are developed, implemented and disseminated to ensure that every child and family gets the right care by the right person at the right time, beginning with the first encounter. Evidence is abundant that secure attachment to an attuned caregiver and a sense of belonging in an ongoing relationship is fundamental to healing and resilience. This makes crucial the work of nurturing a child's relationship with their caregiver(s) and nurturing the caregivers to do that work.

Almost 2 decades ago, Dr. Abraham Bergman published an article titled "The Shame of Foster Care Health Services", which served as a call to arms for pediatricians, policymakers, and health care systems serving children in foster care. He pointed out that despite published guidelines for their health care, health services remained "lamentable" due to cross-systems barriers, lack of care coordination, lack of access and the lack of alignment between financing and goals.[23] Families First affords states the

opportunities to engage in the cross-systems work to actualize the major goals of child welfare. As Dr. Bergman said in his landmark article, “children in foster care need not just ordinary, but extraordinary consideration.” I would expand that to include all families and children who come to the attention of child welfare. Let us begin. The children are depending on us.

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