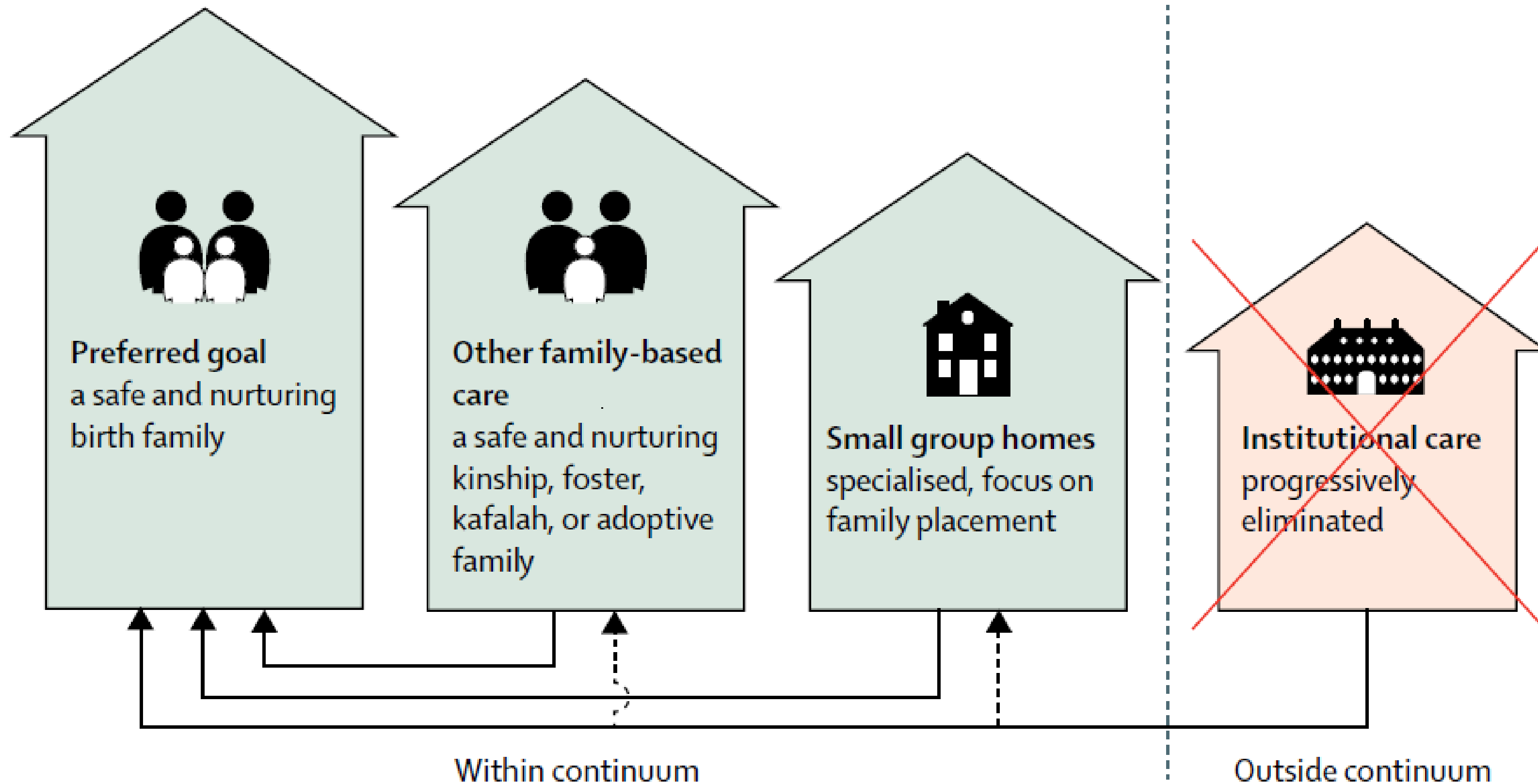# THE HAZARDS, HURDLES AND HOPES OF CHILDREN IN OUT-OF-HOME CARE—HOW CAN WE DO BETTER

CHAN YING TING PURDY

SPECIALIST IN DEVELOPMENTAL-BEHAVIOURAL PAEDIATRICS

SENIOR MEDICAL OFFICER, CHILD ASSESSMENT SERVICE, DEPARTMENT OF HEALTH

Preferred goal
a safe and nurturing birth family

Other family-based care
a safe and nurturing kinship, foster, kafalah, or adoptive family

Small group homes
specialised, focus on family placement

Institutional care
progressively eliminated

Within continuum

Outside continuum

LANCET

LUMOS

KING'S College LONDON

Maestral.

Institutionalisation and deinstitutionalisation of children 2: policy and practice recommendations for global, national, and local actors

What happens in childhood

Doesn't always stay in childhood

ASSUME THAT ALL CHILDREN WHO HAVE BEEN ADOPTED OR FOSTERED HAVE EXPERIENCED TRAUMA.
(AMERICAN ACADEMY OF PAEDIATRICS)

SCREEN PAEDIATRIC PATIENTS FOR ACES, RESILIENCE, MATERNAL PSYCHOPATHOLOGY, PARENTAL ACES AND FAMILY VIOLENCE.

THE HAZARDS

Three Types of Stress Response

Positive

Tolerable

Toxic

Center on the Developing Child
HARVARD UNIVERSITY

Significant Adversity Impairs Development in the First Three Years

Children with Developmental Delays

100%
80%
60%
40%
20%

Number of Risk Factors: 1-2, 3, 4, 5, 6, 7
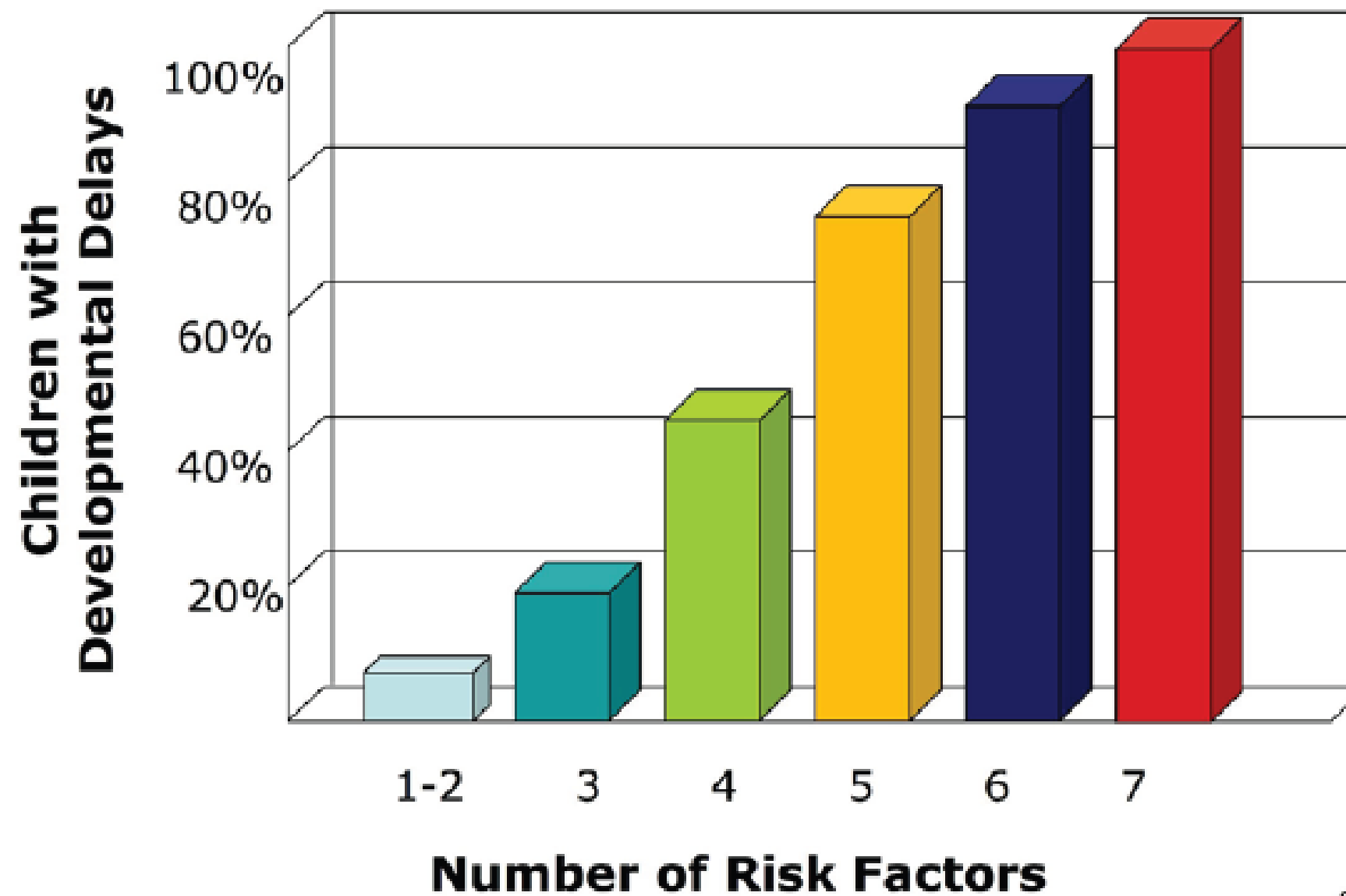
Source: Barth et al. (2008)

ORIGINAL PAPER

Robert F. Anda · Vincent J. Felitti · J. Douglas Bremner · John D. Walker ·
Charles Whitfield · Bruce D. Perry · Shanta R. Dube · Wayne H. Giles

The enduring effects of abuse and related adverse experiences in childhood

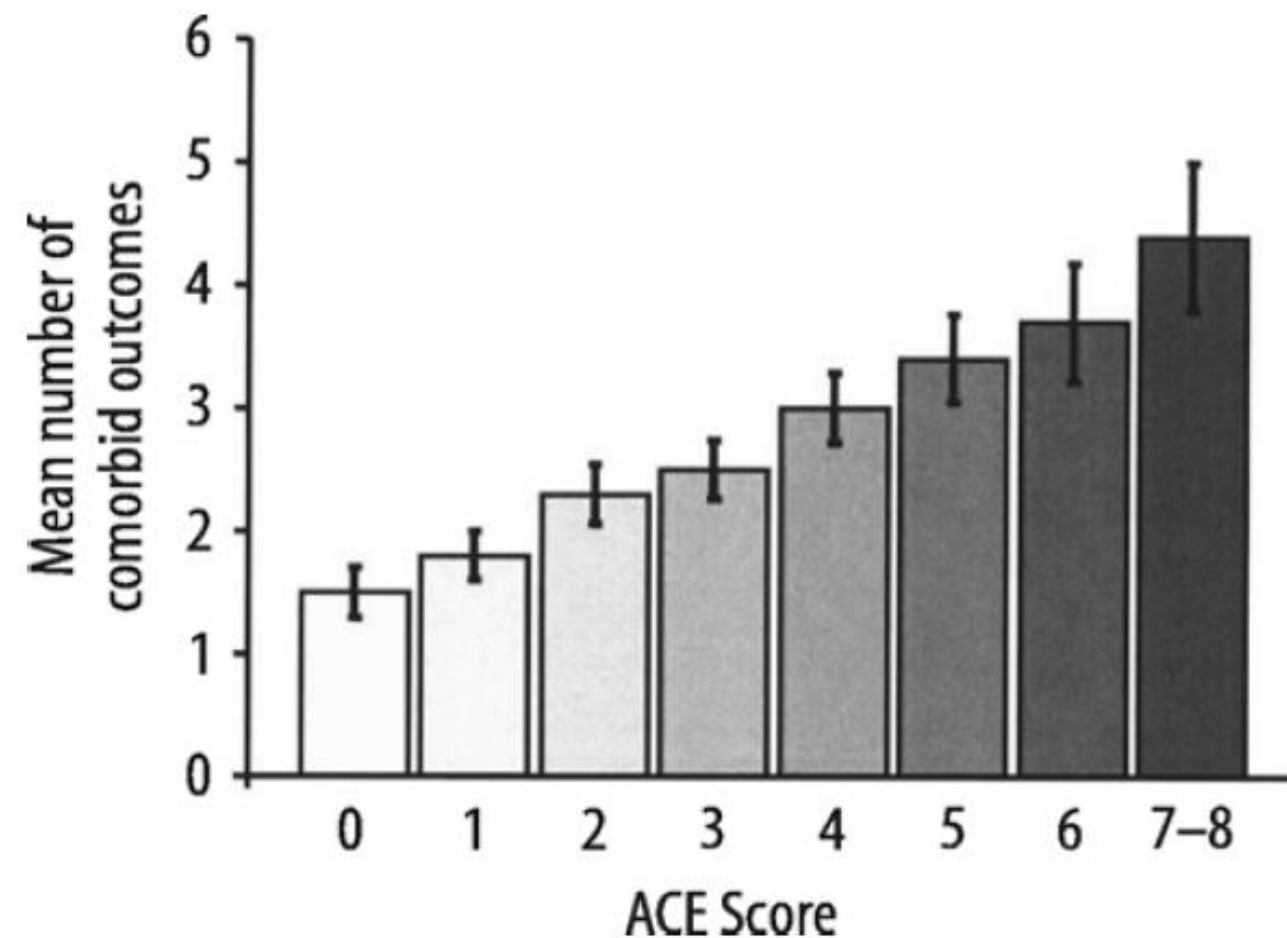## A convergence of evidence from neurobiology and epidemiology

Fig. 1 The mean number of comorbid outcomes in the study sample was 2.1 (range: 0–14); means are adjusted for age, sex, race, and educational attainment. The trend in the means is significant (P < 0.0001); vertical error bars represent 95% confidence intervals

- Emotional abuse
- Physical abuse
- Sexual abuse
- Substance abuse
- Mental illness
- Domestic violence
- Family member in prison
- Divorced or separated parents

BEHAVIOR

LACK OF PHYSICAL ACTIVITY

SMOKING

ALCOHOLISM

DRUG USE

MISSED WORK

PHYSICAL & MENTAL HEALTH

SEVERE OBESITY

DIABETES

DEPRESSION

SUICIDE ATTEMPTS
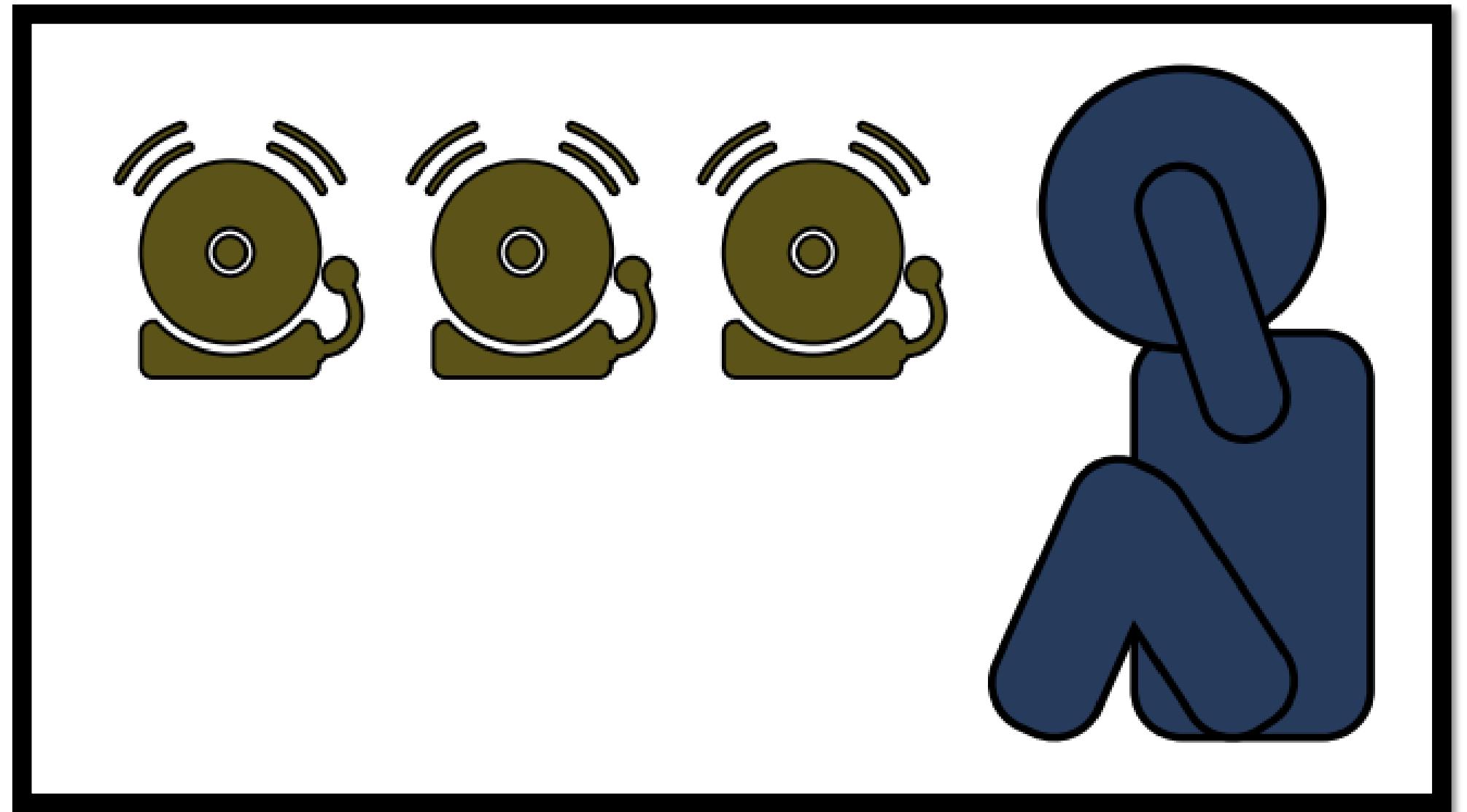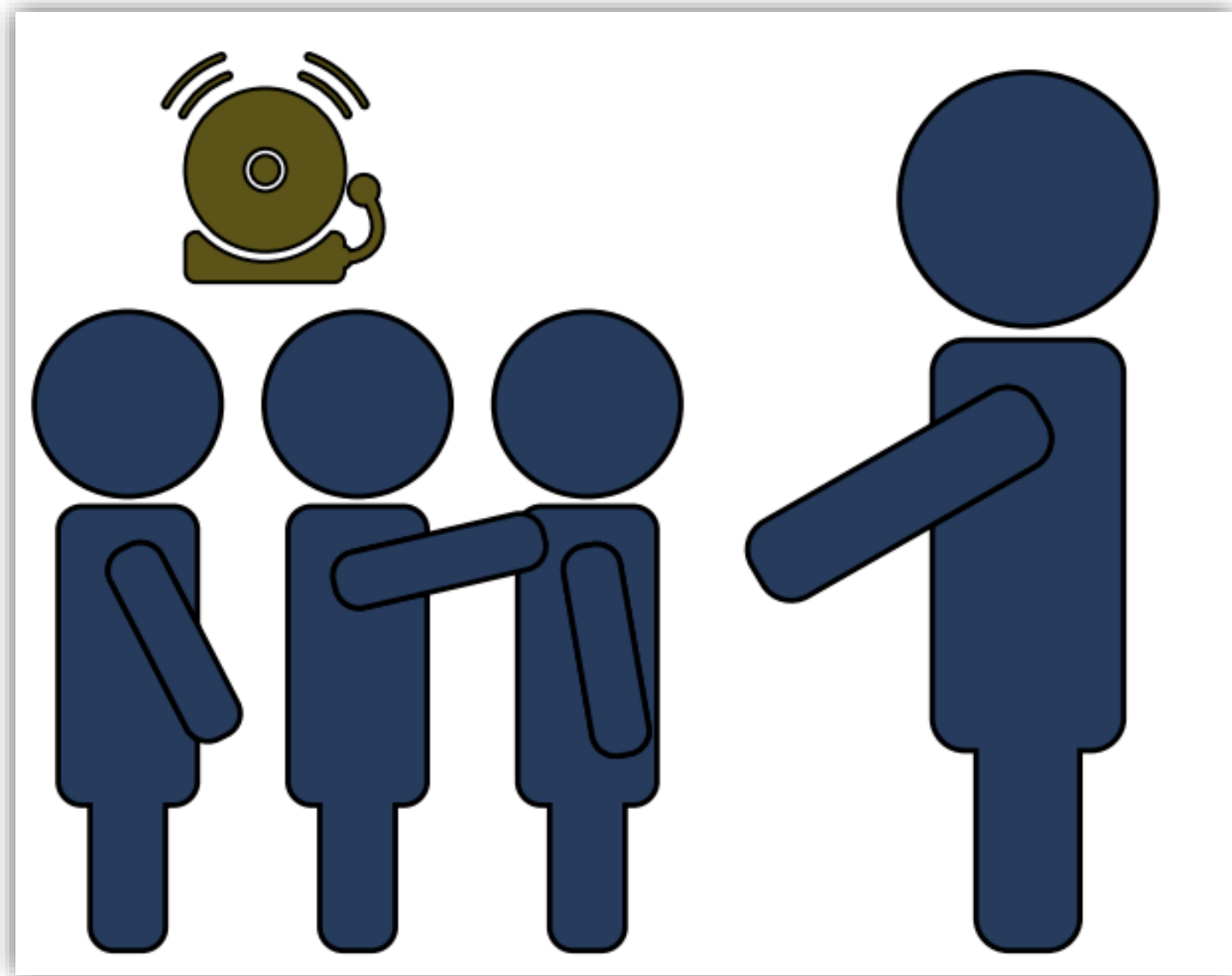
STDS

HEART DISEASE

CANCER

STROKE

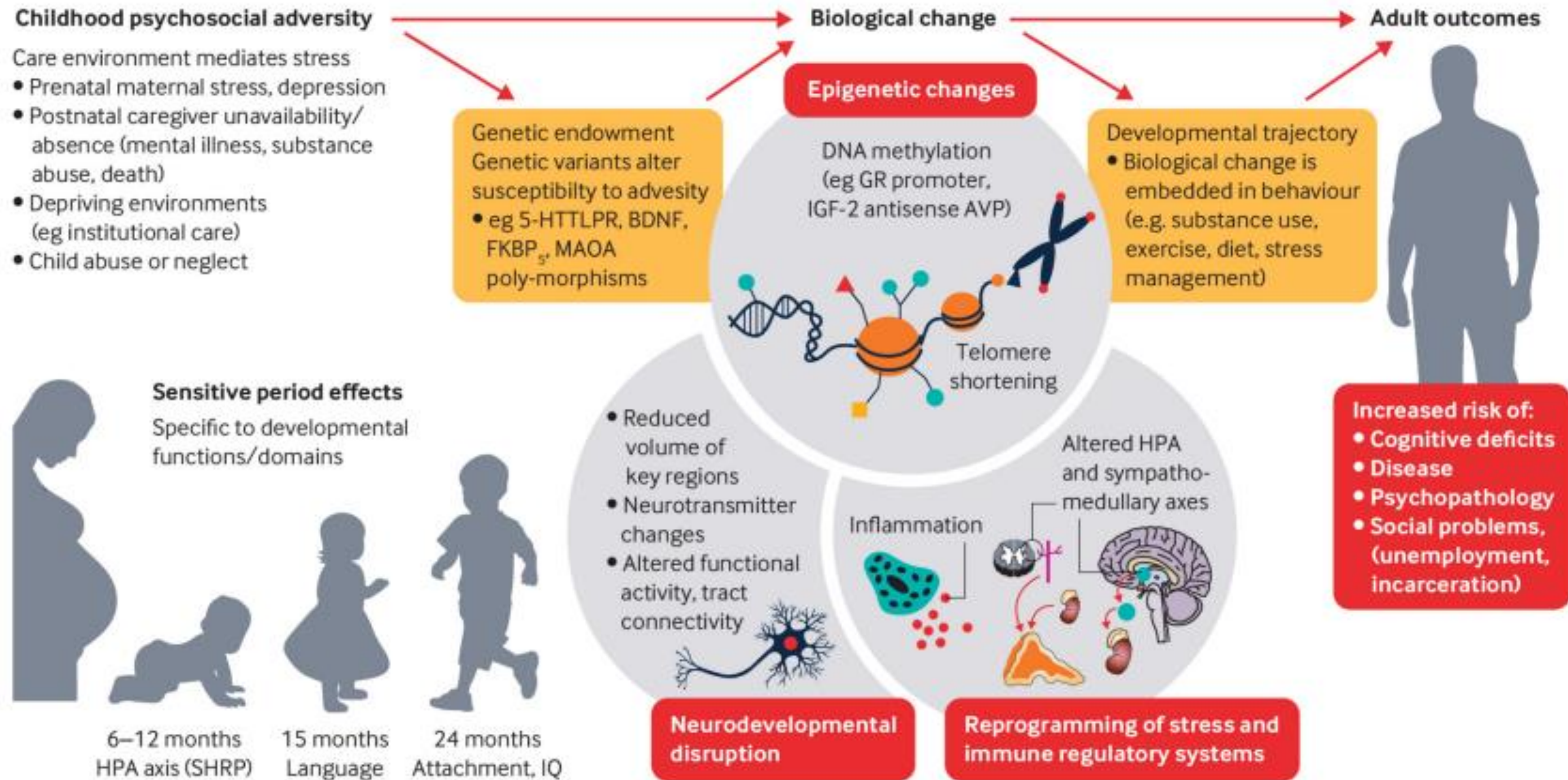**COPD**

BROKEN BONES

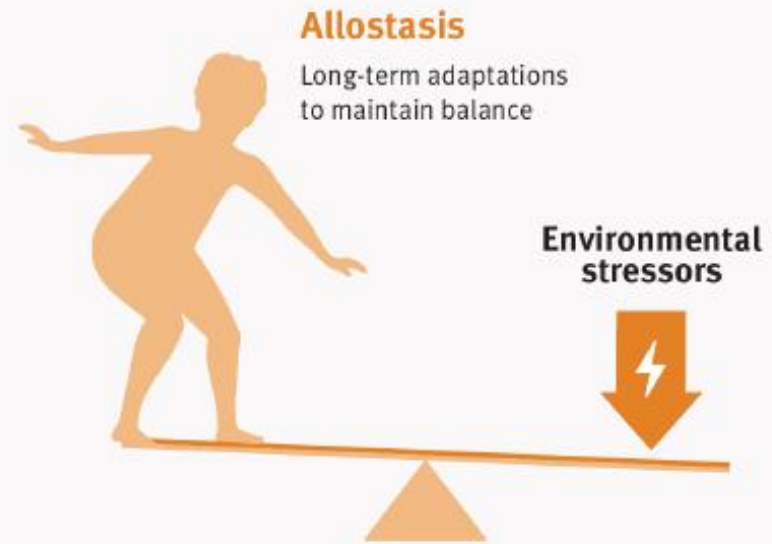# SHORT-TERM VS. LONG-TERM INFLAMMATION

Fig 2 | Some of the pathways that mediate exposure to early adversity and adult outcomes. Exposure to adversity early in life interacts with a child's genetic endowment (eg variations in genetic polymorphisms), which in turn leads to a host of biological changes across multiple levels. These changes, in turn, influence adult outcomes (adapted from Berens et al[23]). HPA axis (SHRP)=hypothalamic pituitary adrenal axis (stress hyporesponsive period)

Homeostasis and Allostasis

Homeostasis
Seeking balance

Allostasis
Long-term adaptations
to maintain balance

Environmental stressors

Allostatic Load/Overload
Long-term adaptations
become problems

Environmental stressors
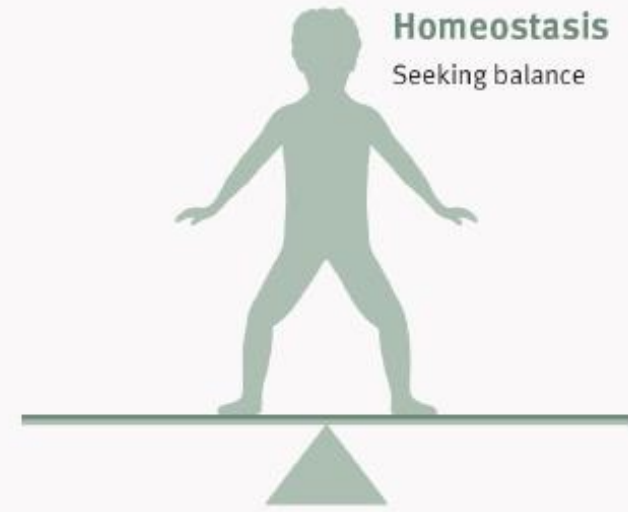
The brain's **ability to change** in response to experiences

The **amount of effort** such change requires

AGE

2 4 6 8 10   20   30   40   50   60   70

SOURCE: LEVITT (2009)[196]
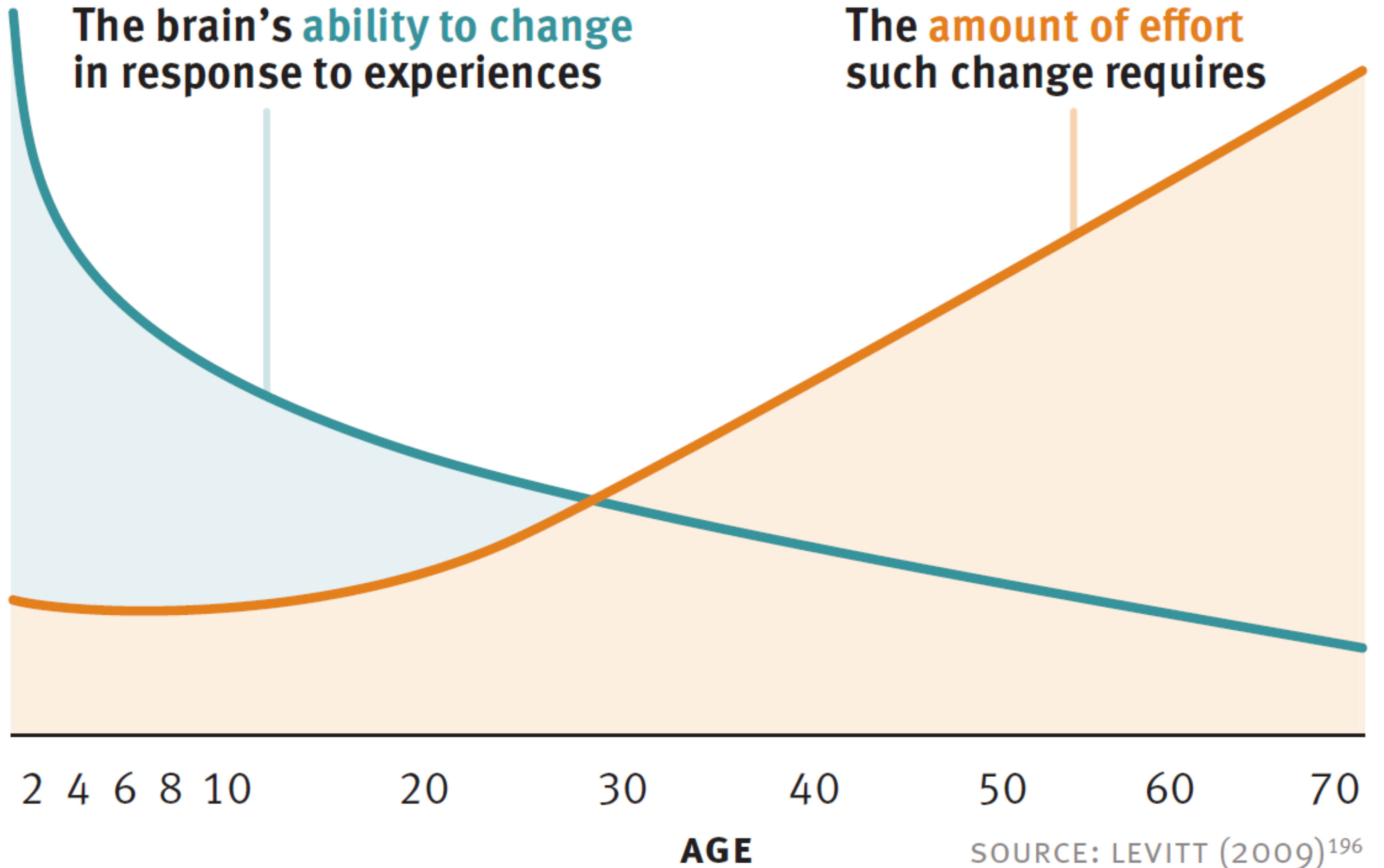
As shown by this conceptual graph, drawn from multiple studies on humans and animals, the brain's plasticity is strongest in the first few years after birth. Thus, it is easier and less costly to form strong brain circuits during the early years than it is to intervene or "fix" them later.

THE HURDLES

Clinical Characteristics and Developmental Profile of Child Abuse Victims Assessed at Child Assessment Service in Hong Kong: A Five-year Retrospective Study

HPW Lo, VWY Lau, ESM Yu

Study Results

M: F= 36: 19 (total 55; 45 established vs 10 at-risk)

Mean age: 57months, ranged 3m to 10y

32(58%) with single developmental problem

20(36%) with more than 1 developmental conditions

Only 3(5%) out of 55 were found normal

Developmental problems

54% Developmental delay

38% ADHD problem/disorder

16% At risk or confirmed dyslexia

9% Language and speech disorder

5.5% Autism spectrum disorder

3.6% Anxiety problem or disorder

3.6% Oppositional problem or disorder

Physical impairment 1.8%

Visual impairment 1.8%

How does trauma look like?

F — • Frets(e.g. worry, anxiety) and Fear(specific or generalized)

R —
• Regulation difficulty
• Lack of self regulation; emotional and behavioral dysregulation

A —
• Attachment challenges
• Lack of a secure attachment relationship; insecure attachment behaviors
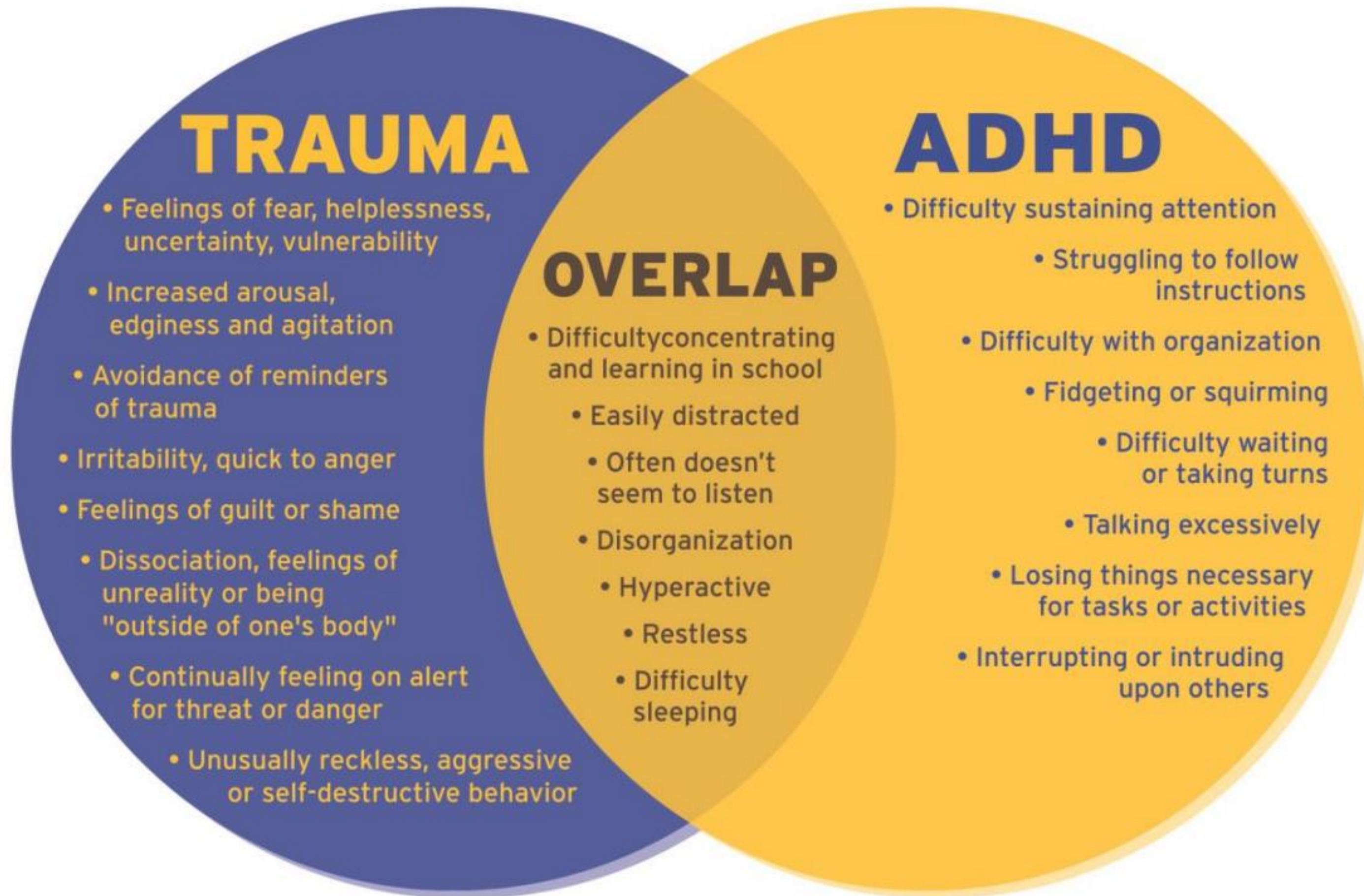
Y — • Yelling(e.g. tantrums, irritable behavior, oppositional behavior) and Yawning(sleep problems); Yucky feeling(e.g. headache, stomachache, somaticizing)

**E** — • Educational and developmental delays, impaired learning and thinking

D — • Defeated(hopeless), dissociating(disconnection between emotions and behaviors; disconnected from reality), or depressed feeling

TRAUMA

- Feelings of fear, helplessness, uncertainty, vulnerability
- Increased arousal, edginess and agitation
- Avoidance of reminders of trauma
- Irritability, quick to anger
- Feelings of guilt or shame
- Dissociation, feelings of unreality or being "outside of one's body"
- Continually feeling on alert for threat or danger
- Unusually reckless, aggressive or self-destructive behavior

OVERLAP

- Difficultyconcentrating and learning in school
- Easily distracted
- Often doesn't seem to listen
- Disorganization
- Hyperactive
- Restless
- Difficulty sleeping

ADHD

- Difficulty sustaining attention
- Struggling to follow instructions
- Difficulty with organization
- Fidgeting or squirming
- Difficulty waiting or taking turns
- Talking excessively
- Losing things necessary for tasks or activities
- Interrupting or intruding upon others

Siegfried, C. B., Blackshear, K., National Child Traumatic Stress Network, with assistance from the National Resource Center on ADHD: A Program of Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD). (2016). *Is it ADHD or child traumatic stress? A guide for Clinicians.* Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress.

The Spectrum of Trauma Symptoms

DTD symptoms

PTSD symptoms

Functional symptoms
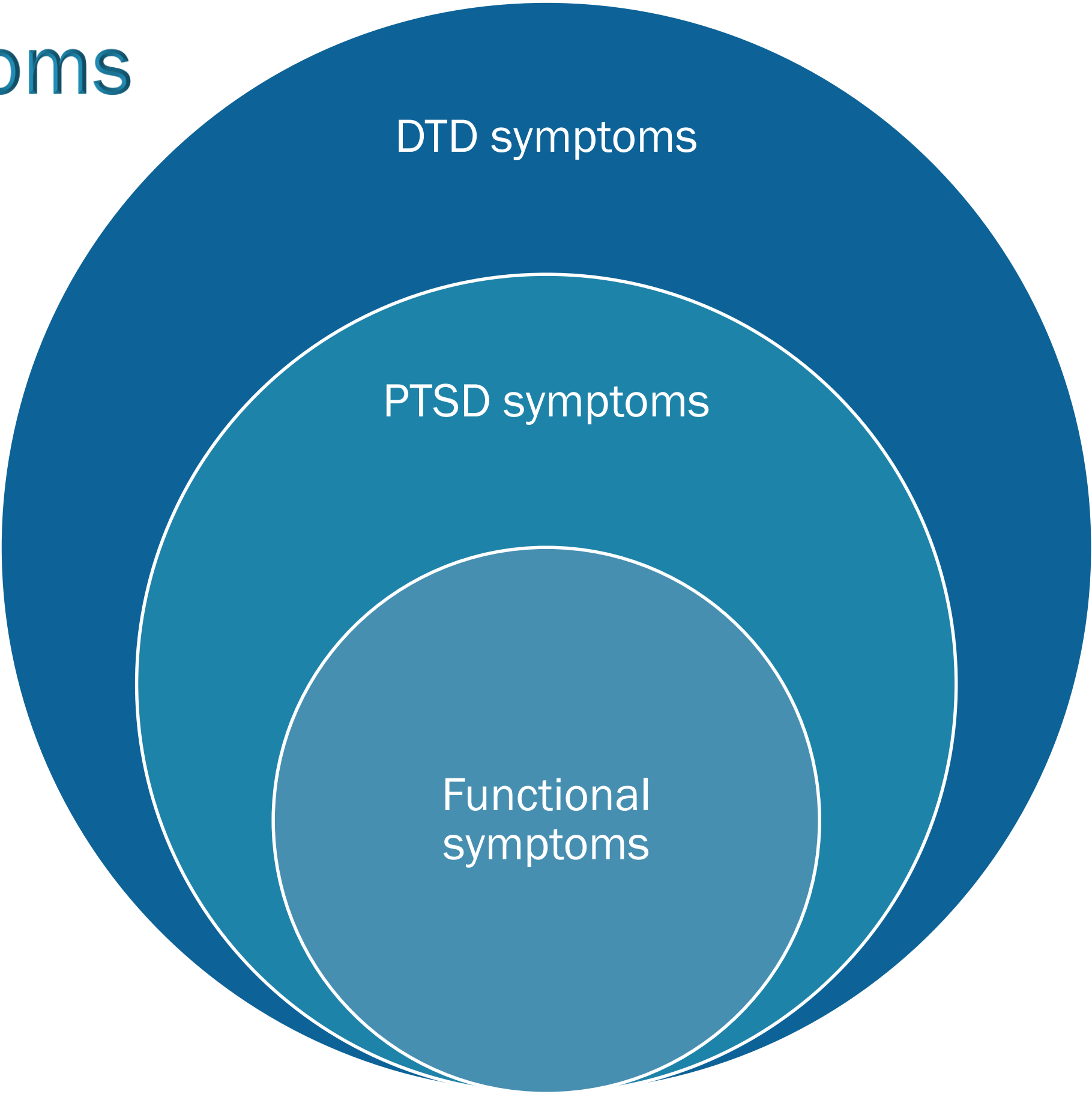
DTD: Developmental Trauma Disorder
PTSD: Post-Traumatic Stress Disorder
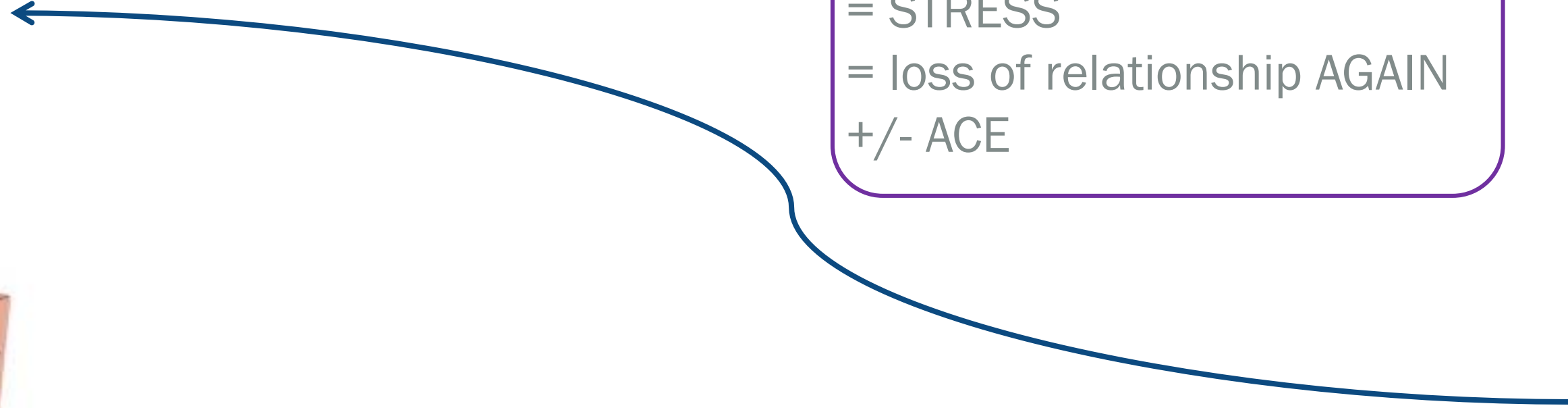
Biological parents

Change of foster homes
= STRESS
= loss of relationship AGAIN
+/- ACE

Adoptive parents

Foster parent 1

Foster parent 2

Foster parent 3

Foster parent 4

FOSTER CARE

- Better than institutional care
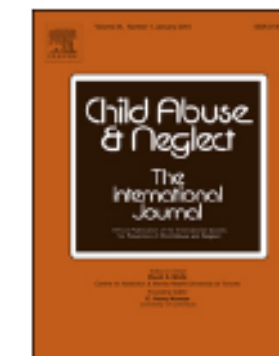- Is it a solution to child care only?
- Is it an intervention?

Research article

Over three decades of longitudinal research on the development of foster children: A meta-analysis

Anouk Goemans*, Mitch van Geel, Paul Vedder

Institute of Education and Child Studies, Leiden University, Wassenaarseweg 52, 2333 AK Leiden, The Netherlands
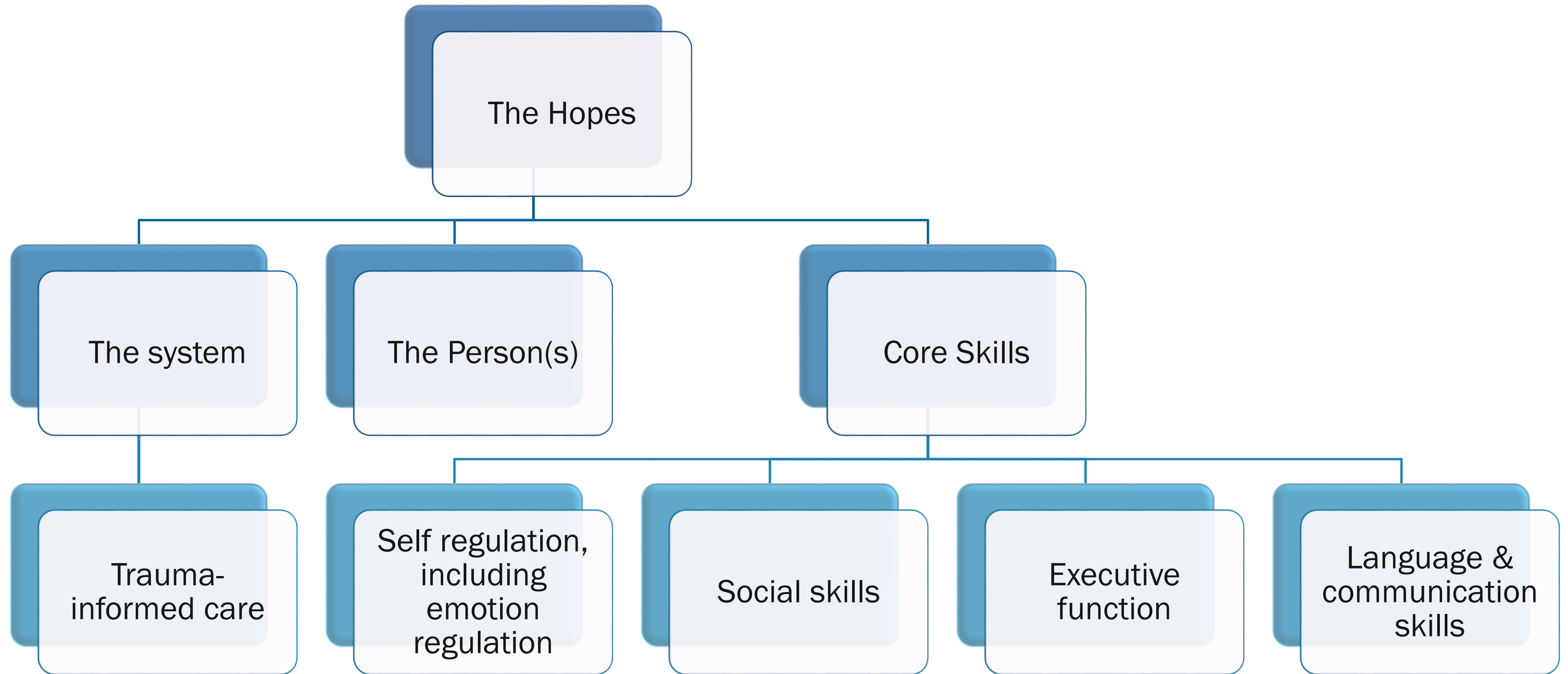
ARTICLE INFO

ABSTRACT

Large numbers of children over the world experience foster care each year. How best to satisfy their developmental needs and how to avoid placement breakdowns and negative consequences of foster care are important challenges. In this study, a series of four meta-analyses is performed to examine the longitudinal developmental outcomes of children in foster care. The focus is on adaptive functioning and behavioral outcomes. A literature search identified 11 studies suitable for inclusion in the meta-analysis on adaptive functioning ($N = 1,550$), 24 studies for the meta-analysis on internalizing problems ($N = 1,984$), 21 studies for the meta-analysis on externalizing problems ($N = 1,729$) and 25 studies for the meta-analysis on total behavior problems ($N = 2,523$). No overall improvement or deterioration was found for adaptive functioning. However, studies with a timespan longer than one year and studies with larger sample sizes showed development toward more negative adaptive functioning than studies with shorter timespans or smaller samples. No overall increases or decreases in internalizing, externalizing or total behavior problems were found. Based on these results, it is concluded that foster care does not negatively or positively affect foster children's developmental trajectories. Given that many children enter foster care with problems, this is a worrying situation. Further longitudinal research to find the factors necessary for improving foster children's developmental chances is recommended. Furthermore, routine screening and targeted foster-care interventions are adviseable to ensure that all children, who cannot be raised by their own parents, receive the support conducive to their positive development.

THE HOPES

The Hopes

The system — Trauma-informed care

The Person(s) — Self regulation, including emotion regulation

Core Skills
- Social skills
- Executive function
- Language & communication skills

THE SYSTEM

The Needs of Foster Children and How to Satisfy Them: A Systematic Review of the Literature

Anne Steenbakkers[1] · Steffie Van Der Steen[1] · Hans Grietens[1]

Table 1 Overview of the four needs categories

Category	N	Description
Medical needs	21	Needs regarding physical health, physical development and treatment and identification of medical conditions
Belongingness needs	17	Needs regarding relationships with others, such as (foster) parents and peers, and related constructs, such as attachment and permanency
Psychological needs	43	Needs about (individual) psychological phenomena such as self-esteem, mental health, autonomy and coping
Self-actualization needs	14	Needs about learning, education, leisure and employment

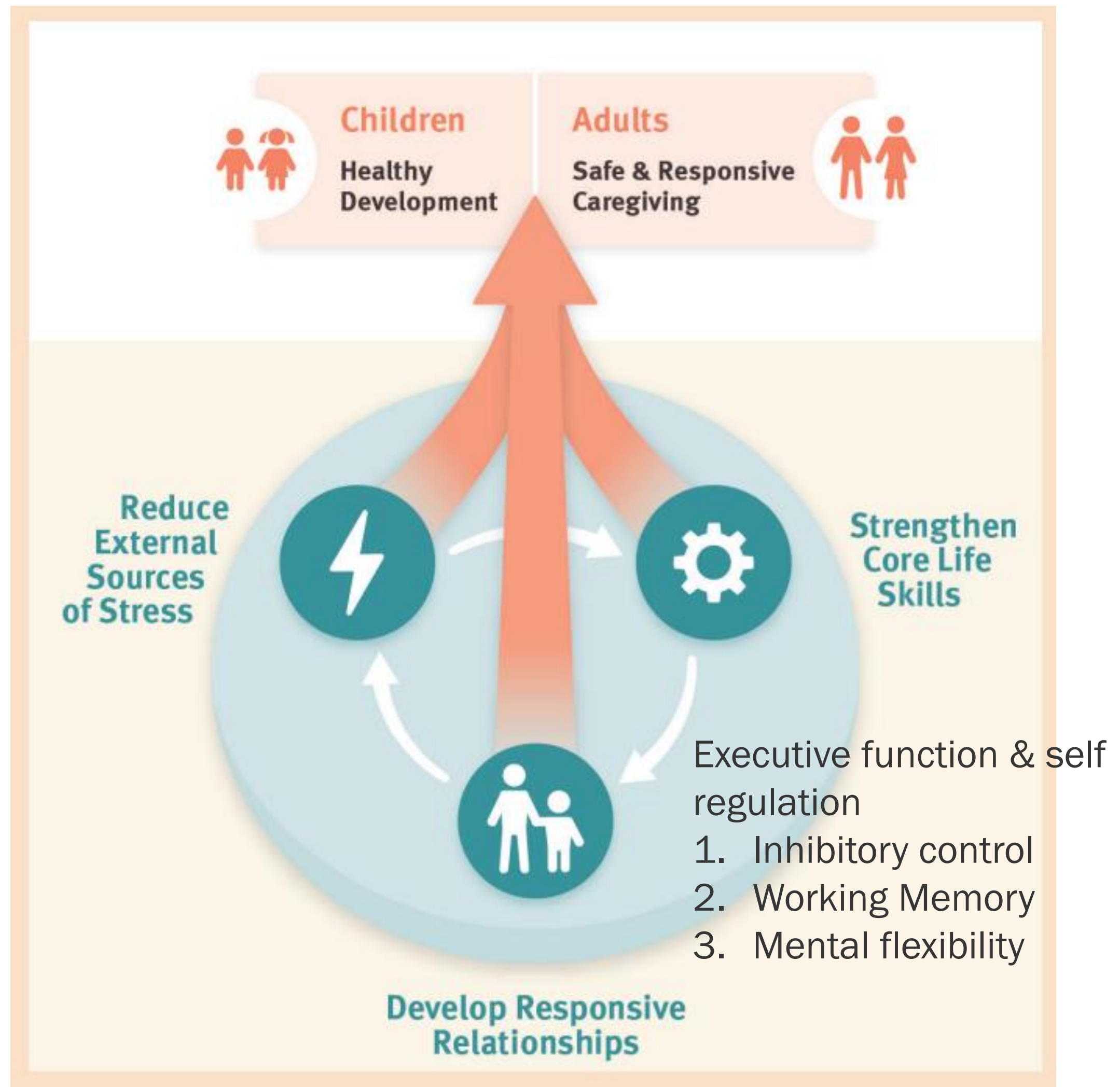Multiple categories per article are possible. $N_{total} = 64$

WHAT DEVELOPMENTAL SCIENCE IS INFORMING CHILD WELFARE?

- Three ways to improve outcomes for children in welfare system:

Center on the Developing Child
HARVARD UNIVERSITY
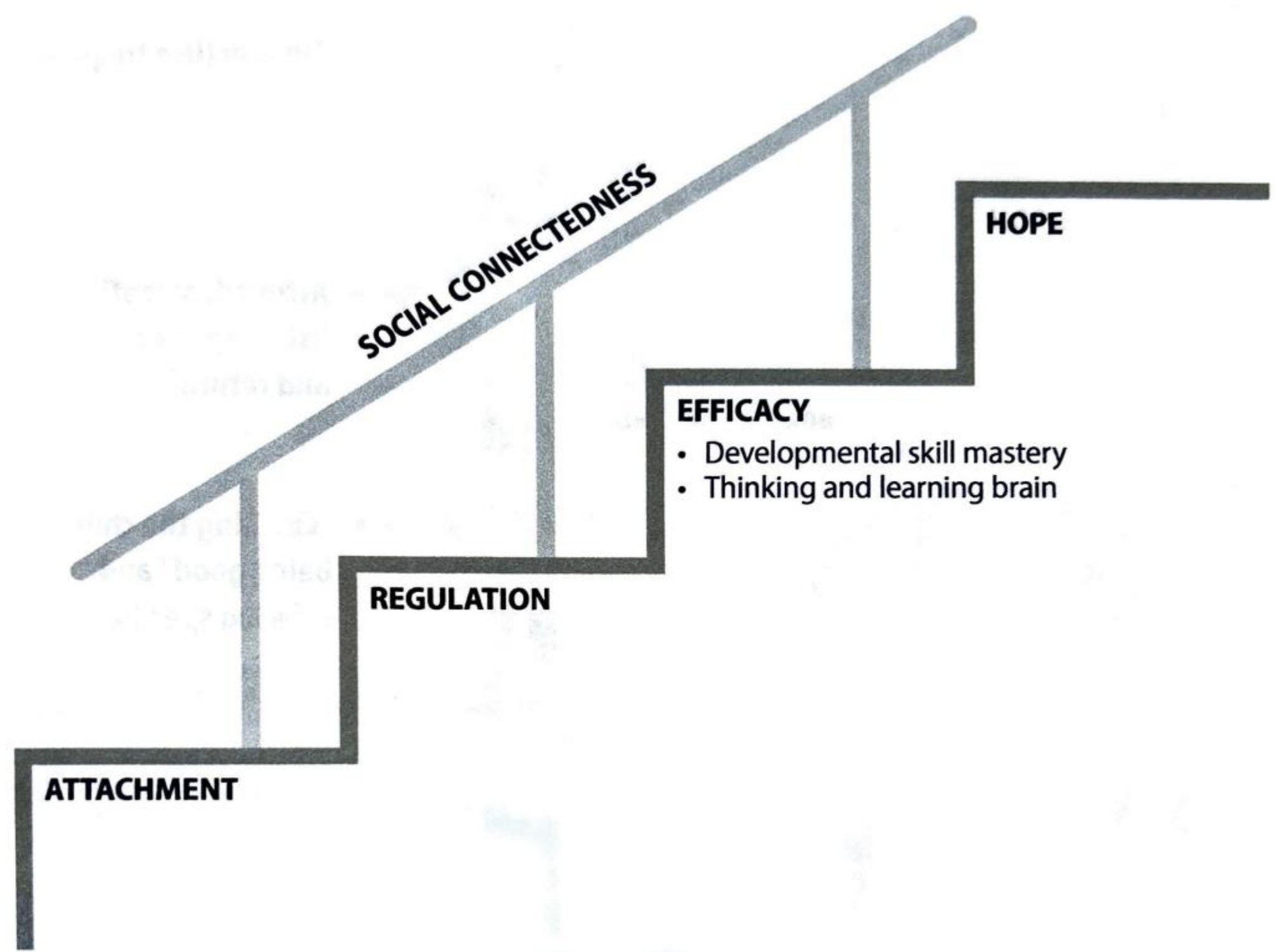
www.developingchild.harvard.edu

The Four Rs of Trauma-Informed Care

Realize

Recognize

Respond

Resist Re-traumatization

Realize the widespread impact of trauma and understand potential paths for recovery

Recognize the signs and symptoms of trauma in clients, families, staff, and others involved with the system

Respond by fully integrating knowledge about trauma into policies, procedures, and practices

Resist re-traumatization of children, as well as the adults who care for them

Elements of Resilience

T	• Thinking and learning brain
H	• Hope
R	• Regulation or self-control
E	• Efficacy
A	• Attachment
D	• Developmental skill mastery
S	• Social connectedness

Heather C. Forkey, MD, FAAP; Jessica L. Griffin, PsyD; Moira Szilagyi, MD, PhD, FAAP. (2021) *Childhood Trauma and Resilience: A Practical Guide.* American Academy of Pediatrics. **ISBN-13**: 978-1-61002-506-5

	Age group	Description and evidence
Home visiting	Newborn to 3 years	A series of home visits for 1–3 years, often accompanied by referral and assessment; shows positive effects in reducing reports of child abuse and neglect, although results are inconsistent[122]
Attachment and Biobehavioural Catch-up intervention (ABC)	6 months to 4 years	Short-term intervention for stable families focused on parent–child interaction, including for children who have experienced neglect or institutional care, and foster families[123]
Video-feedback Intervention to Promote Positive Parenting and Sensitive Discipline (VIPP-SD)	1–6 years	Short-term intervention focused on parent–child interaction, for children with or at risk for behaviour problems; there are adapted modules for children with autism spectrum disorder (VIPP-AUTI) and adoptive and foster care families (VIPP-FC)[124]
Parenting programmes	3–17 years	Short-term interventions shown to be effective in reducing child behavioural problems, even when used in different contexts, with modest reductions in harm markers of child physical abuse[125,126]
Parent–Child Interaction Therapy (PCIT)	4–7 years	Short-term intervention for both parents and children together; shows some of the most consistent evidence in improving outcomes associated with physically abusive behaviour[127]
The Friendship Bench	Adults	Short-term psychological intervention to treat common mental health problems, delivered by lay health workers[128]
The Healthy Activity Program (HAP)	Adults	Short-term psychological intervention for depressed parents, delivered by lay counsellors[129]
Pause programme	Adults	18-month individualised package of support, access to contraception, and referral to partner organisations (such as health and domestic violence prevention) for women who have experienced or are at risk of repeat removal of children from their care[130]
Cash-plus-care programmes	Adults	Programmes that combine access to social protection schemes and cash assistance for economically vulnerable families, combined with family strengthening interventions such as parenting skills development, savings and financial planning, and support groups; ideally supported with case management[131–133]

Table: Examples of evidence-based interventions for strengthening families

THE PERSONS

1. RESTORE SENSE OF SAFETY, PREDICTABILITY AND CONTROL

2. SUPPORT SELF-REGULATION

3. SUPPORT HEALTHY ATTACHMENT WITH ADULTS AND POSITIVE RELATIONSHIP WITH PEERS

4. BUILD CORE LIFE SKILLS

Sensitive

The Person

responsive

Nurturing

5. PROVIDE WAYS TO PROCESS TRAUMATIC EVENTS

6. LEARN CHILD'S TRAUMA TRIGGER and HELP TO COPE

7. PROTECT THEM FROM RE-TRAUMATIZATION

8. HELP THEM HEAL

HOW TO SUPPORT RESILIENCE?
NATIONAL CHILD TRAUMATIC STRESS NETWORK

Support
- Caregiver as "Emotional container"
- Routines
- Time-in

Safety
- Physical & emotional safety

Self-worth/Esteem
- Self efficacy (self-care, decision making, core skills)
- Spiritual/cultural beliefs, goals, or dreams for the future that provide meaning to a child's life
- Talent or skills

Infants
- Security and routines
- Responsive care to build trust
- Reassure safety

Toddlers
- Respond with non-verbal safety cues
- Teach words for emotions

Preschoolers/ Young school-aged
- Create space
- Time-in
- Routines
- Safety cues
- Teach words for emotions
- Cozy corner
- Validate good behavior
- Visual cues

School-aged

- Create opportunities for introspection and reflection
- Matching child's affect while remaining emotionally regulated
- Help identify underlying emotions(assisted verbalization)
- Connect behavior to emotion
- Sensory-based supports

Teens

- Allow space for self reflection
- Words for emotions
- Allow new maps of self
- Teach child to manage expectations
- Attuned, attentive listening
- Exposure to normalizing activities outside home is important for both school-aged and teens.

HOW TO PREVENT PLACEMENT BREAKDOWN?

- Attend to the psychological and physical safety of adults who care for children who experienced trauma(secondary traumatic stress)
- Psychoeducation to caregivers on trauma-informed care
- Stress relieve & self-care activities(buddy system)
- High quality, reflective supervision
- Maintain trauma caseload balance

Panel 9: Risks of behavioural and emotional problems in placement stability

Behavioural and emotional problems, which a child or adolescent might have in the transition from institutional to family care, constitute an important risk factor in placement breakdown. To ease that transition, the following practical steps for case workers might facilitate placement stability.

- Families should be encouraged to focus on the stability and consistency of the caregiving environment because family routines help to reduce problematic behaviours in children
- Psychological support for the child and family should be easily accessible during the immediate transition period
- Families should be linked with social, medical, and mental health services before placement to facilitate access to these support services immediately after the placement
- To the extent possible, families should be provided with basic training in reading and responding to the needs of young children and in trauma-informed responses to the challenging behaviours of children and adolescents, so that families can develop a positive relationship with the child, providing the child with a feeling of safety, security, and love[140]
- Although part of the training can occur before the child arrives, ideally training after the placement begins will allow parents to practise interactions under the tutelage of trained professional or paraprofessional individuals

Panel 10: Assessing the developmental and mental health status of children who have left institutions

The gross and fine motor skills and speech and language abilities of each child who is leaving an institution should be assessed to establish a developmental baseline from which progress over time can be measured. This assessment, including observation and a report from a parent on the social, emotional, and behavioural functioning of the child, will also determine whether professional intervention is needed immediately or if the child can be observed in their new home, which for most children is an adequate therapeutic environment. Taking into account the age of the child and using age-appropriate measures, the physical and mental health screening should include a review of prenatal and postnatal risk factors, an evaluation of the new family environment, a social and medical history, observation of the current behaviour of the child, and a review of the support services the family are currently using.

Children also need vision and hearing testing as well as an assessment of their sensory processing abilities.[144] Misperception (eg, tactile sensitivity) or poor perception (eg, hearing loss) are common problems among children who have left institutions.[144-146] The symptoms of such deficits can incorrectly be interpreted as disorders of attention, hyperactivity, attachment, or autism spectrum disorder. Without robust parental and professional education, the risk of placement breakdown and of children returning to institutional care can be very high.[36]

THE CORE SKILLS

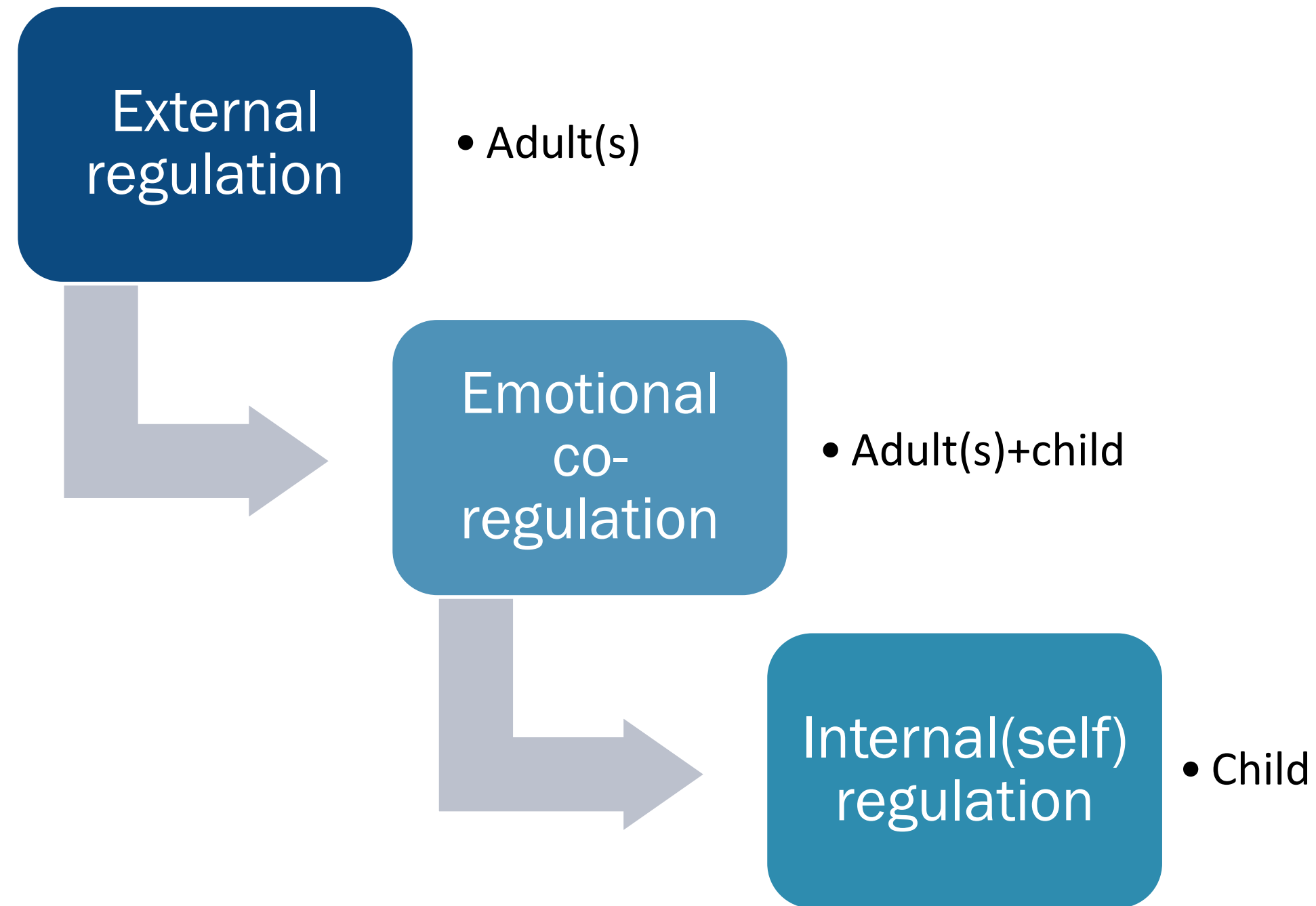# CORE SKILLS

1. Self-regulation
   • Emotional regulation
2. Social skills
3. Executive function
4. Language and communication skills

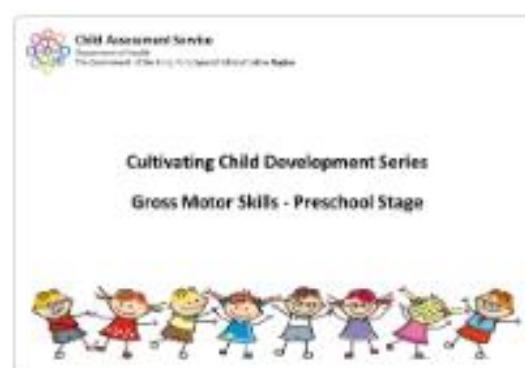# 1. EMOTIONAL REGULATION: RELATIONSHIP-DRIVEN, EXPERIENCE-BASED

External regulation
- Adult(s)

Emotional co-regulation
- Adult(s)+child

Internal(self) regulation
- Child

🏠 > Parent Empowerment > Cultivating Child Development Series

Cultivating Child Development Series

https://www.dhcas.gov.hk

Gross Motor Skills – Preschool Stage

Fine Motor Skills

Language Development

Social Communication

Handling Children's Temper Tantrum

Emotion and Behaviour
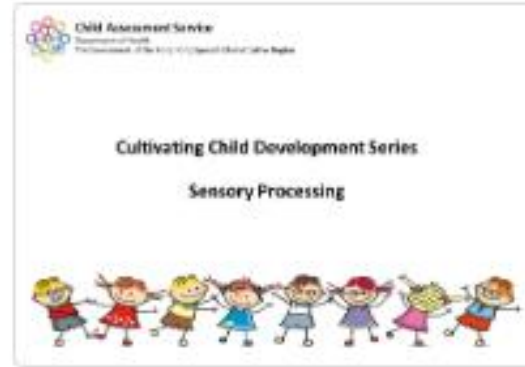
Sensory Processing

Cognitive Development

2. SOCIAL SKILLS
SIX STAGES OF "BUILDING A HOUSE"

	House	Social-emotional stages	Usual Age
1	Foundation	Calmness & attention	0-6months old
2	Frame	Engagement & relating	6-12months old
3	Electrical wiring	Purposeful emotional interaction	From 9months old
4	Rooms & hallways	Shared social problem solving	From 18months old
5	Decorating the house	Creative symbols, use words & ideas	From 24months old
6	Driveway to the world	Emotional thinking & building bridge between ideas	From 42months old

Delahooke M. (2019) *Beyond Behaviors: Using brain science and compassion to understand and solve children's behavioral challenges.* John Murray Press.

THE ABILITY TO SELF-REGULATE DEPENDS ON

1. Which stage of social-emotional development child is at (now)
2. Opportunity for emotional co-regulation to occur (before)
3. Neuro-ception: how the brain perceives "safety" and "threat" in the particular situation (at the moment)

3. EXECUTIVE FUNCTION (執行功能)

I. Working Memory
工作記憶

II. Self control
自制能力

III. Mental flexibility
腦筋靈活性

Executive Function Skills Build Into the Early Adult Years
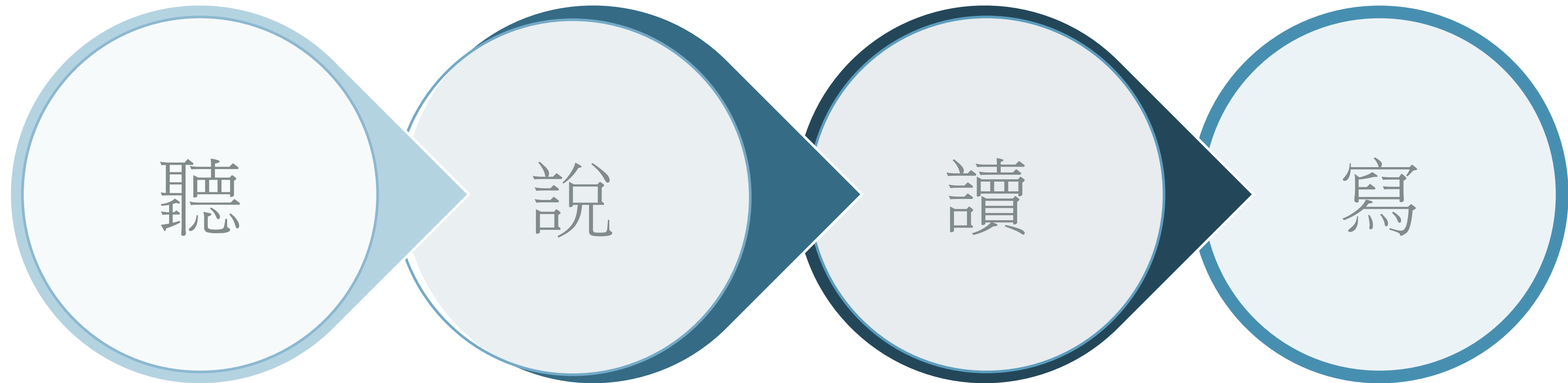
Executive Function Skill Proficiency

Age 0 1 2 3 4 5 6 6-8 9-10 12-15 20-24 25-29 30-35 40-49 50-60 65-69 70-75 76-80 81-85

https://harvardcenter.wpenginepowered.com/wp-content/uploads/2015/05/Executive-Function-Activities-for-3-to-5-year-olds.pdf

4. LANGUAGE AND COMMUNICATION SKILLS

聽 説 讀 寫

Figure 1.9 Reading Rope (Scarborough, 2001)

ROUTLEDGE

Routledge

Taylor & Francis Group

Check for updates

Interventions and Practice Models for Improving Health and Psychosocial Outcomes for Children in Residential Out-of-Home Care: Systematic Review

Emma Galvin [iD] [a], Renee O'Donnell [iD] [a], Rachel Breman[a], Julie Avery [iD] [a], Aya Mousa[a], Nick Halfpenny[b], and Helen Skouteris [iD] [a,c]

[a]Monash Centre for Health Research and Implementation (MCHRI), School of Public Health and Preventive Medicine, Monash University, Melbourne, Australia; [b]MacKillop Family Services, Melbourne, Australia; [c]School of Business, Warwick University, Coventry, UK

Early intervention is KEY

SUMMARY

- Trauma-informed care
  - It is all about relationships.
- "The Person"
- Elements of resilience
  - THREADS

THE END