Pediatricians' Hoffmann & Grigsby Testimony

House Human Services and Housing Committee

KEY POINTS

- PUTTING CHILDREN AND FAMILIES FIRST PRESERVES ESSENTIAL CONNECTIONS.
- A CALL TO CHILD PROTECTION HOTLINE IS BEST PREDICTOR OF CHILD'S POTENTIAL RISK FOR INJURY AND DEATH BEFORE AGE 3[1]
- PEDIATRICIANS HELP NAVIGATE THE INTERSECTIONS OF CHILD HEALTH, SOCIAL DETERMINANTS OF HEALTH & ADVERSE CHILDHOOD EXPERIENCES TO PROMOTE NEURODEVELOPMENT & "CONNECTEDNESS" TO FAMILY AND COMMUNITY.
- FOSTER CARE IS A SUPPORT TO FAMILIES, NOT A SUBSTITUTE FOR PARENTS.
- THERE WILL *ALWAYS* BE A NEED FOR QUALITY FOSTER CARE.

THE ROLE OF THE FOSTER CARE MEDICAL HOME

- NEARLY 40% OF US CHILDREN EXPERIENCE A CPS INVESTIGATION (HYUNIL, 2017)
- MOST SERIOUS AND UNSAFE → CHILDREN ARE REMOVED
- PCP'S SHOULD BE CONDUCTING PRE-PLACEMENT MEDICAL VISITS, OR WITHIN 48-72 HOURS OF TRANSITION TO NEW ENVIRONMENT
- PLACEMENT CONSIDERATIONS → PHYSICAL AND MENTAL HEALTH, SAFETY, CULTURE, COMMUNITY, SCHOOL, ACCESS TO RELATIVES, DISRUPTION IN RELATIONSHIPS
- WHAT PEDIATRICIANS KNOW:
  - PARENTS ARE MOST IMPORTANT INFLUENCE ON A CHILD'S DEVELOPMENT
  - CHILDREN IN FOSTER CARE ARE NOT IMMUNE TO ABUSE/NEGLECT
  - DHS INVOLVED CHILDREN ARE COMMONLY THE POOREST AND MOST VULNERABLE IN OUR POPULATION
  - MEDICAL HOMES PROVIDE CONTINUITY OF CARE OVER THE CHILDHOOD AND ADOLESCENT TRAJECTORY; MEDICAL RECORDS CAN TELL THE "BEHIND THE SCENES" STORY

MEDICAL DIAGNOSES: CHILD ABUSE AND FOSTER CARE CLINICIANS

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- MOST SERIOUS AND UNSAFE → CHILDREN ARE REMOVED
- PLACEMENT CONSIDERATIONS → PHYSICAL AND MENTAL HEALTH, SAFETY, CULTURE, COMMUNITY, SCHOOL, ACCESS TO RELATIVES, DISRUPTION IN RELATIONSHIPS
- MEDICAL DIAGNOSES CAN INFORM DHS DECISION MAKING
- MEDICAL OPINIONS OFTEN CHANGE BASED ON NEW INFORMATION FROM MULTIPLE SOURCES

IMPROVED CARE COORDINATION

OLDEST CHILD OF 3 FOSTER CHILDREN DISCLOSES TO HER COMMUNITY MENTOR THAT HER FOSTER SIBLING HAS BEEN SEXUALLY ABUSING HER SINCE THE TIME OF PLACEMENT. SHE DID NOT DISCLOSE SO THAT SHE COULD PROTECT HER SIBLINGS.

- LESSON LEARNED: REVIEW OF MEDICAL RECORDS REVEALED MULTIPLE EMERGENCY ROOM VISITS FOR SUICIDALITY & ONE ADMISSION AFTER SUICIDE ATTEMPT. FOSTER PARENTS INABILITY TO ESTABLISH MENTAL HEALTH CARE SHOULD HAVE BEEN A RED FLAG, RAISING QUESTIONS ABOUT THEIR ABILITY TO MEET CHILD'S MENTAL AND BEHAVIORAL NEEDS.

IMPROVED MEDICAL KNOWLEDGE

2013 OREGON DHS HOTLINE CALL ALLEGING CHILDREN OF JENNIFER & SARAH HART WERE DENIED FOOD, MALNOURISHED AND HARSHLY DISCIPLINED. MINNESOTA DHS SHARED INVESTIGATIVE FILE; CAC REFUSED TO SEE CHILDREN AS THEY HAD MADE NO DISCLOSURES AND LIMITED MEDICAL RECORDS; DHS CASE DETERMINATION → UNABLE TO BE DETERMINED

- LESSON: DIAGNOSIS OF CHILD ABUSE AND NEGLECT IS A MEDICAL DIAGNOSIS; FOSTER & ADOPTIVE CARE ARE DYNAMIC SYSTEMS AND NEW ALLEGATIONS OF CHILD MALTREATMENT REQUIRE MEDICAL CONSULTATION WITH CHILD ABUSE PEDIATRICIANS OR OTHER DESIGNATED MEDICAL PROVIDER.

SUPPORT FOR ALL CAREGIVERS: BIRTH, KIN, FOSTER & ADOPTIVE

FOSTER CARE ENHANCED MEDICAL HOME RESPONSIBILITIES

- PROVIDE EASY ACCESS TO TRUSTED MEDICAL HOME TEAM VIA ELECTRONIC COMMUNICATIONS, NURSE AND SW TELEPHONE HELP LINES
- EMPLOY CARE COORDINATION (INVOLVING DHS CASEWORKER) TO BRIDGE GAPS IN MENTAL AND BEHAVIORAL HEALTH SERVICES
- IMPLEMENT BEST PRACTICES USING AUTHORITATIVE RESOURCES: NCTSN TRAUMATIC STRESS TOOLKITS & AAP POVERTY, FOSTER TOOLKITS

FOSTER PARENT RESPONSIBILITIES AND EXPECTATIONS

- *HELPING FOSTER & ADOPTIVE FAMILIES COPE* WITH TRAUMA – CONTINUING EDUCATION
- RESOURCE PARENT CURRICULA TRAINING: 4 WEEK WORKSHOPS AT LEMC AND PROVIDENCE (CHILDCARE PROVIDED FOR ATTENDEES)
- BUILDING RELATIONSHIPS BETWEEN FOSTER AND BIRTH FAMILIES
- DATA-DRIVEN RECRUITMENT OF FOSTERING NETWORK
- "WARM LINES": PEER SUPPORT, MENTORING, COACHING

FOSTER FAMILIES *FOSTER* FAMILIES

UNTAPPED POTENTIAL:

- DHS GUIDED INTERFACE WITH BIRTH PARENTS TO TAKE ADVANTAGE OF COACHING OPPORTUNITIES
- MODELING THE BASICS: ROUTINES, CONSEQUENCES, BEHAVIORAL MODIFICATION TECHNIQUES, CONSISTENCY, NURTURANCE
- REAL TIME INTERACTION WITH MEDICAL HOME NURSE, SOCIAL WORKER, BEHAVIORAL HEALTH SPECIALIST
- CRISIS AVOIDANCE – HELPING FOSTER AND ADOPTIVE FAMILIES COPE WITH TRAUMA EXPOSED CHILDREN AND YOUTH
- COMMUNICATIONS WITH SCHOOL, TEACHERS, COUNSELORS, SCHOOL RESOURCE OFFICERS

CHAMPS CAMPAIGN, AMERICAN ACADEMY OF PEDIATRICS

- HOPE COOPER, CAMPAIGN LEADER, SEATTLE, WA
- 10 YEARS, PARTNERING WITH STATES TO ACHIEVE STATE SPECIFIC AIMS
- NETWORK OF ISSUE AND POLICY EXPERTS
- NO- AND LOW- COST APPROACHES TO ACHIEVE EFFECTIVE RECRUITMENT AND RETENTION OF FOSTER PARENTS

CHAMPS POLICY SOLUTIONS → QUALITY FOSTER CARE

1 SUPPORT RELATIONSHIPS BETWEEN BIRTH AND FOSTER FAMILIES

Nurturing a child's relationships with birth parents, siblings and extended family minimizes the trauma of foster care and broadens the child's support system. It's vital because more than half of children who enter foster care go home. Achieving this requires new skills and activities from foster parents to nurture the parent-child bond and provide mentorship to birth parents. Child welfare agencies should recruit, train and support foster families and staff to work with birth families and promote co-parenting.

2 IMPLEMENT DATA-DRIVEN RECRUITMENT AND RETENTION PRACTICES

Maintaining an up-to-date census of licensed foster parents provides agencies with valuable information they can use to improve recruitment and retention activities. A census can help monitor the overall capacity of available foster parents in a community or state. It can also be an important tool for matching children with the most appropriate family, ensuring that the first placement is the best placement.

3 ENGAGE FOSTER PARENTS IN DECISION-MAKING

Foster families spend more time with children than any other professional. They have valuable information needed for decisions about the children's health, education, and other needs. Child welfare agencies should have policies reflect parents as priority partners. Policies should ensure foster parents are engaged in all aspects of case planning including team meetings, court proceedings, visitation and transitions.

4 PROVIDE TIMELY ACCESS TO TRUSTED, DEDICATED STAFF AND PEER SUPPORT TO FOSTER PARENTS

Foster parents must get the help they need, when they need it, to serve the children in their care. State policy should require that case workers be assigned to support foster parents and offer them access to "warm" help lines where they can connect with experienced foster parents, peer mentors, coaching, and other support networks.

5 PRIORITIZE PLACEMENTS WITH FAMILY MEMBERS

When children enter foster care, a placement with a relative or a close family friend is often the best option. It helps maintain the child's connection to family and cultural traditions. "Kinship care" can increase stability and safety for children in foster care. State policies should strive to make relatives the first placement and offer the same supports for kin as non-kin foster parents.

6 ENSURE TIMELY ACCESS TO PHYSICAL AND MENTAL HEALTH SERVICES

Meeting the physical and mental health needs of children in foster care is critical to their well-being. Policies should remove barriers and provide supports that equip and empower foster parents to help ensure children in their care can access needed health services, including comprehensive assessments and timely mental health services.

REFERENCES

1. COMMISSION TO ELIMINATE CHILD ABUSE & NEGLECT FATALITIES, FINAL REPORT, MARCH 2019
2. NEEDS OF KINDSHIP CARE FAMILIES AND PEDIATRIC PRACTICE, POLICY STATEMENT, 2017
3. CLINICAL CONSIDERATIONS RELATED TO THE BEHAVIORAL MANIFESTATIONS OF CHILD MALTREATMENT, CLINICAL REPORT, 2017
4. HEALTH CARE ISSUES FOR CHILDREN AND ADOLESCENTS IN FOSTER AND KINSHIP CARE, AMERICAN ACADEMY OF PEDIATRICS, TECHNICAL REPORT & POLICY STATEMENT, 2015
5. THE PEDIATRICIAN'S ROLE IN SUPPORTIVE ADOPTIVE FAMILIES, CLINICAL REPORT, 2012
6. CARE OF ADOLESCENT PARENTS AND THEIR CHILDREN, CLINICAL REPORT, 2012
7. HEALTHCARE OF YOUTH AGING OUT OF FOSTER CARE, POLICY STATEMENT, 2012
8. THE PEDIATRICIAN'S ROLE IN FAMILY SUPPORT AND FAMILY SUPPORT PROGRAMS, POLICY STATEMENT, 2011
9. UNDERSTANDING THE BEHAVIORAL AND EMOTIONAL CONSEQUENCES OF CHILD ABUSE, 2008
10. FOSTERING HEALTH: HEALTH CARE FOR CHILDREN AND ADOLESCENTS IN FOSTER CARE, TASK FORCE ON HEALTH CARE FOR CHILDREN IN FOSTER CARE, 2ND EDITION, 2005
11. HTTP://FOSTERINGCHAMPS.ORG/POLICY/ LAST ACCESSED 5-1-2019