

Childhood Trauma

Did you know...

A report of a child abuse is made every 10 seconds (Childhelp, n.d.).

Occupational Performance

Children who experience trauma may be challenged in the following ways:

Social Participation

- Impaired social skills
- Increased depression, anxiety, and emotional numbing
- Over activated traumatic stress response
- Poor interpersonal boundaries
- Fear of failure/hyperawareness of possible failure, leading to decreased participation in activities
- ADL deficiencies (listed below) that can lead to difficulty interacting with peers (e.g., being teased about poor hygiene)
- History of isolation and lack of opportunity to interact with others

Activities of Daily Living

- Diminished motivation to complete daily routines
- Difficulty managing hygiene
- Difficulty controlling bladder and bowel for toileting
- Trouble eating (e.g., food hoarding behaviors)
- Lack of exposure to direct instruction on how to complete ADLs such as hygiene
- Fear of ADLs; abuse and neglect are frequently associated with locations where ADLs are completed (e.g., bedroom, shower/bathroom)

Education

- Impaired executive function
- Difficulty envisioning a future (Bloom & Yanosy-Sreedhar, 2008)
- Impaired attention and arousal regulation
- Negative attention seeking
- Poor attendance and homework completion
- Staff or teacher not understanding the reason for negative behaviors ("What is wrong with him?" vs. "What happened to him?")

Work

- Difficulty attaining and maintaining employment (Bloom & Yanosy-Sreedhar, 2008)
- Lack of insight with how poor self-care (e.g., hygiene) and social skills impact ability to be successfully employed
- Difficulty managing emotions to successfully navigate stressful situations

Play/Leisure

- Decreased initiation in play and healthy leisure activities
- Over-aggressive play and bullying
- Frequent fear of failure and withdrawing from activities (e.g., "I quit!")

Sleep/Rest

- Difficulty falling and staying asleep (Humphreys, Lowe, & Williams, 2009)
- Increased occurrence of nightmares and sleep disturbances (Caldwell & Redeker, 2005)
- Increased bed wetting (Humphreys et al., 2009)

OCCUPATIONAL THERAPY PRACTITIONERS use meaningful activities to promote physical and mental health and well-being. Occupational therapy practitioners focus on participation in the following areas: education, play and leisure, social activities, activities of daily living (ADLs; e.g., eating, dressing, hygiene), instrumental ADLs (IADLs; e.g., preparing meals or cleaning up, caring for pets), sleep and rest, and work. These are the usual occupations of childhood. Task analysis is used to identify factors (e.g., motor, social-emotional, cognitive, sensory) that may limit successful participation across various settings, such as school, home, and community. Occupational therapy practitioners offer activities and accommodations within their service to promote successful performance in these settings.

WHAT IS CHILDHOOD TRAUMA?

Childhood trauma is a psychologically distressing event involving "exposure to actual or threatened death, serious injury, or sexual violence..." (American Psychiatric Association, 2013, p. 261). Such events involve a sense of fear, helplessness, and horror. Childhood trauma occurs whenever both internal and external resources are inadequate to cope with an external threat (van der Kolk, 1989). Children may experience trauma from abuse (physical, sexual, emotional), neglect (physical, medical, emotional, educational), natural disasters, illness, and violence (school, community, domestic).

Trauma exposure activates fight, flight, or freeze stress reactions, the human response to experiences of overwhelming stress. Most children exposed to an isolated traumatic event will recover in time. However, exposure to chronic interpersonal trauma (i.e., child maltreatment) results in complex trauma, a condition that adversely affects virtually every aspect of development. Complex trauma in childhood is termed *developmental trauma* (van der Kolk, 2005), a condition that presents with significantly higher levels of dysregulation (affective, physiological, attentional, behavioral, and relational), functional impairments, and psychiatric hospitalizations compared with children with posttraumatic stress disorder and histories of "non-violent" trauma (Kisiel et al., 2014).

More than 3 million cases of child abuse and neglect are reported in the U.S. each year (U.S. Department of Health and Human Services [HHS], 2013). In 2013, the national rate of reported child abuse and neglect was 28.3 per 1,000 children in the national population (HHS). Because occupational therapy practitioners serve young children in homes, schools, and communities, they have a significant role in (1) recognizing the signs of trauma; (2) creating safe environments that support learning and development; (3) with advanced training, treating children who have experienced trauma; (4) collaborating to model and facilitate skills for managing emotions for the adults who serve children who are survivors of trauma; and (5) with advanced training, collaborating with children who are survivors of trauma and the adults who serve them to develop skills and techniques to safely and proactively avoid crises, and to develop reactive strategies to safely work through crisis situations to minimize additional trauma.

WHAT IS TRAUMA-INFORMED CARE (TIC)?

According to the National Child Traumatic Stress Network (n.d.), a trauma-informed care perspective is one in which program staff, agency staff, and service providers (1) routinely screen for trauma exposure and related symptoms; (2) use culturally appropriate evidence-based assessment and treatment; (3) make resources available to children, families, and providers on trauma exposure, its impact, and treatment; (4) engage in efforts to strengthen the resilience and protective factors of children and families impacted by and vulnerable to trauma; (5) address parent and caregiver trauma and its impact on the family system; (6) emphasize continuity of care and collaboration across systems; and (7) maintain an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress, and that increases staff resilience.

Occupational Therapy's Role in Addressing Childhood Trauma

OCCUPATIONAL THERAPY'S ROLE IN ADDRESSING CHILDHOOD TRAUMA

Occupational therapy practitioners can serve an important role in addressing trauma at the universal, targeted, or intensive levels of intervention. They are invaluable members of the mental health team because of their knowledge of the cognitive, social and emotional, and sensory components of activity and its impact on behavior (Petrenchik, 2015; Petrenchik & Guarino, 2009).

Children who have experienced complex trauma need environments and opportunities to regain a sense of personal safety, competence, and pleasurable connection to others. Safety, predictability, and “fun” are essential ingredients for helping a child to be “in the moment” where all learning, skill development, and healing happen (van der Kolk, 2005). Because occupational therapy practitioners have specialized training in task analysis and environmental modification, they can optimize the child-environment-occupation fit to enable successful activity engagement and social participation.

Traumatized children have difficulties handling emotions, sensations, stress, and daily routines. They often feel hopeless, worthless, and incompetent (van der Kolk, 2005). Occupational therapy practitioners work with other disciplines to structure environments, teach cognitive strategies, and develop social and emotional skills that promote self-regulation, competence development, trust building and confidence, and resilience through participation.

Promotion

- Raise awareness about the occurrence and impact of child trauma.
- Create a culture of nonviolence through promoting positive behaviors.
- Foster children's interests in healthy and safe play and leisure occupations.
- Teach children positive coping skills, relational skills, and problem-solving skills.
- Model and teach staff and adults who serve survivors of trauma principles of emotional regulation and co-regulation.

Prevention

- Recognize signs and symptoms of trauma.
- Provide group-based interventions focused on self-regulation and sensory modulation, as well as self-efficacy.
- Use self-awareness techniques to teach children emotional regulation strategies (see The Zones of Regulation in Check This Out!).
- Educate parents and teachers about healthy discipline, including the use of positive behavioral supports and ways to effectively deal with crises.

Intensive

Occupational therapists with training in trauma and sensory-based interventions are qualified to:

- Provide trauma-informed sensorimotor arousal regulation interventions in collaboration with mental health professionals (see LeBel & Champagne, 2010; Warner, Spinazzola, Westcott, Gunn & Hodgdon, 2014;).
- Teach children mindfulness strategies to reduce stress and to cope with overwhelming emotions.
- Provide environments and opportunities intentionally designed to increase a traumatized child's sense of mastery, connection, and resiliency (see *Treating Traumatic Stress in Children and Adolescents* in Check This Out!).
- Provide opportunities for play and social interaction to facilitate the development of likes, interests, and motivators.

IN THE HOME, occupational therapy practitioners work with caregivers to create predictable routines. Children who experience trauma often feel out of control. Practitioners provide opportunities in the home that are predictable and routinized, and that allow the children to have a sense of control. They can also create structured daily routines, promote safe family activities, and support self-regulation, including addressing sleep and eating issues.

Children who experienced trauma in early childhood often have difficulty developing healthy attachments to caregivers. Occupational therapy practitioners who understand attachment theory work with caregivers to create a healthy attachment and encourage bonding through developmentally appropriate childhood occupations (see Circle of Security International in Check This Out!).

Occupation-based strategies could include:

- Making activities and routines predictable
- Helping children regain control by allowing for choice within activities
- Pairing sensory approaches with cognitive approaches to teach children to calm their bodies and minds
- Providing frequent positive reinforcements
- Recommending stress management strategies
- Collaborating with clients to identify goals and interventions designed to empower
- Providing frequent direct instruction and modeling to create ongoing competence and success
- Collaborating and modeling emotional management strategies consistently among the staff, teachers, and other adults

Did you know Massachusetts has adopted an initiative that includes sensory interventions to help reduce restraints? For more information on the occupational therapist's role in embedding sensory interventions into agencies that provide services for children who have experienced trauma, see: http://www.aota.org/-/media/Corporate/Files/Secure/Publications/SIS-Quarterly-Newsletters/MH/MHSIS_June_2010.pdf

Occupational Therapy's Role in Addressing Childhood Trauma

IN SCHOOL, occupational therapy practitioners promote social interactions among peers and support the teachers to create a safe and nurturing environment that enhances learning. They help educators and staff understand the impact of trauma on learning and identify supports, create an environment that promotes self-regulation and predictability, and help establish an environment to secure the child's trust.

IN THE COMMUNITY, occupational therapy practitioners have a role in promoting healthy activities. They help facilitate successful community outings and instruction that support friendships and a sense of safety, and foster development in children who have experienced trauma. Occupational therapy practitioners may also collaborate with and provide services at organizations, such as community-treatment centers, group homes or residential facilities, and foster care agencies.

CHECK THIS OUT!

- The National Child Traumatic Stress Network www.nctsn.org
- Child Trauma Academy childtrauma.org
- The Adverse Childhood Experience Study www.acestudy.org
- Child Welfare Information Gateway. What is Child Abuse and Neglect? Recognizing Signs and Symptoms <https://www.childwelfare.gov/pubs/factsheets/whatiscan.pdf>
- Information on occupational therapy approaches www.OT-innovations.com
- American Academy of Pediatrics Trauma Guide www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Trauma-Guide.aspx
- National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraint (NCTIC) www.samhsa.gov/nctic
- Circle of Security International circleofsecurity.net
- Book: *Treating Traumatic Stress in Children and Adolescents: How to Foster Resilience Through Attachment, Self-Regulation, and Competency*, by Margaret Blaustein & Kristine Kinniburgh.
- The Zones of Regulation: Occupational therapy interventions to help foster self-regulation www.zonesofregulation.com

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Foster Care

OCCUPATIONAL PERFORMANCE

How might time in foster care influence occupational participation?

While each individual will demonstrate their own unique strengths and needs, living in a home that is deemed "unsafe" creates an atmosphere for adversity and stress during critical developmental periods. Children in foster care may be challenged in the following areas of occupation.

Social Participation

- Difficulty expressing emotions in a healthy way
- Social cognition limitations, including difficulty understanding perspectives, and analyzing and responding to different social situations
- Difficulty self-regulating and controlling inhibitions (Lewis, Dozier, Ackerman, & Sepulveda-Kozakowski, 2007)
- Inappropriate boundaries with respect to personal space
- Difficulty forming healthy attachments with family, teachers, and peers

Activities of Daily Living (ADLs)

- Limited independence in ADLs, skills are often not commensurate with age
- Delayed hygiene awareness
- Sensory processing impairments that impact engagement in ADLs
- Difficulty accepting ADLs training from "new" caregivers

Education

- Increased risk of absenteeism from school (Zorc et al., 2013)
- Varying impact of birth family visits on academics (Fawley-Kinga, Traska, Zhang, & Aarons, 2017)
- Increased rates of grade retention and high school dropout (Scherr, 2007)

Instrumental ADLs (IADLs)

- Age-inappropriate IADLs (e.g., children becoming the primary caregiver for younger siblings)
- Lack of modeling and teaching in higher-level household management tasks
- Decreased knowledge and skills for independent living concepts of money earning and money management, health care management and maintenance, and proper safety procedures and emergency management

Play/Leisure

- Lack of play modeling and engagement prior to the child entering care
- Lack of time and opportunity to play due to constraints of meetings, counseling, and birth-family visits
- Fear of being outside or in play environments because of past experiences; some children experience "seasonal" avoidance of play and leisure activities due to the trauma triggers associated with seasonal changes
- Decreased opportunity to engage in extra-curricular activities
- Little exposure to, and often ensuing hesitancy to participate in, healthy leisure

Sleep/Rest

- Bed wetting and incontinence
- Challenges with sleep onset latency (due to sensory problems, fear and anxiety, etc.) and overnight sleep disruption (due to nightmares and night terrors)
- Sensory processing difficulties limiting ability to self-regulate and to tolerate the sensory aspects of co-regulation to prepare for sleep

OCCUPATIONAL THERAPY PRACTITIONERS

use meaningful activities to help children and youth participate in what they need and/or want to do in order to promote physical and mental health and well-being. Practitioners focus on participation in the following areas: education, play and leisure, social activities, activities of daily living (ADLs; e.g., eating, dressing, hygiene), instrumental ADLs (e.g., meal preparation, shopping), sleep and rest, and work. These are the usual occupations of childhood and young adulthood. Task analysis is used to identify factors (e.g., sensory, motor, social-emotional, cognitive) that may limit successful participation in these areas across various settings, such as school, home, and community. Activities and accommodations are used in intervention to promote successful performance in these settings.

WHAT IS FOSTER CARE? PROCESS, PREVALENCE, AND EMERGING OT ROLE

According to Title IV-E of the Social Security Act, foster care provides safe and stable out-of-home care for children until the children are safely returned home, the children are placed permanently with adoptive families, planned arrangements for permanency are made, or the children age out of foster care (Child Welfare Information Gateway, n.d.; Social Security, n.d.). While year-end statistics indicate that more than 400,000 children reside in America's foster system, more children than this enter and exit foster care at some point during the year. For example, 640,000 children resided in foster care at some point in 2012 (Child Welfare Information Gateway, n.d.). On September 30, 2015, 35% of children in foster care had been there for 6 to 17 months, and 36% of children had been in foster care for longer than that. If a permanent home is not found, a child will age out of the foster care system between 18 and 21 years, depending on the state. Meanwhile, it is important to consider the approximately 205,000 children who do not remain permanently in foster care but were removed from a home that was deemed "unsafe" (U.S. Department of Health and Human Services, 2016).

Children enter foster care because of caregivers' inability to meet the child's basic living and health needs. A precipitating factor may include caregiver abuse (e.g., sexual or physical); unsafe living conditions (e.g., illegal drugs and alcohol abuse by caregivers); and caregiver neglect (e.g., physical, psychological, emotional, and medical) or abandonment. Many of these children may also experience prenatal exposure to toxins, thus compounding their vulnerability with a combination of prenatal stress and early childhood abuse and neglect (Charil, Laplante, Vaillancourt, & King, 2012). After separation from their biological family, children tend to experience multiple foster placements (Newton, Litrownik, & Landsverk, 2000). Continual disruption of living situations results not only in a change of family and home environment, but also changes in school, community, worship, and daycare environments. Such instability in placement may adversely impact social emotional development (Rubin, O'Reilly, Luan, & Localio, 2007). Any child who is removed from a home and placed, even briefly, into the foster care system is at risk for limitations in typical daily living opportunities of childhood, which may impact lifelong health and occupational well-being. For any child experiencing foster care even a single time, issues including caregiver incompetency, diminished child capacity, and system inefficiencies reduce the potential for occupational justice (Cross, Koh, Rolock, & Eblen-Manning, 2013). The impact of early adversity, trauma, and disruption to living situations experienced by these children negatively impacts their overall health and well-being (Anda et al, 2006; Nelson, 2012). The impact of occupational injustice, early adversity, and chronic trauma on youth in foster care may create impairments in areas including cognition, social skills, self-regulation, and emotional and physical well being, leaving these adults ill equipped

Continued on page 2.

Occupational Therapy's Role in the Foster Care System

for employment, maintaining a household, managing finances and healthcare, and sustaining relationships (Child Welfare Information Gateway, n.d.). The occupational injustice experienced translates across generations, as youth in foster care are three times more likely than their peers to become pregnant and attempt to find redemption in parenting their own offspring, despite their lowered parental readiness and skill (Dworskey & Courtney, 2010). Occupational therapy practitioners are emerging in the field of early adversity and foster care as much needed providers, offering a distinct approach to promoting permanency and stability for youth who have experienced foster care (Lynch, 2016; Schefkind, Newell, Ashcraft, & McCown-Lucas, 2015).

OCCUPATIONAL THERAPY'S ROLE IN THE FOSTER CARE SYSTEM

The distinct value of occupational therapy within the context of foster care is to promote everyday participation in meaningful occupations at the universal, targeted, or intensive levels of intervention (Paul-Ward & Lambdin-Pattavina, 2016).

Occupational therapy practitioners can support both the physical and mental health needs of children in the foster care system. They are key team collaborators, supporting and remediating the development of motor, social, cognitive, self-regulation, and sensory skills. Practitioners can advocate for system and individual programming to support the needs of children impacted by unsafe homes in early life, and to develop programs to prevent the scaffolding effects of long-term foster care. A client-centered occupational therapy approach that focuses on motivation, fun, and engagement supports these children in developing skills for independence in ADLs and IADLs, play, leisure, and overall wellness and satisfaction in independent living.

Universal — This level of intervention includes partnering with child welfare agencies, family safety preservation systems, schools, and residential treatment facilities. At this level, occupational therapists may consult with agencies and systems; meet with administrators; develop screening resources for occupational engagement; and develop programming and environmental modifications that match the needs of a child from foster care to promote access to developmental, academic, life skills, and leisure opportunities within the community.

Targeted — At this level, strategies may focus on developing programs and services for children in the foster care system or who are at risk for disruption within their biological family. An occupational therapy focus may include training and providing in-services to places such as schools, places of worship, clinics, and welfare agencies demonstrating the distinct value of occupational therapy; along with clinics or community-based screenings for children in foster care to identify those who may need additional evaluation by an occupational therapist. Practitioners may partner with child welfare agencies to provide training and education parenting classes for both birth families seeking to regain custody of their child and foster families working to understand the unique needs of foster children and strategies to help these children succeed in their homes. Additionally, practitioners can be instrumental in the planning, delivering, and evaluating occupation-based transitional programs in which youth transitioning out of foster care become successful by doing (Paul-Ward & Lambdin-Pattavina, 2016). Practitioners can implement attachment-based, trauma-informed program principles to build healthy relationships. In so doing, a stronger therapeutic alliance foundation develops, thus ensuring that children engage in meaningful occupations so they feel safe and supported (Purvis, Cross, Dansereau, & Parris, 2013). Occupational therapy practitioners can collaborate with others, developing community programming that promotes opportunities for social activities, play, and leisure interactions to reduce the impact of foster care on lifelong maladaptive activity choices, such as drugs and alcohol use (Pears, Kim, & Fisher, 2016). Targeted interventions improve placement stability and overall long-term well-being for children and youth in foster care (Fisher, Kim, & Pears, 2009).

Intensive — Individualized occupational therapy services for children in care from birth through ages 18 to 21 may occur within various environments, including the foster home, home environment pre- and post-reunification, daycare, school, welfare agency, or other natural environments for the individual. Practitioners advocate for individual children's needs at individualized education program (IEP) meetings to ensure the school understands that the potential impact of trauma and

Continued on page 3.

Learn more about occupational therapists' role within an interdisciplinary trauma-informed-care approach to treatment

<https://www.aota.org/~media/corporate/files/practice/children/schoolmhtoolkit/childhood-trauma.pdf>

Did you know? "Nearly 25% of children in foster care experience post-traumatic stress disorder (PTSD). This is double the rate of PTSD experienced by individuals active in military deployments, and more than six times the rate of the general public" (Deutsch et al., 2015, p. 293).

CHECK THIS OUT!
U.S. Department of Health and Human Services

www.mentalhealth.gov/

National Institute of Mental Health
<https://www.nimh.nih.gov/index.shtml>

National Alliance on Mental Health
<https://www.nami.org/mentalhealthmonth>

Substance Abuse and Mental Health Services Administration
<https://www.samhsa.gov/children>

Occupational Therapy's Role in the Foster Care System

foster care on the child's performance warrant special supports in school, including individualized occupational therapy services. Individualized services may also relate to developing parenting skills for birth parents hoping to re-gain or maintain custody of their children, or extended birth family members seeking temporary or permanent custody of children. Individual services for infants, toddlers, and elementary aged children include: training in and development of age-appropriate skills for completing ADLs, participating in education, developing skills for engaging in social groups in the school, improving motor skills, and learning self-regulation skills to support participation in school and community activities (e.g., sports and recreation programs). Occupational therapy practitioners can also collaborate directly with teachers to help teachers better understand the unique relationship challenges for children in foster care and the impact of positive relationships on academic performance. Practitioners can develop individualized learning and social strategies to improve the student's performance in the classroom. Therapists can develop social groups to promote play (Fabrizi, Ito, & Winston, 2016) and engagement with caregivers, peers, and teachers. Individual services for adolescents aging out of foster care or emancipated may include evaluation (including conducting a thorough occupational profile), and occupation based interventions in the areas of managing finances; managing and maintaining one's health; parenting; establishing and managing a home; preparing meals and cleaning up; creating safety and emergency plans; shopping; pursuing an education; identifying employment interests and pursuits; as well as seeking, acquiring, and maintaining employment. Occupational therapy practitioners can assist in training individuals on work skills to increase their employment potential (Pecora et al., 2006). They can also assist youth transitioning out of foster care to develop future goals and skills needed to achieve them (Paul-Ward & Lambdin-Pattavina, 2016).

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Additional Resources

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New Roles for Occupational Therapy to Promote Independence Among Youth Aging Out of Foster Care

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MeSH TERMS

- adolescent
- foster home care
- occupational therapy
- social justice
- social marginalization
- transitional care

Occupational therapy practitioners are qualified to address the needs of young adults transitioning out of the foster care system; yet, to date, the degree to which practitioners have addressed these needs has been limited. The literature on foster care clearly documents the myriad of long-term challenges that this population faces as a result of their lack of preparedness in independent living, academic, and vocational skills. Moreover, it is clear that existing programs are inadequate for meeting the needs of this population because they rarely include individualized, occupation-based, client-centered approaches for skill development. In this article, we argue that by design, the foster care system marginalizes its “members.” Occupational therapy’s emphasis on occupational justice provides practitioners with an ideal opportunity to remediate the injustice that this population often experiences. To support our position, we describe exploratory work that has been conducted with stakeholders and transitioning youth in Miami, Florida.

Paul-Ward, A., & Lambdin-Pattavina, C. A. (2016). The Issue Is—New roles for occupational therapy to promote independence among youth aging out of foster care. *American Journal of Occupational Therapy, 70*, 7003360010. <http://dx.doi.org/10.5014/ajot.2016.017426>

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According to the U.S. Department of Health and Human Services (HHS; 2000), *foster care* is defined as “24-hour substitute care for children placed away from their parents or guardians and for whom the State agency has placement and care responsibility” (p. 1). Although most people are familiar with the single foster family home model, placements may include group homes, emergency shelters, large residential facilities, or homes of relatives (kinship care). This system of foster care has been described as bureaucratic in nature, consisting of many layers (Paul-Ward, 2009). Although these layers were developed to increase accountability among service providers and to lead to youth success after foster care, long-term outcomes, such as educational achievement and employment attainment, have not improved for this population (Courtney et al., 2005).

A paucity of literature within the field of occupational therapy highlights opportunities for intervention with children in foster care at both the individual and community levels. Specifically, occupational therapy practitioners can intervene at the

individual level by assisting transitioning youth to develop future goals and the skills needed to achieve them. At the community level, practitioners can be instrumental in the planning, delivery, and evaluation of occupation-based transitional programs in which youth become successful by doing. Lessons learned from an ongoing exploratory study provide the backdrop for the argument that occupational therapy practitioners’ service is sorely needed in independent living and vocational skill programs that help foster care youth advance toward adulthood.

With the recently implemented Patient Protection and Affordable Care Act (2010; Pub. L. 111–148), both the focus and funding of health care will probably shift to prevention and community-based practice (Sheldon Fields, PhD, ARNP, personal communication, August 2014). This trend bodes well for occupational therapy and opportunities for working with this historically marginalized population because prevention is delineated as a specific approach to intervention in the *Occupational Therapy Practice Framework: Domain and Process*

Background

In the United States, more than 250,000 children are placed in foster care each year (Zlotnick, Tam, & Soman, 2012), with 58% from minority groups (HHS, 2014a). In addition, children in the foster care system have higher rates of physical, psychological, and social problems than children not in foster care (Zlotnick et al., 2012). For example, it has been estimated that between 40% and 60% of children in foster care have at least one psychiatric disorder and that about 33% have three or more psychiatric diagnoses (Stein, Rae-Grant, Ackland, & Avison, 1994). These disorders include depression, substance use, oppositional defiance, anxiety, adjustment, posttraumatic stress disorder, learning disorders, and attention deficit disorder. Treatment for these disorders often includes medications that require ongoing management and adherence to be effective (dosReis, Zito, Safer, & Soeken, 2001).

As U.S. adolescents transition into adulthood, they are typically expected to finish school, gain independence from their parents, and become contributing members of their communities (Arnett, 2000; Chadsey-Rusch, Rusch, & O'Reilly, 1991; Hiebert & Thomlison, 1996). The term *aging out* is used to describe youth ages 18 yr and older who are no longer eligible to remain in foster care and who receive related state services or have chosen to leave the system. The age at which youth are mandated to leave the system varies by state. For many young people, the process of aging out of the foster care system presents many challenges. In particular, most youth lack financial resources as well as familial and other supports, placing them at risk for developmental disruptions and other negative outcomes (e.g., low educational attainment, homelessness, employment and financial difficulties, mental and physical health problems; Barth, 1990; Blome, 1997; Collins, 2001; Courtney, Piliavin, Grogan-Kaylor, & Nesmith, 2001; Lemon, Hines, & Merdinger, 2005).

Youth in foster care typically have higher rates of absenteeism, grade retention, disciplinary referrals, and behavior problems

than the general K–12 population (Berliner & Lezin, 2012). This group also tends to test below grade level on standardized measures and is twice as likely as the general student population to leave school without a diploma. For example, recent data from the Michigan Alumni Study (White et al., 2012), which examines the demographics and experiences of former foster care youth, revealed that foster care alumni are more likely to complete high school by earning a general equivalency diploma rather than a diploma. In addition, the study found that less than half of the alumni (43.1%) were employed at least 10 hr/wk. About 1 in 4 (26.2%) were working at least 35 hr/wk, which is lower than in the general population (57.3%). Moreover, only one-third of alumni (32.3%) reported having a household income that was greater than the Federal Poverty Level (FPL), and only 12.3% reported having a household income that was at least 3 times greater than the FPL (HHS, 2014b).

Eventually, the lack of independent living, vocational, and health maintenance skills results in many former foster care youth receiving services as adults through the criminal justice system (i.e., arrested, convicted, or incarcerated) or the welfare system (Jonson-Reid & Barth, 2000; Needell, Cuccaro-Alamin, Brookhart, Jackman, & Shlonsky, 2002; White et al., 2012). For example, Courtney et al. (2005) found that one-third of former foster children who were tracked in their study of three Midwestern states had high levels of involvement with the criminal justice system. This less than successful transition into adulthood inevitably leads to health and disablement issues in later life, creating more problems both at the individual and societal levels and resulting in the need for more care and higher expenditures, including funds for institutionalization.

Each year, roughly 24,000 youth age out. Research documents numerous barriers that they must overcome to be successful adults. These barriers include poverty, mental health problems, lack of preparedness for the future, history of trauma, involvement with the criminal justice system, and unstable or unsupportive living and school environments (e.g., Blome, 1997; Collins, 2001; Courtney et al.,

2001; Kushel, Yen, Gee, & Courtney, 2007; Lemon et al., 2005). Another concern is that many of these youth do not have the opportunity or training necessary to acquire and master the independent living and employment skills needed for successful community living (Barth, 1990; Blome, 1997; Mech, 1994; Rashid, 2004). Typically, independent living skills are acquired gradually over time, in family environments, through observation and experience, and through guidance from nurturing adults. Instability in living situations and lack of consistent or healthy role models can impede development of these needed independent living skills.

Most states provide some form of independent living program for youth who have aged out, in response to the Independent Living Initiative (1986; Pub. L. 99–272) mandating transition services for this population. These programs are intended to prepare this population for adult independence by addressing a broad spectrum of independent living skills ranging from activities of daily living to education and vocation. Although these programs are mandated for youth preparing to transition out of foster care, they are underused. For example, only 42,600 youth in 40 states (about 60% of all eligible youth) received some type of independent living service in 1998 (Georgiades, 2005; U.S. General Accounting Office [GAO], 1999).

Reasons for underutilization of independent living programs may include poor communication with youth regarding available resources, programs that lack appeal and are not designed with young adults in mind (i.e., they are frequently delivered in offices through pen-and-paper activities and bear no resemblance to the activities and occupations young adults encounter in their everyday lives), and young adults' perception that they already possess the skills necessary for independent living and reluctance to further entrench themselves in a disempowering system (Paul-Ward, 2009). In addition, foster parents often play little, if any, role in the programs offered by case management agencies.

Even when programs have been used, they have not been effective (GAO, 1999; Stoner, 1999, as cited in Reilly, 2003).

Agencies are often not equipped with the appropriate staff to assess each client and to provide client-centered services to address individual needs. The result is that staff often do things for transitioning youth rather than assist them in learning how to do them for themselves (e.g., find housing, arrange for assistance for nonpayment of utility bills and resulting service termination). This situation may create learned helplessness in transitioning youth, teaching them to expect others to fix their problems rather than develop the skills needed to solve them. Learned helplessness can have negative life consequences for these young adults and place a huge financial and public health burden on society. Therefore, child welfare advocates have called for new intervention approaches to improve independent living and vocational skills in foster care youth (e.g., see <http://www.chapinhall.org/> and <http://www.cwla.org>).

Research to Understand the Needs of Transitioning Youth

Although the challenges and barriers to development of independent living skills have been identified, no individualized, occupation-based, client-centered interventions have been created or evaluated with controlled, experimental studies to address this important need (McMillen et al., 2005). To begin to fill this research void, exploratory work was conducted by Paul-Ward (2009) to collect qualitative data pertaining to perceptions of the foster care system. Findings from this ongoing research have indicated that youth preparing to exit foster care do not access available independent living programs in a personally meaningful way. According to the participants, this lack of utilization is due to several factors, including lack of knowledge of available services, lack of motivation and confidence to ask for such services, perceptions that these services are not for them, and the didactic and unengaging format of the services (i.e., programs use paper-and-pencil exercises rather than opportunities for experiential learning).

Other problems have been that most youth leaving foster care do not have a bank account; most of Paul-Ward's (2009) study participants reported having difficulties

with budgeting. The study also indicated a disconnect between young people's perceptions of their abilities and their actual possession of skills needed for successful transition to adulthood. Moreover, Paul-Ward has suggested that society holds higher expectations for adolescents in foster care than for teenagers in more stable family situations by imposing the need for self-sufficiency during the time they age out (i.e., ages 18–23 yr). The study also found no consistency across agencies regarding information about availability of independent living skills classes, resulting in poor attendance rates. A considerable number of study participants who had participated in independent living programs reportedly relied on the independent living staff to solve all problems. The result, as reported by staff, was that staff felt they were often reacting to emergencies rather than working proactively with clients to ensure that they learned and mastered problem-solving skills.

The lack of youth engagement and the didactic format of many independent living programs can result in adolescents leaving the foster care system with their skill needs unmet. However, practitioners working with foster care youth, regardless of disciplinary perspective, can move beyond the existing didactic models and implement innovative programs. These transition programs must be developmentally appropriate and provide opportunities for these youth to acquire the behaviors needed to master independent living, vocational, and health maintenance skills. Moreover, it is clear that a critical piece is missing from the program development process, namely, a client-centered approach that takes into account the target audience's perspectives and ideas about what constitutes useful programming. By offering innovative and client-centered approaches, these programs have the potential to provide a unique opportunity to engage professionals and transitioning youths in a meaningful, experientially driven process that supports the acquisition of the skills needed for these youths to become successful, self-sufficient adults.

Opportunities for the Profession

Because young people transitioning from foster care face so many disadvantages

and because existing interventions have failed to achieve positive outcomes, it is critical to adopt new theoretical and programmatic approaches to address their independent living, vocational, and health needs (see HHS, 2008). Occupational therapy practitioners are ideally suited to address these needs but traditionally have not been included in foster care programs. Occupational therapy is based on the understanding that meaningful occupations and activities, with their inherent power to maintain, restore, and transform one's sense of competency, are fundamental to health and well-being (Mee, Sumsion, & Craik, 2004; Wilcock, 1998). When people engage in meaningful occupations, their physical, mental, and emotional health are enhanced (Townsend, 1997).

As part of a generalist education, occupational therapy practitioners have acquired the knowledge and skills necessary to intervene at both the individual and the community levels. According to the *Occupational Therapy Practice Framework*, examples of interventions at the individual level may target client factors, such as emotional regulation and self-concept; performance skills, such as process and social interaction skills; activity patterns, such as engagement in health-promoting roles and routines; and occupations, such as activities of daily living, instrumental activities of daily living, education, and work. Additionally, practitioners can evaluate all aspects of the environment (most notably, the social and physical environments) to ensure that necessary supports are in place to promote success.

Much work has yet to be done at the individual level of foster care transitioning, and most occupational therapy practitioners are perhaps more familiar with the skills and interventions at this level than at the community level. However, to address the larger community and to build on the broader movement of social justice, practitioners cannot ignore the fundamental right of all people to participate in meaningful occupations, or *occupational justice*. *Occupational injustice* occurs when a person's participation in meaningful occupation is barred, limited, undeveloped, disrupted, or marginalized (Townsend & Wilcock, 2004). This notion is relevant to foster care

because by design, the foster care system tends to marginalize its “members” by institutionalizing them, not necessarily within physical structures but through systemic barriers (Paul-Ward, 2009). For example, the system disrupts occupations because children are often moved from one foster care home to another. Moreover, many of the factors associated with foster care lead to children’s underdevelopment in the areas of exploration and mastery of independent living skills, a phenomenon not typically seen in children in stable environments.

Empowerment, the process of giving voice and opportunities for participation to people regarding the decisions that affect their lives, is an important concept related to occupational justice. This process emphasizes a person’s responsibility to control his or her own life and resources. Therefore, use of an empowerment approach that moves the development of independent living, vocational, and health maintenance skills out of didactic classroom settings into the community, providing opportunities for experiential learning for real-life problem solving, is crucial to promoting successful transitions. We argue that instead of preparing youths in foster care with the skills necessary to overcome challenges, currently available programming suppresses their ability to assume responsibility by facilitating a culture of learned helplessness that serves to perpetuate the challenges they face.

The foster care literature has shown that a clear need exists to develop programs that address the challenges of foster care youth during transition, specifically, programs that increase the likelihood that these youth are equipped with the necessary skills to live independently, find employment, and maintain health and well-being (Courtney et al., 2005; McMillen et al., 2005). AOTA’s (2007) *Centennial Vision* recognizes the opportunities for occupational therapy practitioners to work in a broad range of settings with people who have diverse needs. The overarching areas of practice identified include mental health, children and youth, health and wellness, disability, and participation, all of which are relevant to the needs of youth transitioning out of foster care. With the *Centennial Vision* in mind, the needs of this population clearly

identified, health care shifting toward a greater emphasis on community-based prevention and care, and a professional calling to serve as agents of change and voices of advocacy, practitioners stand poised to meet the occupational needs of this underserved population.

The challenge for occupational therapy practitioners in delivering services to transitioning foster care youth is logistical because there is little precedent to do so. The independent living, vocational, and health maintenance skills needed by these youth are typically not reimbursable for practitioners working in community-based settings. The primary mechanism for reimbursement of such services in the community is Medicaid. To bill for these services under Medicaid, the practitioner must be recognized as a qualified mental health practitioner (QMHP). Currently, only a few states recognize occupational therapy practitioners as QMHPs. Although efforts have been made at both the state and national level to change the Medicaid status of occupational therapy practitioners, the struggle to adequately deliver services to community populations is ongoing. Despite this struggle, the profession cannot shy away from the challenge of meeting the needs of the underserved.

As health care reform rolls out, occupational therapy practitioners are positioned to play a larger role than before in the community. Now more than ever, the profession needs to identify alternative routes for service delivery and advocate for an occupational therapy presence in the community. One possible alternate route includes filling nontraditional roles in which practitioners can have a positive influence on the future outcomes of transitioning foster care youth without holding the title of occupational therapist or occupational therapy assistant. One such role includes functioning as a living skills provider. In this way, practitioners would have a direct impact on the service delivery model of developing independent living, vocational, and health maintenance skills in transitioning foster care youth. Occupational-based learning would be central to the process, and the match between the client and the activity could be tailored for success.

Another route to meeting this need includes developing partnerships between academic institutions and community-based programs that serve youth in foster care. Partnerships might involve service learning, program development, nontraditional fieldwork placements, or research projects (e.g., see Paul-Ward [2009]) to meet the occupational needs of these youth, which are currently not being adequately addressed by the system. In the early stages of these partnerships, intermural and extramural grants can fill the gap until traditionally recognized avenues of funding (e.g., insurance or third-party payer systems) become available.

Yet another route is to consider other professional activities that would increase awareness about occupational therapy services in foster care among stakeholders who are involved in foster care issues. For example, by publishing more widely in youth-oriented journals, occupational therapy practitioners who are working on foster care issues can add to the dialogue on policy and programmatic issues for improving foster care outcomes. In addition, to overcome limited financial resources, practitioners can serve as consultants to foster care agencies to incorporate experiential learning activities to help transitioning youth learn developmentally appropriate independent living, vocational, and health maintenance skills. Practitioners can also provide educational workshops that help agency staff better incorporate just-right activities for youth in their care.

Conclusion

The time has come for the occupational therapy profession to embrace community practice to help marginalized youth transitioning out of foster care. The current shift in the health care system toward prevention creates an environment that necessitates the need for occupational therapy practitioners and other care providers to assume leadership roles for tackling challenges in service delivery. It is imperative that occupational therapy as a profession embraces these new opportunities to provide much needed services to underserved youth, thereby answering the call to meet society’s occupational needs (AOTA, 2007). ▲

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