Trauma-informed care in foster care for providers transcript

Hello, and welcome to the second installment of trauma-informed education for all providers.

This training centers on trauma-informed care as it relates to children and the foster care population.

If you have not already completed the trauma-informed care introduction training, please pause this training and complete that before continuing.

This training has five lessons.

The first lesson will be a review of trauma-informed care.

In the second lesson, we'll be discussing the impact of trauma on children. We will focus on the impact trauma has on the developing mind and body of a young person and how that predisposes them to certain complications and challenges.

In the third lesson, I will introduce you to the foster care system. I'll establish a basic understanding of what the foster care system is and who some of the key parties involved are for children and youth.

As you might suspect, children in foster care are disproportionately exposed to trauma as compared to children not in foster care; this 4th lesson will speak to the intersection of the two.

It goes without saying that our entire trauma transformation effort is designed to decrease the short and long-term implications of trauma, but our fifth lesson will dive a bit deeper into some of the specific ways we do this in our workspaces as well as our communities.

Before we go any further, let me take a moment to acknowledge that trauma is a sensitive topic.

If at any time you need to pause this training and step away, please know that you are welcome to.

Review of trauma-informed care

As you will recall, there are four basic assumptions of trauma.

The first assumption is that trauma is common.

So common, in fact, that 70% of adults in the US report experiencing some type of traumatic event at least once in their lives. That is equivalent to approximately 223.4 million people[1].

The second assumption is that trauma is widespread.

[1] www.thenationalcouncil.org, 2013.

To the extent that we may consider it a public health problem.

Trauma is pervasive, diverse, life-shaping and misunderstood.

The third assumption is that trauma can and does happen inside the very systems meant to protect from trauma.

In the last training we talked about examples in the behavioral, educational and medical systems. As we will discuss today, the foster care system may be among those as well.

And, our fourth assumption – people can and DO overcome trauma. This is often aided by the right supports and interventions. Trauma-informed care is one such support.

By being *informed* about a person's trauma, we are, in fact, committing to caring for that person through a lens of understanding and empathy that can break down some of the barriers to recovery that trauma often builds up.

Remember, a doctor, nurse, behavioral health clinician, pharmacist or other service provider does NOT define what might or should be considered traumatic by others. **Trauma is always defined by the individual who experienced it.**

Remember too, that trauma results from an EVENT, series of events or set of circumstances that is EXPERIENCED as overwhelming or life-changing by the individual and has a profound EFFECT on them and their life.[2]

Recall that there are many types of trauma. And no trauma is exclusive: a person may experience any combination of these and other traumas throughout their lifetime. Let's review.

Historical trauma is trauma that passes through generations.

Physical trauma is trauma that occurs to one's physical body.

Emotional trauma is trauma that occurs to one's connectedness to others.

Environmental trauma is trauma the occurs to one's immediate or global space.

Chronic trauma is trauma of any kind that is experienced repetitively over an extended period. Chronic trauma is particularly detrimental as the body and mind stay in a constant state of stress.

We will talk much more about chronic stress in today's training, but why? Why does all this matter for you, for me, for our organization?

Let's connect the dots.

Providers contracted with managed care organizations, like Aetna, serve vulnerable members with complex medical, behavioral and social conditions, many of which are related to traumatic events they have sustained. Those traumatic experiences have a *direct* impact on our member's health

[2] SAMHSA, 2012

and how they choose to engage with services. One of the #1 things that facilitates positive engagement from our members is when they *feel* heard, understand and not judged.

Trauma-informed care has the potential to improve engagement outcomes – when our members disclose past or current traumas, we need to know how to respond. Knowing what to listen for and understanding the impact that trauma had, or is having, on that person allows for a deeper connection.

It also allows us all to manage risk.

When our members feel safe and understood by their providers, they are more likely to engage positively with services. This translates to things like fewer cancelled appointments and higher rates of adherence to your medical recommendations.

To provide trauma-informed services, all staff in your organization must understand how trauma impacts the lives of the people you serve. It means every interaction is consistent with the recovery process and reduces the possibility of re-traumatization.

Bringing it all together then, trauma-informed care is an organizational change process centered on principles intended to promote healing and reduce the risk of re-traumatization for vulnerable individuals.[3]

Trauma in childhood

As you might imagine, children are some of our more vulnerable individuals.

They come into this world entirely dependent on their caregivers for the most basic elements of survival.

What's more, research on early brain development shows that infancy and early childhood are the most critical periods during which the foundations of trust, attachment, self-esteem, conscience, empathy, problem-solving, focused learning and impulse control are formed.[4]

SO, when those care givers lack the education, availability or wherewithal to give them what they need, these children can experience trauma that impacts their developing mind and body and predisposes them to certain complications and challenges.

This notion that the traumatic things that happen to us as children lead to problems later in life is a topic we covered in the introduction training.

To refresh your memory, the Adverse Childhood Experiences, or ACEs, study was a joint project between Kaiser Permanente and the Center for Disease Control (CDC) launched in 1995. This

[3] Bowen and Murshid, 2016.

[4] Greenough W, Gunnar M, Massinga R, Shonkoff JP. The impact of the caregiving environment on young children's development, 2001.

study surveyed several thousand adults about their experiences in childhood and any present-day health problems they were dealing with as adults.

The findings were staggering: not only did 67% of adults report at least one adverse childhood experience, but there was also sufficient statistical evidence to support the correlation between traumatic experiences in childhood and physical, social and behavioral health challenges later in life.

In the studies that have continued since 1995, Doctors Felitti and Anda, among others, have gathered research supporting that ACEs are the most basic cause of health risk behaviors, morbidity, disability and mortality.[5]

For example, reporting multiple ACES is correlated to a 30x greater risk of suicide attempt, a 20-year reduction in lifespan, a 10x greater risk of post-traumatic stress disorder and a 2x greater risk of getting heart disease or some form of cancer.

While these statistics are quite staggering, they are not necessarily unexpected. Scientists have long known that healthy childhood development is rooted in the positive, loving, nurturing experiences and that unhealthy childhood development occurs when those early experiences are negative, unloving and neglectful.

Let's talk a bit more about why this is true.

According to studies on pregnant women experiencing stress[6], it is possible that much of the stress response is developed as early as 7 months in-utero. This means that we can be exposed to stress and our brains wired for a stress response before we have ever experienced stress first-hand.

This is coupled with the long-held fact that, infants are born ready to learn. They may have just arrived in our world, but their brains have a huge surplus of neurons at the ready to begin making sense of the world. As soon as they receive stimuli from their environment, that could be a sound, a smell, a smile, a bright light, anything, their brain kicks off forming pathways, categorizing and organizing that stimuli.

As early as age 2, the brain begins to wire itself with permanent connections and pathways that set the stage for future brain development.

If those pathways are ones of love, happiness, comfort and security — terrific! The brain and body will thrive.

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[5] Felitti and Anda, 2007

[6] Cognitive Neuroscience Society. *Prenatal stress changes brain connectivity in-utero.* March 26, 2018.

But, if there is chronic stress and those pathways are built on experiences of neglect, uncertainty, abuse or other traumas, the course of that brain and body development will be altered in a negative way.[7]

As the ACEs study suggested, those early negative impacts set the stage for long-term consequences.

Toxic stress alters genetic expression in ways that change the very architecture of the brain. The areas of the brain most affected — the frontal lobe and limbic system — are those involved in stress response, emotional regulation, attention, cognition, and executive function and memory, all lending to the problems we see with poor emotional regulation, aggression, hyperactivity, inattention and impulsivity.[8]

Aggressive displays of rage, hyperactivity, disassociation and other fight-flight-freeze behaviors are commonly triggered in traumatized children.

The trigger essentially sets off the child's alarm system.

Now, this alarm system is designed to protect the child, which is a great thing, but, in instances of chronic trauma, the alarm system malfunctions and gets triggered any time the child's safety feels threatened because they are reminded of an associated traumatic event.

Introduction to the foster care system

Now that we have reviewed the basics of trauma and looked specifically at the implications of trauma in childhood, we need to begin to understand that children in the foster care system are a population uniquely vulnerable to the traumas and challenges we just talked about.

Before we look at that, though, let's take a moment to understand the basics of the foster care system in our community.

Foster care is a micro-culture: It is governed by its own set of vocabulary, laws, regulations, goals and institutions.

Great, so it is a microculture, but, what, exactly IS it?

Well, foster care is a temporary arrangement in which adults provide for the care of a child or children whose birthparents or legal guardians are unable to care for them and those care needs have come to the attention of the child welfare agency.

It is where children go when their parents or guardians cannot, for a variety of reasons, care for them[9].

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[7] https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Developmental-Health.aspx

[8] http://developingchild.harvard.edu

[9] www.acef.org/blog/what-is-foster-care/

Let's explore a few other commonly asked questions.

Why are kids in foster care?

While the exact circumstances of children in foster care are as unique as the children and families themselves, most children are in foster care because the birth parents are unable to provide a safe and stable living environment for the child.

Who are foster parents?

Foster parents are relatives or nonrelative adults (sometimes called *resource parents*) who are licensed by the state and trained as caregivers to house and provide for the children placed into foster care.

What is the relationship between foster care and adoption?

Foster adoption is when a foster child is placed into a home with the expectation that they will become adopted by the foster parents.

Some children are not adopted by their foster parents. In those cases, if the rights of the birth parents have been terminated, they are legally free for adoption by someone else.

A key goal of foster care programs is to ensure that children live in stable, lifelong families, whether that is through reunification with the birth family or with foster or adoption parents.

This means that the goal is not to keep children from their birthparents; in fact, by law, children are supposed to have contact with their existing immediate family while in foster care to the extent that their situation and safety allows.

This goal is designed around the evidence-based research supporting the fact that secure attachment to at least one parenting adult is crucial to healthy child development and well-being — a fact that we know, too, through the ACEs study.

There are many people and groups that make up the foster care system in the United States. We are going to look at two of them: the Child Welfare Agency and the Administration for Children and Families.

The Child Welfare Agency is the organization that is initially made aware of the mistreatment of a child. They are focused on ensuring all children live in safe, permanent and stable environments. They are also the ones who coordinate with social workers and judges to determine placement for mistreated children.

This agency is part of the national group known as the Administration for Children and Families, or ACF. The ACF is a division of the Department of Health and Human Services that promotes economic and social well-being for children and families in the communities in which they live.[10]

[10] www.acf.hhs.gov

When it comes to actually placing mistreated youth in foster homes, one key term to be familiar with is "congregate care." In some instances, children taken from their birth families do not live with a foster family; instead, they live in a non-family group setting with several other children and youth in foster care. Among the options of placements for children and youth in the foster care system, congregate care settings are supposed to be used as a temporary placement, until youth are considered stabilized and ready for a family setting.

Sometimes this is an appropriate choice based off the needs of the child, but there is research to support that all too often group placement settings are detrimental to young people because the natural element of parent-child relationships gets eroded by strict policies.

One such example would be prohibiting physical contact between congregate care workers and the children living there. On the one hand, these policies are in place to safeguard against inappropriate physical contact, but they also prohibit natural contact like giving or receiving a hug when someone is upset.[11]

While some youth may require short term stays in these highly structured congregate care settings to address significant emotional and behavioral challenges, many young people in these settings do not need such intensive supervision. Many are placed in congregate care simply because family homes are not available. In fact, the ACF found that as many as 40% of children in group placement lacked the mental health diagnosis, medical disability or other behavioral issue that might warrant such a restrictive setting.[12]

Because of this ACF study and others with similar findings, the Family First Prevention Services Act was passed in 2018. This Act was designed to be proactive instead of reactive: increasing overall resources for foster prevention instead of simply funding foster care maintenance while also reducing funding for congregate care situations that are clinically unnecessary.[13] As a managed care organization, Aetna is uniquely positioned to be a part of these prevention services among our Medicaid and expansion populations that include children and youth in foster care.

And that is no small number either. Let's review some statistics.[14]

676, 000 registered maltreatment cases in the U.S.

443,000 U.S children in foster care.

67% of children who enter foster care because of neglect.

50,000 U.S. children adopted each year.

The intersection of foster care and trauma

[11] National Foster Care Youth & Alumni Policy Council, 2013.

[12] U.S. Department of Health and Human Services, Administration for Children and Families, 2015.

[13] http://www.ncsl.org/research/human-services/family-first-prevention-services-act-ffpsa.aspx

[14] www.childwelfare.gov/pubs/factsheet/foster

While the number and demographic of children in foster care ebbs and flows naturally over time, one thing remains constant: many of the children and adolescents involved in the system — especially those who are removed from their family of origin and placed in out-of-home care — present with complex issues rooted in adverse childhood experiences[15].

Families who come to the attention of child welfare are often experiencing multiple stressors, many of which could be outside of their immediate control, such as unemployment, low literacy rates, violence and poor parenting skills. But the single largest risk factor for entry into the foster care system is POVERTY.

Not only are children born into poverty more likely to be in the system, they are more likely to have compounding problems in the system. For example, children in poverty are **twice as likely** to have developmental delays; **three times as likely** to be hospitalized for a chronic illness; and **five times as likely** to die earlier than expected from a physical illness.

The second largest risk factor for entering the child welfare system is parental substance use. This has taken a new front seat just in the last handful of years because of the opioid epidemic. Current available data from the CDC estimates that the opioid epidemic kills approximately 91 people a day,[16] many of whom are parents. There is obvious concern for the well-being of children growing up in the home with a parent or parents abusing substances, but there is also great concern for those children exposed prenatally to drugs. High rates of in-utero alcohol and drug exposure leave many in the foster care system with cognitive, sensory and emotional impairments.[17]

In addition to poverty and parental substance use, children and adolescents are placed into foster care at alarming rates because of exposure to significant levels of violence, including but not limited to domestic violence.[18]

Let's take a moment to level set on the initial experiences of children and youth in foster care.

They have been experiencing extreme levels of abuse, neglect, poverty, violence or other combination of maltreatment from their birth family.

They may have been moved to different caregivers within the family for small durations before the child welfare system is involved.

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[15] American Academy of Pediatrics technical report on *Health care issues for children and adolescents in foster care and kinship care. October 2015.*

[16] CDC, 2018.

[17] Salisbury AL, Ponder KL, Padbury JF, Lester BM. 2009

[18] Stein BD, Zima BT, Elliott MN, et al. Violence exposure among school-age children in foster care: relationship to distress symptoms, 2001.

Traumatic circumstances arise such that child welfare is now involved, and they are removed from their home.

They may be separated from siblings.

And children, no matter what their age, are now separated from all that they knew: their pets, toys, friends, schools and overall routines.

These children and youth, understandably, have human reactions to ALL of these situations and may face emotional and psychological challenges in trying to adjust to their new and unfamiliar surroundings.

What's important to understand here is that the traumatic experience of entering foster care and the immediate disruption of routine affects the likelihood of a child being re-placed in multiple foster homes, establishing a traumatic event with each transfer.

Among the many implications we see from that trauma-compounding set of circumstances, we see some very specific educational implications for children and youth in foster care.

They have higher rates of school enrollment delays and transfers; more difficulty making and keeping friends due to foster care stigma and stricter policies governing their social involvement, particularly in group care settings.

One-third of children and youth in foster care are below grade level in reading, writing and math, and 30 – 40% are in special education classes.[19]

These statistics, like the others we have covered in this training, are profound, but what about the kids themselves. What do they have to say about their own situations?

Well, consistently, young people have emphasized that their foster care experiences were far from normal. What they needed — but all too often did not receive — was what their peers NOT in foster care typically have:

- Parents to love and guide them
- Close relationships with their siblings, extended family and other committed adults
- A stable sense of identity and belonging
- Daily experiences of extracurriculars such as sleepovers and hanging out with friends[20]

[19] Taussig HN, Culhane SE, Garrido E, Knudtson MD. Placement and permanency outcomes for foster youth. 2012.

[20] www.acef.org

These basic experiences are collectively referred to as "normalcy" in that they define a typical, normal childhood. It is widely accepted that normalcy is a critical component in healthy social, emotional and cognitive development.[21]

Unfortunately, normalcy tends to be elusive for children and youth in foster care. Their well-being needs often take a back seat to systemic issues and over-restrictive policies.

Let's hear from a few children directly about what these barriers felt like for them.

FOSTER CARE[22] ALUMNI say

"Everything and anything was restricted for us…We couldn't use the bathroom on our own, wash our clothes, use the phone, watch TV, or go out with our friends…"

EDDYE[23] says

"The main thing I wanted to do but couldn't because I was in foster care was basketball!

There was nowhere for me to stay for games out of town. I did not want to ask my coaches and teammates' parents if they could have a background check done. It wasn't normal.

It was humiliating and I lost out on so many supports and meaningful experiences I could have had during my teenage years."

JUSTIN[24] says

"*I felt normal the day I was in my foster home and my foster parent said I am now a part of their family and I could call her mom…She treated me AS if I were her own son by spending quality time with me and even introducing me to people as her son. It felt so good to feel wanted*"

Children and youth in foster care absolutely have a tough road to travel. The great news is that they do not have to travel it alone.

In addition to extended family, case workers and foster parents, there is also a national association that steps in to assist: CASA. Court-appointed special advocates.

This national association supports and promotes court-appointed volunteers who advocate for abused and neglected children in order to provide them opportunities to thrive in the community.

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[21] Center for the Study of Social Policy. *Advancing health adolescent development and well-being. 2014.*
[22] National Foster Care Youth& Alumni Policy Council, 2013.
[23] Personal communication with Eddye, Jim Casey Initiative Young Fellow, Jim Casey Youth Opportunities Initiative, February 2015.
[24] Personal communication with Justin, Jim Casey Initiative Young Fellow, Jim Casey Youth Opportunities Initiative, September 2015.

CASA volunteers are assigned to only one or two children or sibling groups at a time, so they are able to provide stability and attention in ways that other case workers in the system may not be able to.

Decreasing the impact of trauma

In our previous training we talked about the fact that working with people who are traumatized, may, itself, be trauma inducing. There are a few different terms associated with this phenomenon: vicarious trauma and compassion fatigue.

Vicarious trauma is the trauma felt by the person listening to the traumatic stories of others.[25] The person begins to feel effects of the pain, fear and terror of the trauma they are hearing about or seeing as if it were their own. This tends to occur over time as a person bears witness to an accumulation of traumatic events.

Compassion fatigue, better known as "burn out," is a condition characterized by a gradual lessening of compassion over time due to overexposure to others' traumatic circumstances.[26]

Whether you work with individuals who have sustained trauma, live with someone who works with them, or have gone through something traumatic yourself, recognizing these traumas and engaging in self-care is of the utmost importance.

Let's look at an effective 8-step plan to help you practice self-care during times when you are exposed to trauma.

Step 1 – Recognize and acknowledge what you are feeling.

Step 2 – Acknowledge that working with people who have experienced trauma can be emotionally draining and leave you feeling helpless at times.

Step 3 – Remember that the person or people you are trying to help may be experiencing incredible pain; do not take their behaviors personally.

Step 4 – Be aware of your own triggers; set personal boundaries and seek support for yourself as needed.

Step 5 – Be calm, compassionate and open to the other person's story.

Step 6 – Make an effort to learn about different types of trauma and their impact.

Step 7 – Always listen to understand before trying to fix anything.

Step 8 – Engage in your own self-care routine.

Here are five ideas for starting or enhancing your own self-care routine.

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[25] www.counseling.org

[26] www.compassionfatigue.org

Exercising: Get outside if you can! The most important thing to do is pick an activity you enjoy doing by yourself or with others to help you stay committed.

Eating healthy: Commit to packing a lunch or healthy snack items at least a few times a week. Examples may include nuts, yogurt, hummus, veggies, whole grain crackers and fruit.

Getting enough sleep: Working adults need an average of 7-8 hours of sleep per night. Do what you can to minimize distractions before bed and allow yourself one morning each week to wake up naturally without an alarm.

Expressing gratitude: Consciously name at least one thing every day for which you are grateful. If appropriate, share your gratitude with someone else.

Journaling: Give yourself the freedom to write whatever thoughts come to you. You may decide this notebook should be private, or you may use it to help you organize thoughts for a conversation you want to have with someone else.

In addition to self-care, there are 3 other best practices and tools you should be aware of when working to decrease the impact of trauma: wrap-around care, SAMHSA's Six Principles and protective factors.

Wrap-around care

The idea here is that we manage the health of the ENTIRE individual, ideally in a way that is proactive instead of reactive, meaning we engage in preventative measures as opposed to only treating problems once they arise. This is true for primary care, dental care, mental health care, education, developmental and occupational services as well as social services.

SAMHSA's Six Principles

SAMHSA, the substance abuse and mental health services administration, has six principles to base our trauma-informed organization on. The six principles are shown here.

"Safety" means expressing kindness, patience and reassurance in all interactions while ensuring a clean, organized, comfortable environment.

"Trust and transparency" means providing clear direction, setting expectations early and having clear, sensible policies that incorporate feedback.

"Collaboration and Mutuality" means leveling power differences and remembering to see others as the expert of their own bodies and goals.

"Empowerment, Voice and Choice" means acting and speaking in a way that focuses on strengths and successes and creates person-centered practices.

"Peer Support" means capitalizing on those with lived experiences and embracing the truth that "one does not have to be a therapist to be therapeutic".

"Respect for Gender, Cultural, and Historical Differences" means promoting a sense of cultural humility and cultural competency.

Protective factors

Protective factors are conditions or attributes that promote well-being and reduce the risk of negative outcomes, including the long-term consequences we learned about through the ACEs study.

There are protective factors at the individual level, such as having a sense of purpose and your own relaxation techniques; there are protective factors at the relationship level, such as having competent parents or caregivers and positive social networks; and there are protective factors at the community level, such as a stable, safe school and neighborhood and a reliable, established living situation.

In closing, consider this quote from Fred Rogers –

"We live in a world in which we need to share responsibility. There are those who say: 'it's not my child, not my community, not my world, not my problem.' Then, there are those who see the need and respond. I consider those people my heroes…"

With that, I wish you well and thank you for taking the time to engage with this training; thank you for all your do for our members and THANK YOU for continuing to participate in the trauma transformation.