ADVISOR

May 2018

The American Professional Society on the Abuse of Children
IN PARTNERSHIP WITH
THE NEW YORK FOUNDLING

Strengthening Practice Through Knowledge

In This Issue

Foster Care

Navigating complex systems to meet the needs of vulnerable children

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Vol. 30 | No. 2

Introduction to the Issue: Children and Adolescents in the Foster Care System

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Despite concerted efforts in the early- to mid-2000s to successfully reduce the number of children placed into foster care, there has been an unsettling national trend in our child welfare system, with increasing numbers of children placed into foster or kinship care. FY16 estimates (as of 10/20/17) identify 437,465 children in the U.S. foster care system, a nine percent increase over the past 5 years (U.S. Department on Health and Human Services, Administration for Children and Families, Administration on Children Youth, and Families, Children's Bureau, 2017).

Substance use by a parent had the largest percentage increase of any circumstance reported as the reason for foster care placement. This well-recognized national epidemic of opioid use is of concern, and we are experiencing the tip of the proverbial iceberg in terms of the impact of increasing numbers of children needing placement due to multifactorial familial challenges.

Efforts to improve outcomes for children and adolescents in foster care should not be solely a child welfare system responsibility. Innovative, integrated approaches to the multiple domains of care are needed now more than ever. This includes improving our efforts in child welfare, healthcare, and the court systems, and truly developing a collaborative, inter-professional response for our clients-patients-victims who require placement into foster care.

In this special issue of the APSAC Advisor, our goal is to provide a comprehensive, inter-professional lens on the unique issues faced when a child is placed into foster care. This includes recognition of:

- The special healthcare needs and health system response in providing physical, behavioral, developmental, and dental health services;
- The need to enhance medical education training to support frontline clinicians in their efforts to provide competent, trauma-informed care;
- The need for child welfare and legal systems to ensure best practices are utilized for optimal child protection and advocacy decision-making.

Finally, we highlight the critical need to anticipate aging out of foster care to ensure a successful transition to adulthood and independent living, given the high risk of unemployment, homelessness, and ongoing chronic medical conditions for graduates of our U.S. foster care system. We have identified multiple, known barriers to high-quality care, but we have also provided best practice solutions within the various inter-professional domains.

We encourage readers to pursue knowledge and understanding across the multi-disciplinary systems, regardless of one's own primary discipline, to be as effective as possible in supporting optimal care to these children and adolescents. It is in this context that these articles have been written, with the hope that when a child is placed into foster care, they are provided with the necessary support and interventions to foster well-being, safety, permanency, and the ability to live healthy and productive lives.

U.S. Department on Health and Human Services, Administration for Children and Families, Administration on Children Youth, and Families, Children's Bureau. (2017, October 20). *The AFCARS Report*. Retrieved from https://www.acf.hhs.gov/sites/default/files/cb/afcarsreport24.pdf

About the Guest Editor

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Coordinating Care to Provide Quality Health Services to Children in Foster Care

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Literature Review

Special Health Care Needs

Research has linked maltreatment in childhood to serious physical and mental health problems throughout childhood and adulthood (Conn et al., 2013; Felitti et al., 1998; Flaherty et al., 2013; Herrenkohl, Hong, Klika, Herrenkohl, & Russo, 2013; Ringlesen, Casanueva, Urato, & Cross, 2008). Children in foster care have higher rates of chronic health problems compared to children not in the foster care system (Nelson et al., 2011; Ringelsen, Casanueva, Urato, & Cross, 2008; Simms, 1989; Sobel & Healy, 2001). An examination of the National Survey of Child and Adolescent Well-being found that 27.9% of children in foster care had at least one chronic illness including such conditions as asthma, severe allergies, eczema, and repeated ear infections (Ringelsen et al., 2008). This rate is almost double that of chronic illness in the general population of children across the United States, which is between 15% and 18% (Bethell, Read, Blumber, & Newacheck, 2007).

Additionally, many children in foster care are likely to be diagnosed with mental health problems (e.g., Sullivan & van Zyl, 2008). A medical claims review from two foster care clinics in one county in New York found that between 73% and 82% of children in foster care were diagnosed with a mental health problem (Jee, 2010). The most common diagnoses for children in foster care are attachment disorders, depression, anxiety, and behavioral problems (Sobel & Healy, 2001). Finally, these children are also prescribed psychotropic medications at higher rates compared to their peers (e.g., Cohen, Lacasse, Duan, & Sengelmann, 2013; Raghavan et al., 2005; Steele & Buchi, 2008).

Developmental delays, not reaching developmental milestones at expected times, are more likely to occur within children in foster care compared to those children not in foster care (e.g., Gorski et al., 2002). The percentage of children in foster care that have developmental delays varies widely in the research, ranging from less than 5% to greater than 80% (Leslie et al., 2005; Jee et al., 2010; Steele & Buchi, 2008). Developmental delays can have lifelong effects on the well-being of children in foster care (e.g., Miller et al., 2000).

Oral health is critical to child well-being (Guarnizo-Herreno & Wehby, 2012) and research has linked it to academic problems in populations who suffer from dental issues (USDHHS, 2000; Schechter, 2000). Dental caries in young children have been associated with missing more school as well as having more significant health issues, and can be a focus of distraction from effective learning (Tinaoff & Reisine, 2009; Ramage, 2000). Children in foster care frequently have dental issues, with 20% of children entering foster care reported as having significant

dental issues (Szilagyi, Rosen, Rubin, & Zlotnik, 2015). The health and well-being of children in foster care can seriously impact their permanency (Becker, Jordan, & Larsen, 2007; Leslie et al., 2005; Oosterman, Schuengel, Wim Slot, Bullens, & Doreleijers, 2006; Rosenberg & Robinson, 2004). Medical problems and developmental delays are associated with higher numbers of placements, longer stays in foster care, and increased difficulty in achieving permanency (Becker et al., 2007; Rosenberg & Robinson, 2004). Behavioral problems exhibited by children in the foster care system have been shown in multiple studies to be associated with failed placements (Leslie et al., 2005; Oosterman et al., 2006). A mental health diagnosis has been found to have a negative effect on the permanency of children in foster care (Becker et al., 2007).

Legislation Regarding Health Care for Children in Foster Care

Federal legislation and the development of practice guidelines through the American Academy of Pediatrics (AAP) and the Child Welfare League of America (CWLA) have mandated the critical responsibility to address the health of children in the foster care system. In order to comply with section 422(b)(15)(A) of the Social Security Act, every 5 years each state must submit a proposal to the Administration of Children and Families (ACF) outlining a concrete plan to address the healthcare needs of children in foster care (Department of Health and Human Services, 2015). The proposals must include how the state plans on providing continuity of care for children in foster care, and how they will keep medical information up to date and share it among providers (Department of Health and Human Services, 2015). Along with meeting the requirements outlined in the Social Security Act, states are also required to address the emotional trauma and developmental health of each child entering foster care in accordance with the Fostering Connections to Success and Increasing Adoptions Act of 2008 and the Child and Family Services Improvement and Innovation Act of 2011 (Szilagyi et al., 2015). States are also required to plan for the treatment of mental health and dental health of children in foster care (American Academy of Pediatrics [AAP], n.d.).

Organizations such as the AAP and CWLA provide up-to-date guidelines on addressing the healthcare needs of children in the foster care system. These guidelines indicate the need for children in the foster care system to be connected to a medical home and to have health information easily accessible and sharable with members of the treatment team, ideally through an electronic record system (Kim et al., 2011). These guidelines also outline time schedules for routine medical care.

While policies and guidelines help dictate the standard of practice for addressing the healthcare needs of children in the foster care system, gaps still exist within the implementation and the policies themselves. According to a national survey, less than half (42.6%) of child welfare agencies had policies that provide physical, mental, and developmental health care for foster children, while a third of the agencies lacked policies to provide mental or developmental health care entirely (Leslie et al., 2003). The Inspector General of the United States reported that almost a third of children in foster care missed a required health screening and another third of children in foster care received their required exams late (Levinson, 2015). Clearly, medical care for children in the foster care system continues to be inadequate.

Barriers to Care

Many of the barriers that prevent children within the foster care system from obtaining quality medical care are systemic and pervasive. One barrier, which may result from children not receiving care through a medical home or primary care provider, is the lack of complete and comprehensive medical and health records. A survey of caregivers found that incomplete medical and placement histories are one of the primary causes of children receiving inadequate medical care (Greiner, Ross, Brown, Beal, & Sherman, 2015). With incomplete or missing health histories, many children receive discontinuous, uncoordinated medical care, which can lead to duplication of costly diagnostic and treatment services and difficultly adequately treating chronic illnesses and behavioral problems. Likewise, in the absence of a primary healthcare provider who knows a child's medical history and needs, it is unlikely that the child will receive preventative care in a consistent and meaningful manner.

With the mounting research on the physical, emotional, and behavioral consequences stemming from early trauma and abuse, it is vital for medical providers to approach assessment and treatment planning from a trauma-informed lens. A trauma-informed approach would take into consideration the role of toxic stress and what could be done to mitigate and prevent further exposure for the child (Garner et al., 2012). In addition, a trauma-informed approach helps providers to look critically at presenting problems and to make distinctions between true physical, emotional, or behavioral conditions (e.g., ADHD) and physical, emotional, or behavioral manifestations of trauma. Unfortunately, not all medical providers are trained on the assessment and understanding of the impacts of trauma, specifically for children in foster care, leading some to diagnose and treat trauma symptoms as behavioral or mental health issues. This barrier to effective treatment for children in the foster care system could also contribute to the high rates of psychotropic medication observed in the literature.

Addressing the Barriers to Care

The use of a medical home is a standard of care for all children, and foster care professionals make efforts to provide this model of care for children in the foster care system (Syilagiyi et al., 2015). The medical home model provides a base for the delivery of ongoing health care for a child in foster care. At a medical home, healthcare professionals conduct initial and ongoing screening and assessment and treatment, and offer necessary referrals for specialized care. A medical home can either be a specific physical location or be a community network of medical professionals who work collaboratively to coordinate care for children in the foster care system. A medical home model can break down the systematic barriers that prevent children in foster care from obtaining comprehensive, quality health care by ensuring continuity of care, keeping health information current and providing staff that are trained in trauma-informed care.

Continuity of Care

Health care provided through the medical home model is continuous and consistent because of the communication of medical professionals within the network. Research shows that children who have a stable place to obtain medical care, like a medical home, are less likely to have unmet medical needs (DeVoe, Saultz, Krois, & Tillotson, 2009). Although the AAP recommends all children obtain care through medical homes, it is especially important for children in the foster care system (Council on Clinical Information Technology, 2011). Placement instability has long been recognized as a problem for many children in foster care, especially with regards to their healthcare needs. A study of youth entering foster care in San Diego found that on average, a child experienced four different placements in 2 years (Newton, Litrownik, & Landsverk, 2000). Within the medical home model, as long as a child is placed within the catchment area of the medical home, the child's health care remains consistent through the time in foster care. In the case that a child leaves the area in which the medical home is located, the staff at the medical home can facilitate the transition of medical records to a new practice or clinic to ensure that the child receives uninterrupted health care.

Up-to-Date Medical History

Many medical homes rely on the medical passport as a way to manage health records. The medical passport seeks to provide an up-to-date digital file with all of the medical information that travels with the child throughout the time in foster care. Each time a child in foster care seeks medical care, the medical home team updates the file. This digital medical chart is available to any medical professional a child goes to for treatment, promoting more continuous and coordinated health care. There are many commercial programs used by foster care clinics and child welfare agencies to administer the medical passport, such as Epic and eClinicalWorks (AAP, 2016).

Specialized Training

Another benefit of providing children in foster care with care through a medical home is the better access to specialists that a medical home provides. In most medical homes, primary care doctors work closely with specialists (e.g., pediatric cardiologist, occupational therapist, behavioral health specialist) to ensure that children receive targeted and timely care. Specialists are either on site or available through

referral. It is essential for children in foster care to have easy access to specialists because of their higher rates of chronic illness, developmental delays, and behavioral problems, which could be effectively managed with the help of specialists.

Within the medical home model, not only do children have access to specialized providers, but also these specialists often have training and expertise in working with children who have experienced significant trauma. The providers are trauma-informed (Fratto, 2016). They are also aware of contextual factors associated with foster care, such as type and severity of abuse, which could have an impact on a child's health and treatment. The greatest strength to specialized training is that trained medical professionals are aware and sensitive to the frequency and type of trauma that children in foster care may have been exposed to, and they are prepared to respond appropriately with trauma-informed interventions (Garner et al., 2012).

Discussion

Children in foster care present with complex physical, dental, emotional, and behavioral health needs. While recognized by and addressed through federal mandates and guidelines from the AAP and CWLA, meeting the health needs of children in the foster care system remains a challenge. Trauma-informed coordinated care, often through the use of a medical home, can help create a safety net for children to ensure that they receive proper assessments, treatments, and referrals for specialized services in an efficient and timely manner. The model, however, is not without limitations. There are significant costs associated with the development and maintenance of a medical home (e.g., medical passport), making this strategy less than achievable for clinics without substantial financial resources. The medical home also requires large amounts of social capital (e.g., time, commitment, collaboration) on the part of busy professionals (e.g., doctors, nurses, social workers).

While many national programs exist to meet the health needs of children in the foster care system (see AAP list), there remains a paucity of research documenting whether these programs have a measurable effect on helping to solve physical, dental, emotional, and behavioral health problems. Much of the research is descriptive in nature, documenting the health needs of children in the foster care system or examining service utilization of children in the foster care system along with the costs of providing these services. These studies are essential in helping to advocate for the need for specialized care and treatment; however, the field is left wondering if the efforts are truly effective, and whether specific populations within the foster care system (e.g., infants, youth aging out, LGBTQ youth, children of color) are adequately served.

A trauma-informed system recognizes that no two children entering the foster care system will present with identical needs that can be easily addressed with a manualized approach to treatment. Instead, programs must remain flexible and take into account unique aspects of each case as assessment, treatment, and referrals for specialized care make traditional quantitative evaluation challenging.

This population needs continued research to refine models of care and demonstrate positive outcomes, especially given how heterogeneous both the foster care population and the healthcare systems providing that care may be. Variable focused, quantitative approaches to data analysis may not be able to adequately detect divergent ways in which a program addresses the health needs of a child. Person-focused approaches (e.g., latent class analysis) may assist researchers in identifying clusters of children who navigate their medical care in unique ways. Evaluation of these types of programs likely requires mixed methods approaches whereby qualitative analyses can help provide deeper, more nuanced understanding of program impacts from the various perspectives (children, foster care providers, healthcare providers, and child protection workers).

Finally, study of long-term effectiveness is needed. One approach would be to examine healthcare utilization through programs such as Medicaid using longitudinal research design. As data becomes more available and integration of data systems becomes standard, these types of research efforts will inform practice and improve outcomes, including cost outcomes, which would provide a useful tool for advocacy and sustainability.

Conclusion

In an ideal world, no child would ever experience abuse, neglect, or the many other forms of trauma that negatively impact psychosocial development. Unfortunately, too many children each year are victims of maltreatment and trauma. For those who enter the foster care system, the medical home model provides a platform for addressing the current healthcare needs of these children. As the field seeks practice innovations for addressing the healthcare needs of children in the foster care system, rigorous evaluations are necessary to understand whether the significant investments of person and financial resources are leading to improved well-being, safety, and permanency for these children.

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The Physical Health Needs of Children in Foster Care

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There are over 400,000 children living in foster care in the United States (Health and Human Services and Children's Bureau, 2016). Of these children, 70% are placed into the foster care system for cases of substantiated abuse and/or neglect. The remaining 30% are placed for behavioral problems and complex medical issues that extend beyond the biological parents' ability to provide appropriate care (Christian & Schwarz, 2011; Garner et al., 2012). In addition to abuse and neglect, children placed in foster care may have experienced adversities such as homelessness, parental substance abuse, prenatal exposure to drugs, prematurity, and/or family violence, all of which contribute to poor health (Forkey & Szilagyi, 2014).

Many children enter the foster care system with chronic health conditions, developmental delays and psychiatric disorders that reflect the neglect and abuse experienced before their placement (Simms, Dubowitz, & Szilagyi, 2000). Researchers have estimated that between 30% and 80% of children in foster care have chronic health problems, and up to 25% of foster children have three or more chronic health conditions (Leslie et al., 2003; Simms, 1989). In addition to medical issues common to all children, foster children's prior social histories place them at increased risk of having physical health problems associated with the type of abuse to which they were exposed (Simms, Dubowitz, & Szilagyi, 2000). Children with histories of medical neglect may have medical issues common to all children that have gone untreated (e.g. ear infections, asthma, eczema, dental caries), requiring extensive medical intervention to control. Children who have been victims of physical abuse may require short-term treatment (e.g. fracture fixation) or long-term (e.g. for neurologically devastated abusive head trauma victims) therapies directed towards the sequelae of these assaults.

For children in the foster care system, lapses in preventative health care occur both before placement and during their time in the foster system (Dubowitz et al., 1992; Leslie et al., 2003). Barriers to care are plentiful, including lack of formal policies to oversee healthcare delivery, placement instability, missing medical data, and erratic medical records (Simms, Dubowitz, & Szilagyi, 2000).

One study found that more than half of the providers seeing children for an initial visit were receiving inadequate medical histories (Risley-Curtiss & Stites, 2007), while another found most children in care had fragmented and incomplete medical histories made worse by difficulties associated with obtaining information (Greiner, Ross, Brown, Beal & Sherman, 2015). Communication between child welfare systems, foster parents, physicians, and biological parents remains an ongoing challenge and often leads to missed or lost medical information, potentially resulting in worse health outcomes.

Chronic health conditions common amongst youth in foster include respiratory issues, vision problems, dental disease, dermatologic conditions, and obesity. A study out of Baltimore, Maryland found that chronic

Table 1. Barriers to Optimal Health.

Level of Barrier	Barrier
Government/Child Welfare Agency	• Resource shortages • Lack of policies to oversee healthcare delivery • Lack of infrastructure to track outcomes • Lack of communication between child welfare and healthcare providers • Lack of understanding of children's healthcare needs
Foster Family	• Lack of access to critical medical information • May not be equipped to identify healthcare issues • May not be able to access healthcare system • Legal consent issues
Medical Providers	• Missing health data • Time constraints • Lack of training to recognize unique needs of children in placement • Little continuity of care • Insurance barriers

health conditions in their foster population included: ophthalmologic (35%), dermatologic (31%), allergic (22%), dental (17%), and physical growth (12%) problems. Asthma is one of the most significant chronic childhood diseases, effecting an estimated 6 million children nationwide (National Institutes of Health, 2007), and is the most common cause for pediatric hospitalization (Hellyer, Garrido, Petrenko, & Taussig, 2013). In the foster care system, estimates suggest that approximately 10% to 16% of children carry a diagnosis of asthma (Hellyer et al., 2013), with about 22% reporting general respiratory disease (Leslie et al., 2005).

In the early 1990's, being underweight was a significant problem for children in the foster system. However, more recently the prevalence of obesity has grown. In Utah between 2001 and 2004, the most prevalent medical condition of children in the foster care system was being overweight or obese (Steele & Buchi, 2008). The high rate of overweight/obese children in the foster care system continues to persist, following national trends of obesity (Deutsch & Fortin, 2015). Dental and oral disease also affects a disproportionate amount of children in the foster system, and is one of the most common reasons for referral to a specialist in children over age 3 (Steele & Buchi, 2008).

Adolescents represent a distinct segment of the foster care population and have unique healthcare needs. Adolescent health concerns are often related to experiencing multiple placements, high-risk sexual behaviors, and substance use (Kools, Paul, Jones, Monasterio, & Norbeck, 2013). Research suggests that there is a link between worsening health conditions and length of time in foster care, making adolescents who have been in the system highly vulnerable (Rubin, O'Reilly, Luan, & Localio, 2007). Foster care placement is associated with younger age of first intercourse, earlier age of pregnancy and greater number of sexual partners (Carpenter, Clyman, Davidson, & Steiner, 2001; Leslie et al., 2010). Girls who have been in foster care are more likely to have sexually transmitted diseases such as trichomonas, and boys are more likely to have both gonorrhea and chlamydia (Ahrens et al., 2010).

These high rates of chronic health problems affecting children in foster care may persist into adulthood. Higher rates of physical health conditions such as obesity and heart disease have been observed in adults who were part of the foster care system as children (Anda et al., 2006; Dregan & Gulliford, 2012). Failure to adequately address the health needs of children in the foster system contributes to long-term poor health outcomes (Dregan & Gulliford, 2012).

Table 1. Health issues related to lack of medical care.

Lapse in Care	Condition
Lack of routine dental care	• Dental carries • Cavities • Gingivitis
Lack of routine lab screening	• Missed cases of anemia • Undiagnosed lead poisoning • Missed high cholesterol levels
Lack of growth monitoring	• Significant proportion of children malnourished or obese
Lack of preventative care	• Missed vaccinations • Missed cases of sexually transmitted infections • Poor medication management • No vision or hearing screening

Currently, there are myriad practices and procedures in place across the county meant to address the gaps in care for foster children. The American Academy of Pediatrics (AAP) has identified this population of children as "Children with Special Healthcare Needs" (Council on Foster Care, Adoption, and Committee on Adolescence, 2015). The AAP recommended models such as foster care clinics, which provide initial assessments and recommendations, foster care medical homes, which provide continuing primary care to these children, and community preferred providers, who provide primary care through specially trained providers serving a larger geographical area (Greiner & Beal, 2017). The AAP also recommends child welfare agencies ensure proper storing and transfer of medical information, especially for children who undergo multiple placements. Strategies suggested for improvement of communication include the creation of patient medical passports and the uptake of guidelines that outline appropriate care for children in foster care. Over the years, the population of children in foster care continues to have significant physical health conditions when compared with their non-foster peers. Continued efforts to overcome barriers and provide coordinated effective health care is paramount to improving their health outcomes.

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Meeting the Developmental, Behavioral, and Mental Health Needs of Children in Foster Care

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Introduction

Children and adolescents in foster care face significantly increased risk of having developmental, behavioral, and mental health issues. Healthcare providers play a critical role in addressing the interplay of complex childhood trauma and toxic stress on the developmental, behavioral, and mental health of this vulnerable population.

Many children in foster care have complex trauma histories and are at risk for toxic stress. Toxic stress, defined as the "prolonged activation of the physiologic stress response systems in the absence of the buffering protection afforded by stable, responsive relationships," significantly impacts early childhood development (Garner & Shonkoff, 2012, p. e225). Toxic stress can disrupt the developing architecture of the brain and adversely affect the development of adaptive capabilities and coping skills during early childhood (Garner & Shonkoff, 2012; Shonkoff & Garner, 2012). Research has associated exposure to complex trauma with increased risk for mental health disorders including Post Traumatic Stress Disorder (PTSD) (Greeson et al., 2011). Additionally, research has shown a dose-dependent effect of exposure to adverse and traumatic events during childhood on increased risk of mental health, substance use, sexual health, and physical health issues (Anda et al., 2006).

Given the risk of complex trauma and toxic stress among these children, it is critical that medical providers develop a comprehensive, trauma-informed approach for identifying and addressing their developmental, behavioral, and mental health needs. The American Academy of Pediatrics (AAP) recommends that all children and adolescents entering the foster care system undergo a comprehensive evaluation that includes mental health and developmental assessments within 30 days of placement. The AAP also recommends that any child with a chronic medical problem, significant *developmental delays, mental or behavioral health problems* be evaluated within 24 hours of entry into foster care (Counsel on Foster Care et al., 2015; Szilagyi et al., 2015).

Developmental Delays in Children in Foster Care

Prevalence & Screening

Children in foster care are twice as likely to have learning disabilities, developmental delays, and speech problems compared to their peers not in foster care (Turney & Wildeman, 2016). A recent meta-analysis found that 39% of children less than 7 years of age in foster or kinship care have a developmental delay, with cognitive problems occurring in 23% and motor delays occurring in 16% (Vasileva & Petermann, 2016). Research has also shown that there is higher prevalence of foster care involvement for children with Autism Spectrum Disorder when compared with children with other intellectual disabilities or typically developing children (Cidav, Xie, & Mandell, 2017). These findings underscore the importance of comprehensive developmental assessment for children entering the foster care system to ensure both recognition of delays as well as appropriate referrals for developmental services. Multiple validated screening tools exist to screen for developmental delay in children. For example, standardized screening with the Ages and Stages Questionnaire was shown to increase detection of

developmental delay in children in foster care (Jee et al., 2010).

Barriers to Developmental Screening and Services

Despite both evidence that children in foster care are at high risk for developmental delays and the AAP recommendation for timely developmental assessment, there is both under-recognition of developmental delays and under-utilization of developmental services, especially for younger children (Zimmer & Panko, 2006). Barriers to recognition include lack of use of standardized assessment tools, lack of comprehensive assessment on entry into foster care, and lack of prioritization of developmental assessment (Leslie et al., 2005). Once needs are identified, there are obstacles to linkage with services. While federal legislation states that children under 36 months of age with substantiated cases of child abuse or neglect are automatically eligible for Early Intervention evaluation, this is not true for older children (Child Welfare Information Gateway, 2013). Other barriers to services include difficulty accessing services, lack of effective services, foster care placement instability, and issues with obtaining consent (Leslie et al., 2005; Molin & Palmer, 2005).

School System and Foster Care

The educational experience for many children in foster care is characterized by high rates of absenteeism, school changes, suspensions, dropouts, and below-average academic performance (Trout, Hagaman, Casey, Reid, & Epstein, 2008). Placement stability affects absenteeism such that youth with unstable placement were 37% more likely to be absent from school than those who achieved early placement stability (Zorc et al., 2013). Interestingly, children who reunified with caregivers also demonstrated higher rates of absenteeism (Zorc et al., 2013). Federal law now mandates that child welfare and educational agencies collaborate to maintain children in their school of origin if that school is in the child's best interest in order to minimize school disruption (U.S. Department of Education & U.S. Department of Health and Human Services, 2016).

Behavioral and Mental Health Conditions for Children in Foster Care

Prevalence & Screening

Children in foster care are disproportionately burdened by mental and behavioral health concerns (Turney & Wildeman, 2016). The most common concerns are oppositional defiant disorder, conduct disorder, reactive attachment disorder, adjustment disorders, and mood disorders (Steele & Buchi, 2008). Children in placement are three times as likely to have attention deficit disorder or attention hyperactive deficit disorder, five times as likely to have anxiety, six times as likely to have behavioral problems, and seven times as likely to have depression compared to children not in foster care (Turney & Wildeman, 2016). Adolescents in placement are four times more likely to have a history of suicide attempts and are more likely to have substance use disorders (Pilowsky & Wu, 2006). Approximately 61% of youths in the foster care system have had at least one psychiatric diagnosis during their lifetime, a majority of which had onset of the disorder prior to entering foster care (McMillen et al., 2005).

The mental health needs of these children can also be quantified through the lens of healthcare cost and resource utilization. Approximately 1 in 7 children entering foster care receive a psychotropic medication (Steele & Buchi, 2008). Additional studies have shown the disproportionately high cost of mental health service utilization for children in foster care, including increased mental health claims, mental health hospitalizations, and outpatient behavioral health services compared to peers not in care (Becker, Jordan, & Larsen, 2006; Harman, Childs, & Kelleher, 2000).

The AAP recommends comprehensive assessments for all children upon entry into foster care, including mental health evaluation. Multiple validated screening tools exist specifically for mental health and trauma, such as the Pediatric Symptom Checklist-17, UCLA PTSD Reaction Index, and the Child PTSD Symptom Scale (Murphy et al., 2016; Strand, Sarmiento, & Pasquale, 2005). Healthcare providers can also assess for symptoms of trauma on review of systems including sleep problems, changes in eating habits related to prior food insecurity, and issues with toileting (Forkey & Szilagyi, 2014).

Foster Care Placement Instability and Behavioral Health

There is a complex and cyclical association between foster care placement instability and behavioral health problems. Behavioral problems have been shown to predict

placement changes and placement instability has been associated with increased risk of behavioral and mental health problems (Aarons et al., 2010; Rubin, O'Reilly, Luan, & Localio, 2007). Sudden placement moves and multiple placements are associated with increased risk of mental health disorders (Hillen & Gafson, 2015). Additionally, multiple placements and episodic foster care placement are associated with increased risk of being a high mental health service user (Rubin et al., 2004).

Barriers to Behavioral and Mental Health Care

Despite a high need for mental health treatment, access to such services is limited, with young children having the least access (Aarons et al., 2010; Burns et al., 2004; Horwitz et al., 2012; Horwitz, Owens, & Simms, 2000; Leslie, Hurlburt, Landsverk, Barth, & Slymen, 2004; Pecora et al., 2005; Rosenkranz, 2006; Rubin et al., 2004). Among children with child welfare involvement, approximately three-quarters of children with concern for mental health needs had not been linked to mental health services (Burns et al., 2004). A multitude of barriers contribute to this finding, including limited access to trauma-informed mental health providers, difficulty obtaining consent for treatment, lack of identification of behavioral and mental health disorders, and limitations of use of the foster parent as a therapeutic agent (Burns et al., 2004; Leslie et al., 2005; Molin & Palmer, 2005).

Trauma-Informed Care

A critical aspect of addressing the mental and behavioral health needs of children in foster care is ensuring that care is provided in a trauma-informed environment, both in their foster care placement and in their medical home. Healthcare providers should be adept at providing care with a trauma-informed approach. This includes evaluating prior and current diagnoses and symptoms within the context of the child's trauma history. Providers should also counsel caregivers on the role of prior trauma and current behaviors and about positive parenting strategies to help the child heal. When needed, providers should make referrals to appropriate trauma-informed therapy. Evidence-based therapies that have been successfully utilized with foster families include Parent Child Psychotherapy and Trauma-Focused Cognitive Therapy (Forkey & Szilagyi, 2014).

Foster caregivers play an essential role in creating a trauma-informed environment for children in their care, and research suggests that the quality of the relationship between the foster caregiver and the child impacts the child's behavioral health. Children with higher quality interactions with foster mother and higher commitment from foster mother (as exemplified by kinship care) had less externalizing and internalizing symptoms as well as higher levels of adjustment (Dubois-Comtois et al., 2015). Recent studies have shown positive outcomes with parenting programs for foster caregivers, including reduction in child behavior problems and caregiver tolerance of disruptive behavior (Bywater et al., 2011; Sullivan, Murray, & Ake, 2016). The following evidence-based parenting programs and therapies have demonstrated positive outcomes with foster families: Parent-Child Interactive Therapy, Keeping Foster and Kin Parents Supported and Trained, and Incredible Years (Buchanan, Chamberlain, Price, & Sprengelmeyer, 2013; Bywater et al., 2011; Forkey & Szilagyi, 2014; Price et al., 2008). There is evidence that wraparound services and relational interventions have shown effectiveness in reducing children's difficult behavior as well (Kinsey & Schlosser, 2013).

Future Research and Recommendations

Though substantial efforts have been made to investigate the developmental, behavioral, and mental health needs of children in foster care, significant challenges exist in meeting their needs. Future research and policies could establish clear and specific guidelines for screening for developmental and behavioral health problems.

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Medical Education and Foster Care

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There are an estimated 653,000 children involved annually in the U.S. public foster care system (U.S. Department of Health and Human Services, 2015). The American Academy of Pediatrics designated youth in foster care as children with special health care needs due to high rates of medical, mental health, and developmental conditions in this population (Council on Foster Care; Adoption, and Kinship Care; Committee on Adolescence; & Council on Early Childhood, 2015). As many as 30% to 80% of children in foster care have chronic health conditions (Szilagyi et al., 2015). Based on these estimates, it is reasonable to assume that the majority of pediatricians, pediatric subspecialists, pediatric trainees, and even medical students will come into contact with a child in foster care at some point in their practice, and therefore, should develop competencies to manage these patients in their practices. Unfortunately, medical literature suggests that pediatricians may be ill prepared or uncomfortable in caring for these complex patients (Leslie et al., 2003; Webster & Temple-Smith, 2010). Research has reported lack of self-efficacy and competence in addressing the unique health needs of these children, including the inability to successfully navigate through the legal and child welfare systems, as significant barriers to providing quality health care to this population. Therefore, education about the medical care of children in foster care is needed, and should begin early in training, from the starting point of medical students, and pediatric residents, to practicing pediatricians, to ensure that competencies can be developed over time.

Content of medical education curriculum should focus on the specialized knowledge, patient care skills, and communication abilities needed to provide optimal care to children in foster care. Background knowledge about the foster care system will provide a foundation for medical care and advocacy. For example, knowledge about the negative impact of placement instability on health outcomes (Rubin, O'Reilly, Luan, & Localio, 2006) can spur advocacy for behavioral health services essential to maintaining a current placement. Knowledge of clinical manifestations of toxic stress will prevent misdiagnosis of trauma symptoms. Information about the child protection system will allow providers to navigate legal aspects of caring for foster children (consents, mandated reporting, confidentiality). Medical education should also address clinical and communication skills needed to deliver optimal care to foster children. Given the prevalence of special healthcare needs and barriers to care, care coordination skills are essential. Communication skills include providing medical information to non-medical members of the child's multidisciplinary team. Curriculum could also address how to communicate medical information in court. Providers must learn to translate their knowledge of trauma symptoms to anticipatory guidance for foster parents. Some visits may involve both foster and biological parents, and effective communication navigates the concerns and needs of all caregivers.

Although there are a number of ways to deliver a medical educational curriculum, one of the models that has gained momentum recently is the flipped classroom (Bergmann & Sams, 2012). The term

"flipped classroom" refers to reversing the traditional educational model of teachers providing educational content in the classroom followed by learners completing homework to test their knowledge and apply concepts outside the classroom. In the flipped classroom, teachers provide educational content to learners prior to class time, which is then used for solidifying facts and concepts set forth in the pre-class lesson. This model allows learners to complete the pre-class materials at their convenience, and then allows the teacher to act as a guide during class time to help learners develop a deeper understanding of the educational content. The flipped classroom allows the learner to be self-directed in their learning experience. A learner can view the educational content at a time convenient to them, and can even view it multiple times to ensure understanding. Adult learners have a wide range of learning styles, and the flipped classroom will allow the teacher to engage learners of all learning styles by providing engaging, interactive activities during class time. However, the didactic format is also available to those learners who prefer it, in the form of the prerecorded educational materials. There are numerous apps and software programs available to the teacher, the majority of these in the form of interactive whiteboards, screen-casting apps, or video editing software applications, designed to aid the teacher in producing the most engaging educational materials. Most importantly, the flipped classroom model allows the teacher to provide a context for the educational materials, which again is important to adult learners, and specifically to those in medical education. Case- or problem-based learning has become a mainstay of medical education, and the flipped classroom provides a perfect opportunity to utilize this technique.

Another way to educate trainees on foster care topics is to develop partnerships that allow for practical experiences in the community. At The Children's Hospital of Philadelphia (CHOP), pediatric residents rotate through an advocacy rotation in each year of their training. Relationships with community partners afford residents learning opportunities that are both understandable and relatable. In the course of the advocacy rotation, residents meet with a staff attorney from local nonprofit Support Center for Child Advocates, an agency appointed to represent dependent children in Philadelphia (Support Center for Child Advocates, 2017). Residents meet in the attorney's office and receive a primer on child welfare and an introduction to the work of the agency. They spend the morning in Dependency Court observing cases. Following their observation, residents have the opportunity to debrief with the attorney, ask questions, and make sense of the experience. Trainees also have the opportunity to attend a noon conference on the societal response to child maltreatment and the courts, and they may choose to rotate on a child protection elective, which includes time spent in the hospital's foster care clinic. Residents may fulfill their advocacy project requirement by taking on a project related to children in foster care, with support from clinicians with expertise in foster care. Educating pediatric residents about the child welfare system and the special needs of children in substitute care not only enhances their medical training, but allows them to appreciate the complexity and sheer volume of these types of cases. It also serves to enhance communication among physicians and the child advocates, judges, and social workers who work within the child welfare systems on a daily basis.

In summary, health care of foster care children requires special attention in medical education curricula. Flipped classroom models and practical experiences afforded by community partnerships are ways to deliver the specialized knowledge and skill that our future health care providers can draw upon when caring and advocating for foster care children.

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Foster Care: Child Welfare's Responsibility and Challenge

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Foster care offers children who cannot safely remain in their own homes an alternative family placement. With a trajectory of increasing numbers of children requiring foster placement, and challenges in the recruitment and retention of quality foster homes, the current system is unable to adequately address this need.

Background

Foster care has its roots in the establishment of free homes to care for children by Charles Loring Brace, director of New York Children's Aid Society, in 1853. Massachusetts was the first U.S. state to provide board payments to foster parents, and Pennsylvania passed the first licensing law in 1885. Social service agencies began supervision of foster parents in the early 1990's (National Foster Parent Association, 2017).

Foster care is designed to be temporary, with a plan of reunification after biological parents successfully achieve goals established for the safe return of their children, upon endorsement by the applicable legal authority. If parents are unable to resume care, foster care professionals implement alternative permanency planning.

The administration of foster care programs varies from state to state. The Child Welfare League of America authored and adopted *Standards of Excellence for Family Foster Care Services* (1995), and national accreditation bodies establish stringent standards of practice for foster care agencies that seek accreditation. States promulgate criteria for licensure or approval for agencies to provide foster care services to children within their jurisdiction.

Children enter foster care after local jurisdictional authorities conduct a child abuse investigation and determine that the child or children are unable to remain safely in their own homes. After removal, children are placed with trained and certified/licensed foster parents who are tasked with caring for them while the child welfare system aims to assist the biological family in mitigating the problems that led to their removal (Child Welfare Information Gateway, 2013).

Foster care serves children from birth until age 18, with 46 states currently allowing children to remain in placement until their 21st birthday (Child Welfare Information Gateway, 2017a; Fostering Connections to Success and Increasing Adoptions Act, 2008). The Adoption and Safe Families Act was enacted in 1997 to prevent children from languishing in foster care, setting specific limits on time in care, while mandating a permanency goal of reunification, adoption, permanent legal custodianship, or another planned permanent living arrangement (APPLA). The use of

APPLA was limited by the Preventing Sex Trafficking and Strengthening Families Act in 2014 to children over 16, and is a permanency option only when other options have been ruled out.

Current Practice

Foster or resource parents are individuals who are licensed or certified to provide care for children (National Foster Parent Association, 2017). They receive a daily stipend, varied by state and payment category, to cover the costs of caring for foster children, who also receive Medicaid to provide for medical, dental, and behavioral health needs. Foster parent requirements and guidelines vary by state and licensing agency.

Nearly half of children in out-of-home placement are in non-relative foster family homes, or general foster care, while approximately 30% reside in a kinship home (Child Welfare Information Gateway, 2017b). A relative, non-related extended family member, or anyone else with a family-like relationship can provide kinship care (Child Welfare League of America, 2013).

Attachment and evolutionary theory posit that children are likely to be treated better by kin than non-relative caregivers, and that the existing child-caregiver relationship and implied positive attachment makes kinship placements more stable (Dubowitz, Feigelman, & Zuravin, 1993; Herring, Shook, Goodkind, & Kim, 2009; Koh, 2010). Although children in traditional foster care are more likely than those placed with kin to achieve legal permanence and receive services and financial support, children in kinship care have more stable placements and fewer behavioral problems, mental health diagnoses, and lower rates of re-abuse while in care (Winokur, Holtan, & Batchelder, 2015). Kinship care has been formally recognized as the first-line placement option for children removed from the home under Title IV-E of the Social Security Act.

Treatment, or therapeutic, foster care is out-of-home care provided by foster parents with specialized training to meet the needs of children who have more severe behavioral, psychological, or medical needs, offering more intensive services and supports, enhanced caseworker contact, and psychotherapy if needed. Treatment foster parents are provided with rigorous training and paid higher stipends than general foster care parents (Boyd, 2013). This arrangement can be more cost-effective than residential treatment for children who need a more structured and therapeutic setting. Treatment foster care has been used effectively with medically fragile children and complex, trauma-impacted youth (Child Welfare Information Gateway, 2017c).

Family Finding is the practice of engaging in intensive child-specific recruitment efforts, including work to reestablish relationships and explore ways to find a permanent family placement for children in care. (Fostering Connections to Success and Increasing Adoptions Act, 2008). Developed in 2000 by Kevin Campbell, the practice includes six components: urgency, expanded definition of permanency, effective relative search, family-driven process, development of multiple plans, and well-defined/tactical procedures (National Institute for Permanent Family Connectedness, 2017). Family Finding is considered instrumental in helping foster children reconnect with family members, and shows promise in increasing kinship placements, achieving permanency, and establishing life-long connections (Children's Defense Fund, 2010; Garwood & Williams, 2015).

Challenges in Foster Care

As of September 30, 2016, there were 437,645 children residing in foster care in the United States. These numbers have been increasing steadily over the past 5 years (U.S. Department of Health and Human Services, 2017b). Historically, there has been a shortage of foster families to meet the needs of the number of children in the system (Bass, Shields, & Behrman, 2004).

Recruitment of foster parents is an ongoing challenge for a variety of reasons. Foster parents must navigate complex systems of care and develop relationships with birth parents and professionals, often with little support (Geiger, Piel, and Julien-Chinn, 2016). Many do not remain as foster parents long-term (Gibbs & Wildfire, 2007). The longer a child is in foster care, the

less likely they are to experience placement stability, defined as two or fewer placement settings. For example, although in 2015, 85.6% of children had two or fewer placements in their first year in foster care, only 35.7% of children who had been in foster care more than two years experienced placement stability (U.S. Department of Health and Human Services, 2017a).

Placement instability and disruption increases the likelihood of behavioral and educational concerns (Geiger et al., 2016). Disruption may also negatively impact the ability to form healthy attachments, compounding the trauma already experienced as a result of previous abuse or neglect (Ramsay-Irving, 2015; Rubin et al., 2004).

Improving the Foster Care System

A multi-pronged approach for recruiting and retaining foster parents is critical to address systemic needs for a robust pool of foster homes. An effective recruitment system requires a conscious effort to promote positive messaging/branding about the role of foster parenting. Targeted recruitment toward specific professions, ethnic groups, faith-based institutions, and geographies is a promising recruitment approach. Other effective strategies include engaging children in their own permanency planning and utilizing existing foster parents as recruiters (Casey Family Programs, 2014). Examples of evidence-based and promising programs are highlighted in Casey Family Programs' 2014 report, *Effective Practices in Foster Parent Recruitment, Infrastructure, and Retention*.

Successful retention of foster parents requires the implementation of three key strategies found in many promising programs and approaches (Piescher, Schmidt, & LaLiberte, 2008):

Clarifying the Role of Foster Parents

Clearly defining the role and expectations of foster parents and providing an opportunity to reflect on their role promotes higher satisfaction with the demands of foster parenting and increases retention rates (Piescher et al., 2008). There are also positive correlations between clear expectations about fostering and positive parenting practices (Linares, Montalo, Li, & Oza, 2006).

Developing Foster Parent Skills

Providing ongoing training on living skills, conflict resolution, interpersonal interactions, and therapeutic parenting techniques promotes positive parent-child relationships. Foster parents enrolled in parenting programs display higher levels of positive communication and conflict resolution techniques, allowing them to better manage difficult behavior and ultimately increasing their retention probability (Piescher et al., 2008).

Promoting Self-Efficacy

Building social support through connections with other foster parents and support from agency workers promotes a sense of community and belief in individual capacity and increases satisfaction (Rodger, Cummings, & Leschied, 2006; Piescher et al., 2008). Group-based trainings that build behavior management skills and parenting strategies show promise in increasing foster parent retention rates (Macdonald & Turner, 2005; Pacifici, Delaney, White, Cummings, & Nelson, 2005; Turner, Macdonald, & Dennis, 2007; Piescher et al., 2008).

Moving Forward

The foster care system fails to address the current and emerging needs of children who cannot remain safely at home. Data trends point to a systemic crisis. To better provide a safe, sufficient, and appropriate environment for children in its care, the child welfare system must employ three simultaneous strategies: focusing on preventing foster placement, developing new and innovative recruiting strategies to increase the number of trained and qualified foster parents, and dedicating efforts to retain effective foster homes.

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The Confluence of Medical and Legal Advocacy: Selena's Story

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"Alone, we can do so little; together we can do so much."

- Helen Keller

Baby Selena cried as the blades of the medivac helicopter turned. Selena was being transferred from Philadelphia to Pittsburgh for a liver, pancreas, intestine, and possibly stomach transplant; sitting next to her, her attorney hoped for the best.

The medical needs of children in foster care are often delayed or unmet, and the reasons are many. Selena was born with "short gut syndrome." Selena's mother was unable to manage Selena's medical needs, had little family support, and was dealing with her own legal issues. These concerns caused Philadelphia's children and youth agency to investigate, and become involved with the family.

A children and youth agency's intervention can begin with a report from virtually anybody. Once a report is made, the agency is required to investigate (The Pennsylvania Child Protective Services Law, 1990). If the investigation determines court involvement is necessary, the agency files a dependency petition triggering a court hearing. There, it is determined if a legal basis exists to adjudicate a child dependent, and exercise jurisdiction over the family.

In Pennsylvania, a child is adjudicated dependent if the court finds the child meets at least one of ten grounds that define a dependent child. If the child is found dependent, the court then addresses if it is safer for the child to remain home, or be placed in kinship, or general, foster care (The Pennsylvania Juvenile Act, 1976).

Selena was adjudicated dependent because her mother couldn't safely provide for her needs; Selena's father's whereabouts were unknown. Selena was removed from her mother's legal and physical custody. However, as Selena's medical needs were many, she remained hospitalized, and the agency began working towards reunifying Selena with her mother.

To provide reasonable efforts towards reunification, the agency establishes objectives for the child and parents. Selena's mother's objectives included hospital visits, medical trainings, consenting to Selena's treatments, obtaining suitable housing, and resolving her own legal issues. Selena's father's sole objective was to make himself known; he never did. The court conducted permanency review hearings every 3 months, and assessed Selena's parents' compliance with those objectives.

As Selena's parents were non-compliant with their objectives, there was no one to sign for Selena's medical needs. In Pennsylvania, as in most states, the agency can sign for routine treatment, but consent for non-routine or invasive treatment must be obtained by a biological parent, or court order (55 Pa. Code § 3130.91, 1987). Pennsylvania law does not yet provide for the appointment of a medical decision maker for children in foster care. However, temporary legal custodian's rights, such as a county agency for children in foster care, can be broadened to include consenting for non-routine procedures (*In re J.A.*, 2015). Nevertheless, Pennsylvania

courts are reluctant to broaden agency signing rights when biological parents' rights are still intact. Accordingly, every time Selena needed extraordinary medical treatment, the team had to obtain a court order.

After a year of parents' non-compliance, the court determined it was in Selena's best interest to change Selena's permanency goal from reunification to adoption and terminated her parents' rights (The Pennsylvania Adoption Act, 1980). Selena's legal path toward permanency was now clear, but her medical future was cloudy; her liver was failing. Running out of options, the team looked to an FDA-approved clinical trial conducted in Boston. However, there was approval for only 12 children participants; Selena would be the 13th. The team convinced the FDA to allow Selena to participate, but court approval was again needed. At an expedited hearing, the team convinced the court it was in Selena's best interest to participate in the clinical trial. The trial was deemed successful, but the recommendation was still to move forward with the organ transplants.

A hospital in Pittsburgh was the best transplant option for Selena. However, the hospital was reluctant to perform complex and aftercare-intensive procedures unless Selena was in a permanent post-op environment; this meant adoption. While the agency identified a pre-adoptive home, the hospital required the adoption to be finalized. Foster care agencies recommend a foster child be in the pre-adoptive home for at least six months prior to adoption petitions being filed, but Selena did not have that time. The team negotiated a waiver of the waiting period and convinced the hospital to withdraw its finalization requirement. Selena was now on the organ donor list!

The court approved two airlifts to Pittsburgh for the pre-op evaluations and surgeries. Unexpectedly, the pre-op evaluation revealed the clinical trial had worked better than anticipated, and Selena's liver function had returned to normal, so she no longer needed a liver transplant. What happened next was more than the team could have ever hoped for: Rather than first attempting the intestinal transplant, doctors performed an intestinal lengthening procedure, and it worked! Miraculously, Selena needed no organ transplants.

Looking back, Selena's attorney recognized how crucial this multidisciplinary team collaboration was for Selena. The team established the legal path, including adoption, to secure the best medical treatment possible for Selena. Team collaboration for Selena's young life paved the way - changed her story, if you will - from a tragic one to one where Selena gets to live a happy and healthy life with her forever family.

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Youth Transitioning out of Foster Care: A New Opportunity to Access SSI Benefits

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New Opportunity: Early SSI Applications for Youth Leaving Foster Care

The Social Security Administration (SSA) recently issued a new policy that could make a huge difference in the lives of youth with disabilities who are leaving foster care. As of August 1, 2016, youth of any age who are leaving foster care for any reason can apply for Supplemental Security Income (SSI) benefits up to six months prior to leaving care (SSA Program Operations Manual System, 2016). SSI benefits provide vital cash assistance to people with disabilities and limited income, so they can afford housing, medical expenses, and other basic necessities. A young person with a disability and no income is eligible for up to $750 per month as of January 2018, but historically most youth in care have not been able to apply before discharge, leading to delays in obtaining benefits. This policy change creates an exciting opportunity for child welfare agencies to support youth by setting them up for benefits they can access without delay at discharge.

Youth transitioning out of foster care are particularly vulnerable, even more so when they have disabilities, and SSI benefits offer a vital source of support. Of all youth who age out of care, approximately 40% are homeless at some point during adulthood (Dworsky & Courtney, 2010). Fewer than half of former foster youth are employed at age 26, and most of those who have a job are not earning a living wage (Courtney, et al., 2011). Families who have recently reunified with their children also face instability in income, housing and employment, and SSI income can help ensure a more stable transition home and prevent unnecessary

Zair's Story

Zair entered foster care at age 8. He was diagnosed with major depressive disorder, spina bifida, and had significant medical issues. He cycled through numerous foster homes before he was placed with a family with whom he bonded. At age 20, discharge from foster care was imminent, and although he was considered part of the family, his foster parents lacked the resources needed to continue to care for him. He had no other viable family or resources, and without a means to contribute to the household, he was facing homelessness.

Fortunately, Zair was referred to the SSI Outreach Access & Recovery (SOAR) Project, which filed an application for SSI benefits on his behalf. The application was approved before discharge, which meant he could remain in the home. The early application for SSI benefits allowed Zair to avoid homelessness and transition smoothly from foster care to stable housing and a supportive family.

re-entries into foster care. In Pennsylvania, 24.8% of children who reunified with their families re-entered foster care within 12 months, signaling a need for greater support to achieve lasting reunification (Kids Count, 2016). Up to 80% of children and adolescents enter foster care with a significant mental health need, and one third have a chronic medical condition (Szilagyi, Rosen, Rubin, & Zlotnik, 2015). Not surprisingly, research suggests that youth with disabilities experience even worse outcomes after leaving the system than their non-disabled peers (Anctil, McCubbina, O'Brien, Pecorac, & Anderson-Harumia, 2007; Schmidt, Cunningham, Dalton, Powers, Geenen, & Guadalupe Orozco, 2013; Deutsch et al., 2015). Public benefits, such as SSI, offer an essential source of support for youth leaving foster care to join family or live independently, but far too many youth leave care without benefits or a plan to get benefits in place.

Best Practices for SSI Applications for Youth Leaving Foster Care

SSA's policy created an opportunity to support youth with disabilities in a new and meaningful way as they leave care. However, awareness of the SSA policy remains low, and applying for SSI benefits is a complicated process that requires interagency collaboration and support for the applicant. Anyone working with youth in care can take advantage of this new opportunity to make sure youth get the stability they need. As child welfare and disability advocates, we developed a toolkit (Community Legal Services, Homeless Advocacy Project, & Juvenile Law Center, 2016) and the following best practice recommendations to help agencies implement the policy:

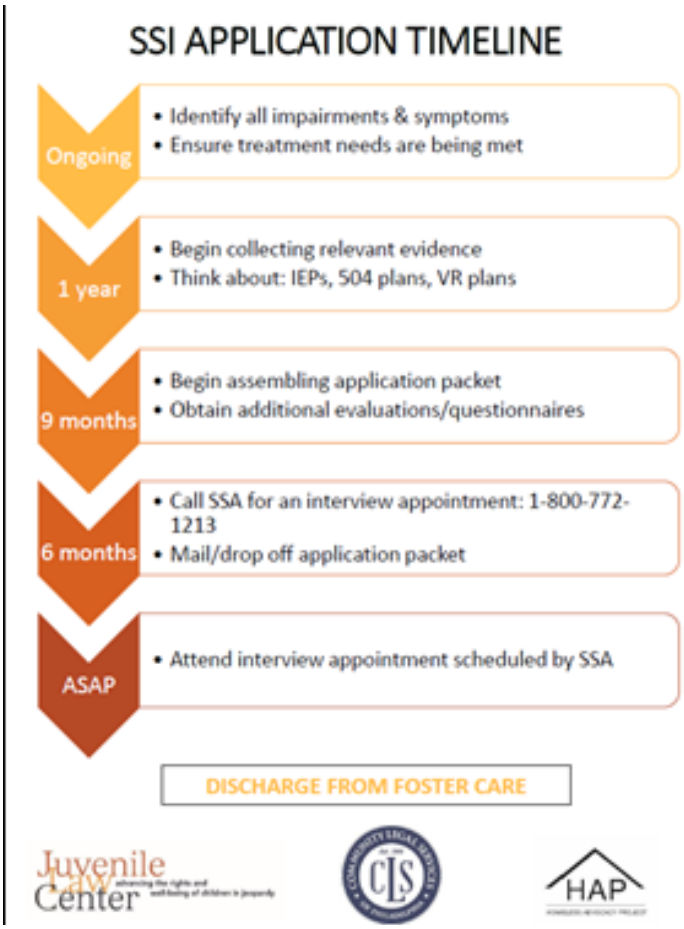
1. **Develop a concrete transition planning protocol for youth in care that includes a specific timeline to prepare and execute the SSI application process.** Essential elements for the timeline include screening youth for disabilities and medical conditions, getting updated evaluations and treatment for all conditions, collecting medical and school records, and securing vital documents. While each jurisdiction may adopt a slightly different approach, a timeline is essential to ensure that important milestones are met prior to leaving care. For example, California law requires that youth in foster care be screened for SSI eligibility at age 16.5 and that the application be timed to allow for a determination of eligibility prior to discharge (California Welfare and Institutions Code, 2016). Timelines are most effective when integrated with other processes, such as court hearings leading up to discharge.

2. **Incorporate specialists in the transition planning process.** Transition planning should incorporate expertise in each substantive area implicated in the transition process. With subjects ranging from transitional housing to SSI, it is unrealistic to think that any one child welfare employee can have the expertise to connect a youth to the many complex programs they will need during their transition. Instead, child welfare agencies should partner with other agencies that have the necessary expertise, such as local legal services organizations, to keep up-to-date with changing laws and best practices. Child welfare agencies may also designate specific staff members to specialize in each substantive area to provide technical advice and expertise. For reunification cases, it is important to incorporate the parent(s) in every step of the transition planning process and ensure they have copies of evaluations and medical, mental health, and treatment records.

3. **Create centralized systems to store and share information.** Completing a SSI application requires interagency cooperation and information sharing. A successful SSI application includes records from all medical providers, up-to-date evaluations, school records, and information from caretakers who know the youth well. It may be useful to develop an electronic method – such as a health passport – of tracking youth with disabilities, monitoring their health needs, and sharing information between the child welfare

and healthcare systems. The information that goes into a SSI application is also useful for applications for other programs, such as Medicaid waivers, and gathering and preserving the information in a central location will save time and resources in the future.

4. **Develop a clear distribution of labor and accountability mechanisms to carry out the transition plan.** Distributions of labor may vary greatly among jurisdictions, but clear roles are essential. A key question in applying for SSI benefits is who will complete the application. The child welfare agency may designate one specialist within the agency to complete all applications. Alternatively, the child welfare agency could decide that the caseworker is in the best position to complete the application. In some jurisdictions, the child welfare agency may be able to partner with a SOAR program for assistance in filing the application. After specific roles are assigned, some form of accountability, such as regular team meetings, must be adopted to ensure work is completed.



SSA's new policy has the potential to make a real difference in the lives of foster youth, and the opportunity must be seized. Due to the cross-disciplinary nature of the application process, all stakeholders can play a valuable role in successful implementation of the policy to set youth up for stability and success.

About the Authors

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Youth Transitioning out of Foster Care: A New Opportunity to Access SSI Benefits

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News of the Organization

Janet Rosenzweig, MS, PhD, MPA, Executive Director

Help Spread the Word – APSAC is Now More Affordable for Front-Line Professionals!

In keeping with our vision of 'strengthening practice through knowledge,' the APSAC Board of Directors approved a special membership rate of $40 annually for front-line professionals. Designed specifically for Child Protective Services and Law Enforcement professionals, this rate provides access to all APSAC benefits, including publications, training and conference discounts, and an invitation to serve on committees and work groups. Please share this news throughout your community and encourage peers and colleagues to take advantage of this opportunity!

And don't forget that APSAC is offering you a 10% discount on your membership for every member you recruit. Recruit 10 members and your 2019 membership is free. To participate, please email info@apsac.org with the name(s) and contact info for the individual(s) you're recruiting.

Let APSAC Help Fulfill Your Training Needs!

A key component of the 'APSAC Renaissance' is our enhanced training department. Under the leadership of Dr. Jim Campbell, we are pleased to now offer educational programs in psychological maltreatment; we are ready to replicate our highly successful symposium on this topic held in New Jersey earlier this year. Continuing education credits can be made available. Other topics include child sexual abuse prevention and intervention, eliminating corporal punishment, teens and sexting, and of course, forensic interviewing. Plan now for Fall 2018 and Spring 2019; contact Dr. Jim Campbell.

The APSAC Amicus Committee at Work

APSAC has recently filed amicus (friend of the court) briefs in three federal court cases. APSAC joined the American Academy of Pediatrics, the California Medical Association, the National Center on Shaken Baby Syndrome and the Helfer Society on a brief in Jones v. Wang, a Ninth Circuit Court of Appeals case that raises the question of a child abuse pediatrician's liability when she ordered a child admitted to the hospital for further testing to determine the cause of several suspicious injuries. The case involves claims for money damages against Dr. Claudia Wang, a child abuse pediatrician at UCLA Medical Center. The court previously dismissed all but one of the claims against Dr. Wang, and the recently filed brief supports the dismissal of the last remaining claim. APSAC is represented by Audra Ibarra in this case.

We recently filed two briefs in cases challenging the federal government's intent to end the Deferred Action for Childhood Arrivals (DACA) program. Ending DACA risks separating citizen-children from their non-citizen parents (who were brought to the United States illegally when they were children). Deporting the non-citizen parents of leaves the citizen-children vulnerable to a number of negative consequences including foster care placement. These briefs, authored by Mary Kelly Persyn, were filed in the Ninth Circuit Court of Appeals in San Francisco and the Second Circuit Court of Appeals in New York.

If a case involving a critical issue in child maltreatment is being heard in your state, consider asking the APSAC committee to file an amicus brief. APSAC members who are skilled and dedicated attorneys comprise this committee, and they have filed briefs in state and federal courts on issues ranging from the admissibility of sexual abuse accommodation syndrome to procedural issues in child testimony. For

more information, contact amicus committee chair Frank Vandervort.

An Extra Advisor is on the Way!

What's the best way to celebrate the increase in APSAC membership? Invest the revenue in more service to our members! While the gold standard has been four issues of the APSAC Advisor per year, we're planning on five for 2019. Stay tuned!

Reserve Your Place Now in our Forensic Interview Clinics

We've added a third clinic for 2018! Along with Seattle and Virginia, you can now take full advantage of our highly regarded clinic experience in New Orleans! Topics include:

- Overview of various interview models and introduction to forensic interview methods and techniques
- How investigative interviews differ from therapeutic interviews
- Child development considerations and linguistic issues
- Cultural considerations in interviewing
- Techniques for interviewing adolescents, reluctant children, and children with disabilities
- Being an effective witness

Clinics are scheduled for June 4-8 in New Orleans, July 9-13 in Seattle, and October 22-26 in Norfolk. You can register for clinics here. Special training for staff at all levels of expertise can be tailored specifically for your community. For information, contact Dr. Jim Campbell.

Fulfill Your Continuing Education Requirements in New Orleans! Join Us June 12-16 for Our 25th Anniversary Colloquium

The Colloquium will provide up to 26.50 contact hours for continuing education. Credits have been approved or are pending for the fields of Social Work, Psychology, Counseling, Nursing, Medicine and Law. The CE processing fee is $40 per person and may be paid with registration or on site.

Earn the maximum number of credits by adding a pre-conference institute!

- Trauma Focused Cognitive Behavioral Therapy for Children and Families (two-day institute)
- Forensic Interview Institutes
  - Forensic Interviews with Individuals with Developmental Disabilities: Mini Practicums
  - Interviewing Child Victims with Disabilities
- Psychological and Emotional Maltreatment of Children
- Parent-Child Care (PC-CARE) Clinician Training: Phase One
- Cultural Institute 2018 -Hot Topics in Culture and Child Maltreatment: Reducing Risk for Children of Color, Immigrants & Refugees
  - Helping Young Men of Color Embrace Non-violence: Visions & Exercises
  - Immigrant & Refugee Families & Child Maltreatment
  - Managing Trauma: Supporting Refugee Children & Teens Today
  - Small Steps, Big Goals: Safety Plans & Resiliency Skills with Immigrant Youth
- Advanced Issues in Child Sexual Abuse
- Student and Young Professional Career Development (special $20 registration rate!)

We're celebrating our 25th with a New Orleans-style second line parade and fundraising party on a Bourbon Street balcony featuring fine wines and NOLA-style cuisine. Plan now to be there! Early bird registration rates expire May 14.

Update on Our Work to Eliminate Corporal Punishment

And an invitation to participate!

In October 2017, APSAC and the Vincent J Fontana Center for Child Protection of the New York Foundling hosted The National Summit to End Corporal Punishment in the United States. Two days of intense work seeded many good ideas, and an organizational structure is now in place for implementation. An Executive Committee has formed

six working committees including Communications/ Social Media, No Hit Zones, Policy, Fundraising, Faith, Resource, and Marketing. We welcome anyone who wants to be on a committee; please email info@apsac.org.

APSAC member and Summit participant Dr. Shawna J. Lee, Associate Professor and Director of the Parenting in Context Research Lab, University of Michigan School of Social Work, represented APSAC by leading one of the digital dialogs hosted by CANTASD: Having the Conversation About Hitting: Incidence, Effects, and Alternatives to Physical Punishment.

Dr. Lee presented the latest research on corporal punishment, trends, incidence, attitudes, and myths—and how positive parenting resources such as the CDC Essentials for Childhood can provide an alternative for parents. You can view the presentation here.

Ready to Start a State Chapter?

State chapters are eligible for financial support from APSAC and help provide a unified voice on behalf of all aspects of child maltreatment in your state. For information, please contact info@apsac.org.

New Resources from APSAC!

Child Maltreatment Academic Program Database

APSAC is proud to announce a new tool for prospective students to search for academic programs from multiple disciplines related to child maltreatment. The database currently contains over 75 programs and allows prospective students to filter and search for programs relevant to their interests. APSAC will continue to update the database regularly, so be sure to keep checking back for new programs! Faculty and administrators can add their programs to the database here.

From the APSAC Center for Child Policy: The Digest of Child Maltreatment Reporting Laws

A new resource from the Child Maltreatment Reporting Laws Committee, the Digest of Child Maltreatment Reporting Laws features a comprehensive collection of the most current reporting laws from every jurisdiction in both the United States and in Australia.

Information from the resource is represented on an interactive map on the Center for Child Policy website. The map displays a summary of laws a link to download the section of laws for each state.

The complete digest can also be downloaded as PDF files. It is organized into two searchable PDF downloads. The Digest of Child Maltreatment Reporting Laws - Australia includes statutes from Western Australia, Victoria, Tasmania, South Australia, Queensland, Northern Territory, New South Wales, and Australian Capital Territory. The Digest of Child Maltreatment Reporting Laws - United States includes statutes from all 50 states and the District of Columbia. Each volume includes a hyperlinked Table of Contents that allows specific states statutes to be easily and quickly accessed.

Washington Update

Marissa Morabito, BA

Lawmakers have turned to working on spending bills for fiscal year (FY) 2019, and they are expected to reach the House and Senate floors by July. In the coming weeks, Cabinet and agency leaders will continue testifying before appropriations panels about their wish lists and priorities.

The Senate recently introduced a bill to combat the opioid epidemic, and a floor vote on the legislation is expected prior to Memorial Day. Considering the impending midterm elections in November, it is not expected Congress will take up major legislation other than spending bills necessary to keep the government running.

Senate Appropriators Aim to Restore Regular Order to Spending Bill

Chairman Richard Shelby (R-AL) and Ranking Member Patrick Leahy (D-VT) of the Appropriations Committee both voiced their desire to start getting individual spending bills for FY 2019 to the Senate floor in June or July. Shelby and Leahy have indicated that they are working together to promptly consider spending bills in an effort to avoid another omnibus spending package. The Trump Administration has made it clear that the recent tradition of packing spending bills into a last-minute omnibus package must be avoided for the upcoming fiscal year.

"It'll have to be something other than an omnibus because we're not signing one," Mick Mulvaney, Director of the White House Office of Management and Budget, said at a House Appropriations Committee hearing. While Congress and the White House seem to be in agreement about restoring regular order to the appropriations process, appropriators are not sure how they would convince President Trump to sign stand-alone spending measures with historically liberal priorities, such as money for the Environmental Protection Agency or the Department of Labor, if such funding is not attached to historically conservative priorities such as defense. Spending packages need 60 votes in the Senate, which gives the minority party, in this case the Democrats, leverage to negotiate on behalf of their priorities.

"I'm not sure what the regular order looks like, budget to appropriations bills, to avoid an omnibus," said Senate Minority Whip Richard Durbin (D-IL). As appropriators aim to move forward with a swift timeline for FY 2019, the administration's threat to rescind some funds for FY 2018 still looms large. However, no formal action has been taken on that front to date.

Trump Administration Proposed $15.4 Billion Spending Cuts

This week, the Trump administration sent lawmakers $15 billion in proposed spending cuts. The cuts would affect 10 federal departments, including children's health insurance and public housing programs. These cuts target money that has been authorized to be spent but has not been spent yet. It doesn't affect the FY 18 omnibus spending package passed by Congress earlier this year, but the administration has said that will also be a target in coming weeks. The White House has said none of the proposed cuts released this week would affect current programs, focused entirely on unspent dollars from previous years.

House Republican leaders hope to pass the measure

this month, but prospects are unknown in the Senate, where Democratic opposition would mean the bill lacks the 60 votes needed for passage. White House Budget director Mick Mulvaney called the cuts "an obvious step toward reducing unnecessary spending and protecting the American taxpayer." The White House's proposed reductions include: $6.96 billion from the Children's Health Insurance Program, $800 million from the Center for Medicare and Medicaid Innovation, and $40.8 million from Public and Indian Housing Programs, among others. Hill Democrats are revealing the White House's planned cuts to the low-income children's health program months before midterm elections. A full list of proposed cuts can be found here.

Senate HELP Committee Approved Bipartisan Legislation, the Opioid Crisis Response Act of 2018

On Tuesday, April 24, the Senate HELP Committee approved bipartisan legislation, the Opioid Crisis Response Act of 2018 (S. 2680). The legislation passed out of Committee without dissent. This bill is designed to improve the ability of the Department of Health and Human Services, including the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration, and the Health Resources and Services Administration, as well as the Departments of Education and Labor, to address the opioid crisis, including the ripple effects of the crisis on children, families, and communities. It will also help states implement updates to their plans of safe care for babies impacted by drug addiction and improve data sharing between states. Section 514 of the bill provides grants to improve trauma support services and mental health care for children and youth in educational settings that span from Head Start and Early Head Start all the way through high school. The bill requires coordination with existing federal laws as well as assurances that federal funds will not replace state and local funds.

The text of S. 2680 can be found here and a brief summary is available here.

April 26: Congressional Briefing: "Innovations and Opportunities to End Child Maltreatment Fatalities"

The Senate Caucus on Foster Youth, the Congressional Caucus on Foster Youth, Senator Diane Feinstein and the National Coalition to End Child Abuse Deaths held a briefing on innovations and opportunities to end child maltreatment fatalities. Organizations represented at this event included Within Our Reach, American Academy of Pediatrics, Virginia Department of Social Services, U.S. Department of Health and Human Services, and National Children's Alliance.

In the first assessment of progress made in implementing the recommendations of the federal Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF), a new report found a rise of recent reforms in child welfare practices across the country. The report, *Steps Forward*, published by the Within Our Reach office at the Alliance for Strong Families and Communities and the Children's Advocacy Institute at the University of San Diego School of Law, found dozens of changes in policy and law directly reflecting the recommendations put forth by the Commission in a comprehensive March 2016 report presented to Congress. Detailed descriptions of activities and a U.S. map of activities occurring at the national, state, and local levels are available online at the highlighted link.

Congress Comes to Final Agreement on Fiscal Year 2018 Spending Levels

On March 23, Congress passed the Consolidated Appropriations Act of 2018 to fund the federal government for the remainder of FY 2018. Congressional passage came just 23 hours before the fifth short-term stop-gap spending measure for FY 2018 was set to expire, and without action, a government shutdown threat loomed.

The Bipartisan Budget Act of 2018, which was signed into law on February 9, paved the way for significant increases to both defense and non-defense spending, enabling many programs to receive a boost for FY

2018. Thanks in large part to the role Senator Patty Murray (D-WA)—a staunch advocate for early childhood programs—had at the negotiating table, and in part due to the opioid crisis sweeping the country, the Consolidated Appropriations Act included major increases in programs for children and families. Opioid-specific funding initiatives will receive $3.3 billion and include prevention, treatment, and law enforcement.

Highlights include:

- A historic increase in Child Abuse Prevention and Treatment Act (CAPTA) state grants from $25 to $85 million. The increase is aimed at assisting states in implementing plans of safe care, and is the first increase in CAPTA state grants since 2005
- A near doubling of Child Care and Development Block Grants (CCDBG) to $5.226 billion, which is a $2.37 billion increase above the FY 2017 level
- An increase in Head Start, including the Early Head Start-Child Care Partnership and preservation of the Preschool Development Grants
- $5 million in new funds for Screening and Treatment for Maternal Depression authorized under the 21st Century Cures Act
- $75 million for the Adoption and Kinship Incentive Fund
- $20 million for Kinship Navigator Programs and $20 million to supplement the Regional Partnership Grants to fund community collaborations among substance abuse treatment, courts, and child welfare agencies to improve the lives of children and families affected by opioids and other substance use disorders
- $100 million to the Administration for Children and Families to help children whose parents suffer from addiction

The *Consolidated Appropriations Act of 2018* can be viewed here.

Fiscal Year 2018 Omnibus Bill: Child Abuse Discretionary Activities Spending Includes $1M Extramural Grant for a National Child Abuse Hotline

The FY 2018 omnibus spending bill includes a $1 million extramural grant within Child Abuse Discretionary Activities "to develop and expand text and chat capabilities and protocols for a National abuse hotline to determine best practices in appropriate communication, identify verification, privacy protection, and resource sharing with youth seeking assistance."

The Administration for Children and Families (ACF) is "directed to prioritize ability to coordinate with other hotlines administered by ACF."

Child Care Development Block Grant Funding Doubled as Part of the 2018 Consolidated Appropriations Act

After numerous short-term extensions, Congress passed a final spending bill for FY 2018. The bipartisan 2018 Consolidated Appropriations Act included the largest-ever single-year increase in federal funding for the CCDBG. The bill doubled the investment in funding and increased CCDBG discretionary funding by $2.37 billion for FY 2018 for a total of $5.2 billion. This increase will help states fully implement the 2014 reauthorization of the CCDBG Act. This funding will help improve the quality of child care programs, including increasing provider rates and ensuring health and safety standards are met, and expanding working families' access to quality, affordable child care. This investment will fully fund the 2014 child care reauthorization, according to estimates from the U.S. Department of Health and Human Services (HHS). The funds will also allow states to expand access to childcare assistance and to families on waiting lists. According to CLASP estimates, after funding the reauthorization costs, the increase will provide resources for more than 151,370 additional children to gain childcare assistance. The actual number of children served will depend on states' current compliance with the reauthorization as

well as state policy choices, including quality initiatives and provider payment rates.

Federal Register Notice Regarding Updated Statewide Needs Assessment

Newly passed Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program reauthorization included a number of policy changes, including requirements for a new state-level needs assessment by October 1, 2020. To that end, on April 24, 2018, the Health Resources and Services Administration (HRSA), Department of Health and Human Services, released a notice of their request to collect updated statewide needs assessments from MIECHV program state and territory awardees. As described by HRSA, "the statewide needs assessment is a critical and foundational resource that assists awardees in identifying and understanding how to meet the needs of eligible families living in at-risk communities in their states."

The updated statewide needs assessment will update the identification of communities with concentrations of risk factors, including premature birth; low birth weight infants; and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health; poverty; crime; domestic violence; high rates of high-school drop-outs; substance abuse; unemployment; or child maltreatment.

HRSA specifically requests comments from awardees on the necessity and utility of the proposed information collection for the proper performance of the agency's functions; ways to enhance the quality, utility, and clarity of the information to be collected; and the use of automated collection techniques or other forms of information technology to minimize the information collection burden. Comments on the SIR should be submitted to paperwork@hrsa.gov and will be received until June 25, 2018. Click here to view the full proposal.

Announcement from Dr. David Willis

Dr. David Willis will be resigning from the Health Resources and Service Administration (HRSA) as the Director of Home Visiting and Early Childhood Services. His last day at HRSA will be May 18th, 2018. Dr. Willis will become the Executive Director for the Perigee Fund, which is a national philanthropic endeavor. It is committed "to promoting the healthy social and environmental development of babies and toddlers, and advancing the field of early childhood mental health." An interim Director of Home Visiting and Early Childhood Services will take his place until a permanent replacement is hired.

Senate Votes to Permit Children Under the Age of One on the Senate Floor

On April 25th, the Senate unanimously voted to a change in rules, which would allow the children of senators up to the age of one to be permitted on the Senate floor. The vote is timely, as this month, Senator Duckworth (D-IL) became the first sitting Senator to give birth to a child in office. Senator Duckworth, with the help of Ranking Member Senator Amy Klobuchar (D-MN) of the Senate Rules Committee, lobbied her fellow Senators to approve the rule change.

Click here for more information.

About the Author

Marissa Morabito, B.A., *currently serves as the Senior Director of Public Policy at Prevent Child Abuse America. In this capacity, Marissa specializes in public policy and advocacy leadership for the organization, including mobilizing support for the organization's federal policy priorities, outreach to congress, and increasing the advocacy capacity of Prevent Child Abuse America's 50 state chapters and nearly 600 sites of its signature home visiting program, Heathy Families America. Before joining PCAA, Marissa was appointed Research Director at a national legislative political organization and worked closely with legislators and stakeholders. Marissa developed model legislation derived from the best practices and most successful legislation in states across the nation. Prior to her time in D.C., Marissa served as a Senior Advisor at the Arizona House of Representatives, where she helped formulate policy by researching, analyzing, and drafting legislation. Marissa helped draft two bills that were subsequently passed into law, on behalf of the U.S. Department of Defense.*

Conference Calendar

June

June 6-9, 2018
AFCC 55th Annual Conference
Compassionate Family Court Systems:
Trauma-Informed Jurisprudence
Washington, DC
608-664-3750
afcc@afccnet.org

June 13-16, 2018
American Professional Society
on the Abuse of Children
25th Anniversary Colloquium
877-402-7722
apsac@apsac.org
www.apsac.org

June 20-23, 2018
NASW National Conference – Shaping
Tomorrow Together
Washington, DC
https://www.socialworkers.org/Events/Conferences/2018-NASW-National-Conference.aspx

June 20-22, 2018
Juvenile Sex Trafficking (JuST) Faith Summit
St. Paul, MN
866-437-5433
https://sharedhope.org/2017/10/coming-2018-just-faith-summit/

July

July 9-13, 2018
APSAC Forensic Training Clinic
Seattle, WA
614-827-1321
apsac@apsac.org
www.apsac.org

July 22-25, 2018
National Council of Juvenile and Family Court Judges 81st Annual Conference
Denver, CO
775-507-4777
http://www.ncjfcj.org/81st-annual-conference/

August

August 13-16, 2018
Crimes Against Children Conference
Dallas, TX
214-818-2644
www.cacconference.org

Auguat 23-25, 2018
National Association of Counsel for Children
San Antonio, TX
888-828-NACC
www.naccchildlaw.org

September

September 5-9, 2018
22nd International Summit and Training
on Violence, Abuse and Trauma
San Diego, CA
858-527-1860, x 4031
http://www.ivatcenters.org

September 25-27, 2018
Partners in Prevention Conference
Arlington, TX
https://www.dfps.state.tx.us/Prevention_and_Early_Intervention/PIP_Conference/

October

October 22-26, 2018
APSAC Forensic Training Clinic
Norfolk, VA
614-827-1321
apsac@apsac.org
www.apsac.org

November

November 10-14, 2018
APHA's 2018 Annual Meeting & Expo
San Diego, CA
202-777-2742
www.apha.org/events-and-meetings/annual

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