Foster Parents' Perceptions and Beliefs about Social Emotional Development in Infants and Toddlers

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REVIEW, APPROVAL AND ACCEPTANCE

The document mentioned above has been reviewed and accepted by the student’s advisor, on behalf of the advisory committee, and by the Associate Dean for MSN and DNP Studies, on behalf of the program; we verify that this is the final, approved version of the student’s Practice Inquiry Project including all changes required by the advisory committee. The undersigned agree to abide by the statements above.

Susan R. Noel, Student

Dr. Peggy El-Mallakh, Advisor
Final DNP Practice Inquiry Project Report

Susan R. Noel, PPCNP-BC, PMHNP-BC, MSN

University of Kentucky
College of Nursing
Spring 2015

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Dedication

This project is dedicated to my husband, Michael, who has tirelessly and patiently supported me in all my educational and professional endeavors. I would like to dedicate this project to the memory of a wonderful pediatrician, mentor, and friend, Dr. Thomas H. Pinkstaff. It was through his support and encouragement that I initially embarked on this particular educational journey. I would also like to dedicate this to all the foster parents and children in foster care that I have had the honor and privilege of learning from and working with.
Acknowledgements

This project has come to fruition due to the support, encouragement, and scholarly guidance provided by my committee chair, Dr. Peggy El-Mallakh and Dr. Patricia B. Howard, my faculty advisor. I would like to thank the other members of my DNP Project committee, Dr. Heather Risk and Dr. Otto Kaak, for their insight and knowledge about social-emotional development and the effects of trauma on young children. I am indebted to Sue Lindemann for the excellent transcription service she provided and to the many professors at UK College of Nursing DNP Program who played instrumental roles in challenging and expanding my knowledge and broadening my thinking skills.

I would like to thank my co-workers, Dr. Grace Maguire, Sandy Guinn, RN, Melody Kazee, RN, Judy Blackwell, MSW, Dr. Angela Houchin, and Dr. Susan Pollack for their encouragement and understanding as I pursued furthering my education and expanded my clinical experiences.

My husband, parents, and friends were a major source of strength as they encouraged me with their prayers, love, and patience. I give God the glory for sustaining me through a very difficult personal time during the process of completing this project.

I will be eternally grateful to the foster parents who participated in this project. Their willingness to share their knowledge, experiences, and insights is what made this project a reality. I hope that through this project a greater awareness of the need for social-emotional assessment and intervention for young children in foster care is realized and becomes a routine part of healthcare practice.
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DNP Practice Inquiry Project Overview

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University of Kentucky
DNP Practice Inquiry Project Introduction

Every year in the United States, thousands of children enter the foster care system due to the inability of their family of origin to provide a safe, secure living environment. Children in foster care have more physical and mental health needs than their peers. Recognition of the physical health needs is usually more apparent and also more easily addressed (i.e., available resources). Mental health needs, unless grossly obvious, may or may not be addressed. Even when mental health issues are identified, it can be very difficult to find available services to provide intervention due to the national shortage of mental health providers for children, especially for children younger than 5 years of age.

The underlying premise for this project was the goal of integrating mental health services into a primary care clinic for children in foster care. Integrated care would increase accessibility and collaboration for comprehensive and timely healthcare in a medical home that the children, and their foster parents, were already connected to and familiar with. A lack of mental health providers, (especially for young children), Medicaid restrictions on same-day billing, and a gap between science and practice regarding social-emotional development were some of the identified barriers to achieving an integrated practice.

Pediatric primary healthcare providers (PHPs) play an instrumental role in a child’s physical and psychological health and well-being. PHPs are usually the gateway into the healthcare system and they are a trusted informant and advisor for parents about a child’s health. The first manuscript, *Addressing the Mental Health Needs of Young Children in Foster Care in the Primary Care Setting*, addresses how PHPs can help foster
parents understand the impact of trauma on a young child’s social-emotional development. Parenting strategies are outlined that can address the social-emotional needs of a young child. Early identification and intervention may help to decrease the risk of on-going or escalating mental or behavioral health issues.

One of the major barriers to providing mental or behavioral health services in most primary care settings, in the state of Kentucky, is the inability to bill Medicaid for same-day services. The second manuscript, *Policy Change: Removal of Medicaid Same-Day Billing Restrictions in the State of Kentucky*, utilizes John Kingdon’s streams theory for political action and change to posit that Kentucky is in a prime position for a policy change. Same day billing would benefit children, and their families, by providing them with integrated and timely health care that would address both medical and mental or behavioral health needs.

Just as PHPs are the gateway into the healthcare system, foster parents are the gatekeeper for information about the young child in their care. Although the PHPs role is to assess and evaluate, the foster parent’s role is to present concerns and information about the child’s behaviors, activities, and responses to their environment. The third manuscript, *Foster Parents’ Perceptions about Social-Emotional Development of Infants and Toddlers*, is a qualitative descriptive study exploring what foster parents know and understand about social-emotional development. For PHPs and mental health specialists to effectively work with young children in foster care, it is important to understand what foster parents know about SE development and a child’s cues of potential distress or dysregulation.
The transactional model undergirds this project as a theoretical base for understanding the complexity and intricacy of SE development in young children with a trauma history. A young child’s development is fluid as is the interactions and transactions between the child and their environment. Nature and nurture are inseparable influences on a young child’s SE development.

This project is a synthesis of several critically important elements of doctoral education for Advanced Practice Nurses that were identified by the American Association of Colleges of Nursing (2006). These include scientific knowledge and evidenced-based practice, systems thinking, policy development, inter-professional collaboration, and integration and application of research. These essential skills were acquired through the course of studies and clinical experiences in the Doctor of Nursing Practice (DNP) degree program at the University of Kentucky College of Nursing.
Manuscript 1:

Addressing Mental Health Needs of Young Children in Foster Care

in the Primary Care Setting

Susan R. Noel, PPCNP-BC, PMHNP-BC, MSN

University of Kentucky
Abstract:

Children three years of age and younger are the fastest growing cohort in foster care. Separation from a primary caregiver during the first 3 years of life can have lifelong impact on the child’s social and emotional development. Primary healthcare providers are in a unique position to provide screening and initial intervention for social-emotional development which is the base for mental health. Early identification of social-emotional dysregulation or distress can lead to early interventions that may help decrease the risk of long-term sequelae. This article provides a review of the impact of foster care on the mental health of young children and the role that the primary healthcare provider can play in early detection and intervention.

Key Words:

Social and emotional development, social emotional dysregulation, infant mental health, young children, foster care, primary care
Addressing Mental Health Needs of Young Children in Foster Care in the Primary Care Setting

Separation from a primary caregiver during the first three years of life can have a lifelong impact on a child’s ability to form secure attached relationships, an ability that is one of the primary bases for the development of mental well being. In fiscal year 2013, children 3 years of age and younger represented 28% of the over 400,000 children in foster care in the U.S., and accounted for 37% of the 250,000 new placements (Administration on Children and Families [ACF], 2014). Children in foster care are at increased risk for mental health issues due to the psychological trauma of being removed from their primary caregivers and personal trauma many endured prior to removal (Landsverk, Burns, Stambaugh, & Rolls-Reutz, 2006; Oswald, Heil, & Goldbeck, 2010; Szilagyi, 2012). In addition, foster children are often exposed to poverty, violence, and mental health/ substance abuse disorders in their primary caregivers, all of which are known to be confounding risk factors for mental health disorders (Mekonnen, Noonan, & Rubin, 2009; Shonkoff et al., 2012).

Children in foster care have an increased incidence of medical illnesses compared to their peers, particularly chronic medical illnesses. However, it has been well documented that children in foster care are often delinquent in medical care (Jee, Tonniges, & Szilagyi, 2008; Mekonnen et al., 2009; Szilagyi, 2012). Studies also indicate that children in foster care have up to ten times more mental health and behavioral problems and utilize up to fifteen times more medical monies for mental health care than their peers (Horwitz et al., 2012; Mekonnen et al.; Pecora, Jensen,
Hunter, Jackson, & Ortiz, 2009; Pires, Grimes, Allen, Gilmer, & Mahadevan, 2013; Richardson, Mark, & Miller, 2013). In a 2002 policy statement, The American Academy of Child and Adolescent Psychiatry (AACAP) and the Child Welfare League of America (CWLA) estimated that 85% of children in foster care have a mental health and/or substance use issue. In 2008, an AACAP policy statement acknowledged that it is essential for mental health professionals to collaborate with pediatric medical professionals in order to meet the mental health needs of children.

Primary healthcare providers (PHPs) are usually the gateway into the healthcare system and therefore play a pivotal role in identifying mental health needs in young children. The purposes of this article are to 1.) describe mental health development in children ages 3 and under; 2.) describe the impact of children’s biopsychosocial environment on his/her development; and 3.) describe signs and symptoms of mental health problems in young children that are commonly encountered in primary care settings and warrant a detailed assessment for a psychiatric disorder.

Mental Health in Young Children

Mental health in young children is a social and emotional developmental process that encompasses the ability to regulate and express emotions, form secure relationships, and explore the environment (Zero to Three, n.d.). Social emotional (SE) development is rooted within the developing brain of a young child. Children do not develop within a vacuum; there are multiple factors that interact and influence a child’s potential for biological, psychological, and social development. Expectations of and experiences associated with the child’s family, community, and culture influence their
social and emotional development. Studies have found that the most malleable and impressionable time in the brain’s development occurs during the first three to five years of life (Cooper, Masi, & Vick, 2009; Dawson, Ashman, & Carver, 2000; National Scientific Council on the Developing Child, 2007). In addition, children under the age of 5 are dependent on caregivers to provide physical and emotional safety and stimulation. Neglectful or abusive parental behaviors, including inconsistent or absent physical or emotional interactions, failure to provide the child with intellectual stimulation, or the presence of real or perceived danger, can cause the child to develop a prolonged and persistent state of stress, known as “toxic stress” (Shonkoff et al., 2012). Toxic stress keeps the child in a perpetual state of fight or flight and alters the neurochemical production and responses in the brain that can eventually lead to changes in the brain’s structure and function.

A young child’s brain develops at a rapid pace forming neural circuit pathways that are influenced by the child’s internal and external environment. There are sensitive or crucial periods of time during brain development that affect the pruning and maintenance of the neural pathways. “Early experiences have a unique advantage in shaping the architecture of developing brain circuits before they are fully mature and stabilized” (National Scientific Council, 2007, p.3). Influences on brain development begin in utero. Fetal exposure to drugs and alcohol can alter the architecture and neuronal functioning of the brain resulting in behavioral dysregulation and learning disabilities (Fisher, Lester, DeGarmo, Lagasse, Lin, et al., 2011). Exposure to violence and inadequate nurturing (insufficient food, health, safety, and emotional interaction) can
also influence behavior, attachment and relationships, and learning potential (Center on the Developing Child, 2011; Chu & Lieberman, 2010; National Scientific Council).

Research has shown that there is a link between the development of right brain regulatory functions (the seat of emotions), relationship with a primary caregiver, and the development of a healthy emotional state, which consequently allows the child to form relationships and adapt to a changing environment throughout his or her life (Schore, 2005). The responses of young children to the experiences and influences on their social emotional development become an intricate part of their brains’ architecture (Child Welfare Information Gateway, 2009; National Scientific Council, 2004). For example, the hippocampus is responsible for formation, storage, and retrieval of memories, along with the creation of links between memories and emotional responses.

Studies have identified structural and functional changes of the hippocampus among older children and adults who experienced maltreatment. In a small study of young women who had experienced sexual abuse as preschoolers (3-5 years of age), Anderson et al. (2008) found a reduction in their hippocampal volume. Teicher et al. (2012) found that young adults with a history of childhood maltreatment (age of maltreatment was not delineated) had reduced hippocampal volumes.

Research further suggests that children who have fearful and stressful memories may be more prone to mood disorders and dysfunctional attachments. In a small longitudinal study Huang et al. (2012) found that adolescents who had been subject to maltreatment when younger, and who later developed mood disorders and substance use disorders, had disruptions in their brain white matter (in the hippocampal region).
Hanson et al. (2010) found that adolescents who had suffered from chronic physical abuse had smaller brain volumes especially in the orbitofrontal cortex with resultant problems in learning, behavior, and peer and family relationships. Structural and biochemical changes in the brain can have a life-long impact on the way children interact and respond to people and situations, affect their cognitive development, and predispose them to behavioral and mental health issues (Shonkoff et al., 2012).

Abnormal or irregular brain development among abused and neglected children has been linked to societal and interpersonal problems in addition to problems in physical and psychological well-being. Interest in the effects of internal and external stimuli on the brain has become a multidisciplinary science incorporating physiological, psychological, social and economic sciences (Cooper, Masi, & Vick, 2009; Dawson, Asher, & Carver, 2000; Shonkoff et al., 2012). If a child does not mature socially and emotionally this can result in the inability to form secure attachments and later develop meaningful relationships. Poor social interactions and relationships can also influence a child’s ability to learn and eventually be productive in the workforce; this can having lasting economic impact for not only the child but also society.

Mental Health Assessment of Young Children in the Primary Care Setting

Early identification of social and emotional needs, the building blocks of mental health, in young children may lead to a decrease in the incidence of severe and protracted behavioral and mental health disorders as they age. In the United States there is a dearth of mental health care providers to meet the behavioral and mental health needs of children (AACAP, 2010; AAP Policy Statement, 2009). There is an even greater deficit
of mental health providers who provide services for children three years of age and younger.

Primary Healthcare Providers (PHPs) are the focal point for entry into the healthcare system for most children. During a child’s first three years of life there are multiple opportunities for the PHP to encounter the child and family. The family learns to trust and depend on the PHP for information and advice in all areas of health and growth and development. The periodicity schedule set forth by the American Academy of Pediatrics (AAP) for children three years and younger includes at least nine well child exams providing PHPs with multiple opportunities to assess and address physical, developmental, and psychosocial needs (AAP Bright Futures, 2006). The American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP) have issued policy statements recognizing the need to provide mental health services in the primary care setting (AAP Policy Statement, 2009; AAFP Position Paper, 2001). These organizations recognize that there are not enough mental health providers to cover services for all the needs. They also acknowledge that many patients will not seek out a mental health provider but will confide in, and accept treatment from, their PHP. Nurse practitioner programs are incorporating more behavioral and mental health curricula into their primary care programs to address these needs (Hawkins-Walsh, 2004; Melnyk et al., 2010; Van Cleve, Hawkins-Walsh, & Shafer, 2013).

PHPs should have a heightened awareness that social and emotional distress and dysregulation may be subtle and shrouded within somatic signs. Foster parents, as are all parents, are usually attuned to skill acquisition and physical, motor, and language development. If there are overt signs of distress such as a young child refusing to be
held, head banging, or excessive crying the foster parent may be more inclined to express concern; otherwise, social and emotional development may not be on their agenda of concerns.

It is critically important that foster parents and PHPs collaborate to identify and monitor more subtle signs of emotional distress in foster children. Young children do not have the cognitive and verbal skills to express their emotions, and therefore use physical and behavioral manifestations to express both good and bad emotions and feelings. There are four key areas in which the Primary Healthcare Provider (PHP) should provide a thorough assessment to tease out any subtle somatic or behavioral expressions of social emotional distress; these include eating/feeding habits and patterns, sleep, comfort and emotional regulation, and interactions or relational issues. Table 1 provides an overview of signs and symptoms within each of these domains that may indicate a young child is experiencing social emotional distress or dysregulation (AAP Toolkit, 2010; Mayer, Anastasi, & Clark, 2006; www.michigan.gov/mdch; Zindler, Hogan, & Graham, 2010). It is also imperative to rule out medical or physiological sources for the signs and symptoms. For example, a child who is not gaining weight warrants further investigation for sources of failure to thrive. A child who is not talking should have a hearing evaluation. A child who makes little eye contact and/or does not engage socially should be evaluated for autism spectrum disorders.

A red flag should go up whenever a foster parent describes a young child as “good.” The PHP should explore the foster parent’s qualifiers for being “good” to determine if the behaviors are indicative of a child with an easy-going temperament or a child in social emotional (SE) distress. A docile child could be withdrawing emotionally
and socially due to mental distress, much the same way an older child or adult withdraws when depressed (Szilagyi, 2012; Zindler, Hogan, & Graham, 2010).

The PHP should assess the child’s social emotional status at least at every well child exam. If the child presents for frequent acute or chronic illness visits, the PHP should consider assessing for changes in the child’s social emotional status that may be presenting through somatic manifestations. Studies have shown that more data are consistently obtained when standardized tools are used than when screenings are conducted primarily through history and cursory observations (Brown, & Wissow, 2010; Jee, Conn, Szilagyi, Blumkin, & Baldwin, 2010). The American Academy of Pediatrics 2006 Policy Statement recommends that all young children be screened with standardized tools for risks of social, developmental, and behavioral delays. There are several tools that can be used to assess overall development; however, most of the tools only include a few items pertaining to social and emotional development. A screening tool specifically focused on SE development should be used for young children in foster care due to their increased risk for SE distress and dysregulation and the often subtle presentation.

The American Academy of Pediatrics has identified several mental health screening, assessment, and diagnostic tools for use in primary care (AAP, 2010). For a tool to be effective and consistently used in the primary care setting it needs to be easily accessible and easy to administer and score. The AAP identified two screening tools for use with children three years of age and younger. The Bright Futures tool is a mental health surveillance that utilizes open-ended questions from birth through eighteen years of age. The tool is free and available from the AAP. There are no available psychometrics for sensitivity or specificity outcomes. The Ages and Stages
Questionnaire: Social Emotional (ASQ:SE) is a psychosocial screening that can be completed by paper and pen or computerized. It is a self-report completed by parents/guardians for children 6 to 60 months of age. It is a proprietary tool but does not require special training. The tool has good sensitivity of 71-85 percent and excellent specificity of 90-98 percent. The ASQ:SE has been studied in both primary health care settings and preschool/daycare settings (Briggs et al., 2012; Brown, Copeland, Sucharew, & Kahn, 2012; Jee, et al., 2010). Jee et al. used the ASQ:SE to specifically screen children in foster care. They found that a general developmental screening tool did not detect the psychosocial concerns for children in foster care as effectively as a screening tool specifically attuned to social emotional needs.

Intervention and Referral

Providing anticipatory guidance to families about their child’s physical and psychosocial development is a mainstay of pediatric healthcare. Many of the parenting tips given to promote healthy bodies and minds can also be used to help foster parents diminish the adverse effects of the trauma the child has endured. Several strategies are available that PHPs can recommend for foster parents to increase their repertoire of parenting skills that focus on social and emotional development of foster children; some of these are displayed in Table 2. Again, these parenting strategies are focused on the primary areas in which young children express or demonstrate their social-emotional developmental stability or distress; these include the areas of feeding or eating, sleep, comfort and emotions, and interactions and relationships. PHPs should help foster parents understand that foster children need a safe, secure, and consistent environment and interactions with other people to re-establish trust so that they can move forward in their
development. Foster parents need to be reassured that they are not “bad” parents if the child does not readily respond to them, and that they should continue to consistently provide a nurturing environment. Young children should be given a minimum of 3 to 4 weeks to begin to adjust to their new environment. If the child is not beginning to respond or their symptoms of distress are not diminishing in intensity beyond that period of time in spite of efforts by the foster parent, or if at any point in time the symptoms escalate, then a referral to an infant mental health specialist is warranted. If an infant or young child mental health specialist is not available in the clinic, other resources for assistance can include university settings that have a pediatric psychiatry, psychology, or human development department, state and federally funded early intervention programs (IDEA-Part C), child care centers with an early childhood specialist, and community mental health centers.

Conclusion

Primary healthcare providers (PHPs) are in a unique position to screen, assess, intervene, and if needed, refer young children for social and emotional developmental needs. The primary care setting is a familiar, trusting, and accessible site for families to seek assistance and guidance. PHPs need to cultivate a heightened awareness of the interplay between physiological, behavioral, and emotional manifestations and the impact on the mental health of young children. Special attention should be placed on children in foster care due to their increased risk of exposure to personal, relational, and environmental trauma. Studies have shown that adolescents and young adults can recall experiences that occurred at a very young age, and that these memories can trigger mental stress responses (Bruskas, 2008; Johnson & Blum, 2012; Pecora, 2010). This
refutes the hypothesis that children will not remember experiences that occurred when they were infants, toddlers, or preschoolers and therefore will not suffer harmful mental health effects. Research has also demonstrated that the effects of stress and trauma on brain development contribute to risky behaviors in childhood and adolescence (Kinscherff, 2012). The psychological trauma children experience can have a lifelong impact on their cognitive, psychosocial, emotional, and physical health. Early identification and assessment of social and emotional disruption and dysregulation can lead to early interventions that may help decrease the risk of long-term mental health and behavioral sequelae.
References


Table 1.

<table>
<thead>
<tr>
<th>Signs &amp; Symptoms of Social-Emotional Distress or Dysregulation</th>
</tr>
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<tbody>
<tr>
<td><strong>Eating/Feeding</strong></td>
</tr>
<tr>
<td>• Not interested in feeding /eating—eating less than normal for age</td>
</tr>
<tr>
<td>• Wanting to eat all the time—never seems to get full/satisfied</td>
</tr>
<tr>
<td>• Poor or excessive weight gain</td>
</tr>
<tr>
<td>• Upset/fussy during or after feeding</td>
</tr>
<tr>
<td>• Does not want to cuddle with feeding</td>
</tr>
<tr>
<td>• Vomits after eating (may be self-induced)</td>
</tr>
<tr>
<td>• Refuses to feed self (by 18 months old)</td>
</tr>
<tr>
<td>• Eats non-food items—paper, dirt, fabric (need to check iron and lead levels)</td>
</tr>
<tr>
<td>• Has temper tantrums related to food or eating</td>
</tr>
<tr>
<td><strong>Sleep</strong></td>
</tr>
<tr>
<td>• Difficulty going to sleep—screams and cries when put in the bed</td>
</tr>
<tr>
<td>• Refuses to stay in the bed or sleep in the bed</td>
</tr>
<tr>
<td>• Difficulty staying asleep—wakes &amp; cries often during the night (refuses or does not need bottle)</td>
</tr>
<tr>
<td>• Wakes screaming and shaking, unable to console</td>
</tr>
<tr>
<td>• Sleeps more than other children same age</td>
</tr>
<tr>
<td>• Unable to establish a routine</td>
</tr>
<tr>
<td><strong>Comfort/Emotions</strong></td>
</tr>
<tr>
<td>• Excessive crying—cries for hours and hard to calm down</td>
</tr>
<tr>
<td>• Unable to calm self some of the time (by 6-12 months)</td>
</tr>
<tr>
<td>• Difficulty being soothed or comforted—does not respond to caregiver’s consoling</td>
</tr>
<tr>
<td>• Excessive clinginess for age—does not separate from caregiver to explore environment (even after “warming up” period)</td>
</tr>
<tr>
<td>• Excessive fearfulness for age</td>
</tr>
<tr>
<td>• Easily frustrated trying to do things other children same age can do</td>
</tr>
<tr>
<td>• Frequent temper tantrums</td>
</tr>
<tr>
<td>• Appears “expressionless”—rarely smiles, rarely cries</td>
</tr>
<tr>
<td><strong>Interactions/Relationships</strong></td>
</tr>
<tr>
<td>• Poor eye contact—refuses to look at caregiver during feedings, when being held, or during activity (play)</td>
</tr>
<tr>
<td>• Shows limited response to the environment—does not react to sounds, light, movement, does not react to other people or animals, limited interest in exploring</td>
</tr>
<tr>
<td>• Shows limited response to caregiver—does not smile or coo in response to interactions, does not imitate activities or behaviors (“raspberry” sound); arches back or pulls away when held</td>
</tr>
<tr>
<td>• Poor engagement with primary caregiver—does not like to sit on lap for story, does not engage in interactive game (peek-a-boo, pat-a-cake), prefers to be left alone</td>
</tr>
<tr>
<td>• Aggressive behaviors—towards self and others: hitting, kicking, biting, pulling hair, banging head</td>
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AAP Toolkit, 2010; Zindler, Hogan, & Graham, 2010; Mayer, Anastasi, & Clark, 2006; www.michigan.gov/mdch
Table 2.

<table>
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<tr>
<th>Parenting Interventions for Healthy Social-Emotional Development</th>
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<tbody>
<tr>
<td><strong>Eating/Feeding</strong></td>
</tr>
<tr>
<td>• Hold baby when feeding with ‘en face’ positioning</td>
</tr>
<tr>
<td>• Encourage child to touch, pick up finger foods</td>
</tr>
<tr>
<td>• Offer frequent small meals and snacks</td>
</tr>
<tr>
<td>• Talk to baby/child during feedings and meals</td>
</tr>
<tr>
<td>• Eat at the table, leave the table when the meal is completed</td>
</tr>
<tr>
<td>• Reassure child that there will be a snack later</td>
</tr>
<tr>
<td>• Do not force feed</td>
</tr>
<tr>
<td>• Offer healthy/nutritious foods and snacks, do not succumb to junk foods just to get the child to eat</td>
</tr>
<tr>
<td>• Limit liquids if child prefers to drink instead of eat solids</td>
</tr>
<tr>
<td><strong>Sleep</strong></td>
</tr>
<tr>
<td>• Develop a routine—snack, bath, pajamas, read, cuddle</td>
</tr>
<tr>
<td>• Leave a night light on</td>
</tr>
<tr>
<td>• Play soft music</td>
</tr>
<tr>
<td>• Do not rock to sleep—rock till drowsy then place in bed</td>
</tr>
<tr>
<td>• When child cries out during night let them know you are near; try to avoid physical interaction; if child is very distressed, cannot soothe self --pat or rub their back, try to keep conversation to a minimum</td>
</tr>
<tr>
<td>• Make a pallet on the floor if child climbs out of bed to reduce risk of falling and being injured; try to start them off in their bed each night</td>
</tr>
<tr>
<td><strong>Comfort/Emotions</strong></td>
</tr>
<tr>
<td>• Pick up and soothe when crying; speak in soft, sing-song voice</td>
</tr>
<tr>
<td>• Name feelings—happy, sad, mad</td>
</tr>
<tr>
<td>• Give hugs</td>
</tr>
<tr>
<td>• Provide comfort items—blanket, toy, pacifier</td>
</tr>
<tr>
<td>• Monitor for signs of frustration—provide opportunities for child to be successful at a task</td>
</tr>
<tr>
<td>• Express delight/pleasure when child attempts to perform task; is successful in task; Provide encouragement when child is not successful or frustrated with task</td>
</tr>
<tr>
<td><strong>Interactions/Relationships</strong></td>
</tr>
<tr>
<td>• Sing and talk with child</td>
</tr>
<tr>
<td>• Play interactive games</td>
</tr>
<tr>
<td>• Allow child to slowly warm up and join an activity—then express pleasure/delight that child has joined in</td>
</tr>
<tr>
<td>• Stay with child in new settings until they are ready to venture away from you</td>
</tr>
<tr>
<td>• When leaving, reassure of your return—when you pick them up remind them that you said you would be back</td>
</tr>
<tr>
<td>• No harsh punishments—spanking, screaming, hollering</td>
</tr>
<tr>
<td>• Make discipline appropriate for age—directed toward action not child; set limits and be consistent</td>
</tr>
<tr>
<td>• Give 5 praises for every negative comment</td>
</tr>
<tr>
<td>• Read to child everyday</td>
</tr>
<tr>
<td>• Encourage pretend play; encourage exploration</td>
</tr>
</tbody>
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Mayer, Anastasi, & Clark, 2006; www.michigan.gov/mdch
Manuscript 2:

Policy Change:

Removal of Medicaid Same-Day Billing Restrictions in the State of Kentucky

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Abstract

Children and adults in the United States do not receive adequate screening and treatment for behavioral and mental health needs. Recent studies have shown that psychological stresses impact physical health and vice versa. People need to be treated holistically in order to optimize both their physical and mental health yet there are multiple barriers to receiving adequate behavioral and mental health care. Factors include personal and social stigma about mental health, accessibility to providers, availability of providers, and financial restraints. Several successful models across the U.S. have demonstrated that people have improved outcomes when they have access to receiving care for both their medical and mental health needs on the same day at the same location. The purpose of this paper is to address one of the restraints—same-day billing restrictions. Kingdon’s multiple streams model will be used to illustrate how to pursue changes in the reimbursement structure for same-day billing for medical and mental health services in Kentucky. The role Advanced Practice Nurses can play in the policy change process will also be explored.

Key Words: same-day billing, Kingdon, Medicaid, mental health
Policy Change:

Removal of Medicaid Same-Day Billing Restrictions in the State of Kentucky

The totality of health includes both physical and mental components. An interconnectedness exists between the body and the mind that determines a person’s overall well-being. Furthermore, there is a strong relationship between mental disorders and chronic physical health conditions (Center for Disease Control [CDC], n.d.). Nonetheless, for decades, physical health and mental health care have been delivered in separate and distinct systems. This has resulted in a break in communication and collaboration between healthcare providers, leading to fragmented and duplicated services for patients (Horvitz-Lennon, Kilborne, & Pincus, 2006; Kutcher, Davidson, & Manion, 2009). Restrictions on billing for both medical and mental health services from the same provider and/or the same facility have also presented problems for patients who require timely and efficient access to their healthcare needs.

Many people think of mental health as being synonymous with mental illness thus creating a stigma around the concept of health care for the mind and emotions (Corrigan, Druss, & Perlick, 2014). The World Health Organization [WHO] (2014) defines mental health as “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her own community.” In contrast, mental illness is a result of abnormalities in brain functioning which results in alterations in behavior, mood, thinking, and decision-making (CDC, n.d.). Similarly to medical care, mental health care focuses on both prevention and treatment of mental illnesses.
Mental health disorders rank in the top five conditions for healthcare expenditures in the United States for both children and adults (Davis, 2012; Roemer, 2009; Soni, 2014). Although mental health conditions are prevalent, treatment accessibility and availability is lacking for this greatest health disparity in the U.S. Although 18-20 percent of adults and 13-20 percent of children and youth have mental health needs, less than 50 percent receive any kind of treatment (MMWR, 2013; Stagman & Cooper, 2010). Despite the prevalence of mental health conditions, treatment accessibility and availability are lacking for this greatest health disparity in the U.S.

Healthy People is a national program that aims to promote health and prevent diseases. In addition, the Healthy People 2020 program has endorsed the goal of promoting health equity among all people in the U.S. (HealthyPeople, n.d.). Health equity includes more than eliminating disparities; it further involves the “attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities” (HealthyPeople).

The 2010 Affordable Care Act (ACA) and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) have provided a foundation to optimize access to health care, including mental health care (Center for Medicare & Medicaid Services [CMS], n.d.; Substance Abuse and Mental Health Administration [SAMHSA], n.d.). Behavioral and mental health benefits are included in the essential benefits covered as mandated by the ACA (CMS, n.d.). In 2012, Kentucky Governor Beshear signed Executive Order 587, in response to the ACA, to expand eligibility requirements for
Medicaid and develop a state “marketplace” insurance plan; this became effective in 2014, thereby increasing the number of people in the state who are eligible to seek mental healthcare services (Pugh, 2014; Office of Governor Beshear, 2012). This provision eliminates one of the barriers to accessibility of mental health services; however, other barriers remain including availability of mental health care providers and reimbursement restrictions.

This paper will propose a policy change for Medicaid billing, in the state of Kentucky, that would allow for reimbursement of same-day medical and mental health services at the same facility and/or by the same provider. John Kingdon’s (2011) theory of policy process will be utilized to frame the problem about restricted billing and reimbursement as well as present policy ideas for removing the restrictions. The political climate and players that will enable the policy change to move through the political system will also be addressed. This policy change proposal will describe feasible strategies to promote timely and efficient screenings and treatment that potentially could decrease the severity of medical and or mental health issues. Addressing this issue through policy is critical because when people do not receive needed behavioral and mental health services, “They become caught in the revolving door of repeated hospitalizations, involvement with the criminal justice system, homelessness and, sadly, in some cases suicide” (Schuster, 2012).

Nurses throughout the history of the profession, have followed in the footsteps of founding mother Florence Nightingale in being advocates to ensure that patients and clients receive education and services to optimize their overall health and well-being. Advanced Practice Nurses (APNs), as direct healthcare providers, are keenly aware of
patient needs and available resources and the challenges associated with the complexity of the healthcare system. APNs need to be actively involved in the policy process to bring change to the healthcare system to promote optimal access, availability, and reimbursement for integrated healthcare.

The Issue

Physical health conditions, especially chronic illnesses, can lead to comorbid mental health disorders that can influence the overall well-being of a person (Chapman, Perry, & Strine, 2005; Kaiser Family Foundation [KFF], 2011; Unützer, 2013). Conversely, people with mental health disorders, especially chronic conditions, are at high risk for comorbid health conditions that can result in disability and premature death (Croft & Parish, 2012; Druss & Walker, 2011; National Association of State Mental Health Program Directors [NASMPD], 2010;). Untreated, or undertreated, health issues—whether physical or mental—place a burden on the individual, family members, and society.

The ACA provides incentives to integrate service delivery for both medical and mental health care for those with serious mental illness and substance use disorders (Miller, Lentz, Maududi, & Harding, 2013). Integration of physical and mental health care breaks down many of the barriers that interfere with people receiving comprehensive and timely services, namely, access and financing (Croft & Parish, 2012). A patient-centered approach, communication, collaboration, and continuity of care along with quality measurement and improvement are fundamentals of integrated care (Croft & Parish). The ACA has mandated that the eligibility expansions provide full parity, which
means that a person cannot be denied coverage due to a pre-existing condition and limits applied to mental health services cannot be more restrictive than those applied to medical or surgical health services (U.S. Department of Labor, 2014).

Medicaid has created a state plan option for the development of health homes for people with multiple chronic conditions. Health homes are usually led by a single provider who oversees a care delivery team for individual patients. Health homes are eligible to receive 100 percent funding match from the federal government for the first three years (2014-2017), then will decrease to 90 percent by the year 2020. (Miller & Stuart, 2014; Office of Governor Beshear, 2012). The Accountable Care Organization (ACO) model, under Medicare, coordinates services for multiple clients receiving services from multiple providers. The ACO and participating providers share costs and savings; they can be eligible for enhanced payments if they meet quality performance standards that include electronic health records (Miller & Stuart). ACOs have already demonstrated savings in the first year of operations. As of September 2014, there was a $128 million net savings in the Medicare trust fund and ACOs qualified for $445 million in shared savings payments (Miller & Stuart). Although there are incentives to provide integrated, comprehensive, and collaborative care, reimbursement structures prevent many patients from receiving timely services due to restrictions on same-day payments.

Although Kentucky purports to be a progressive state in providing expanded and affordable healthcare coverage, it is one of 14 states that do not allow providers or healthcare facilities to bill Medicaid for both medical and mental health codes on the same-day (SAMHSA, n.d.). This limitation creates a hardship for patients and their families. Patients, or in the case of dependent individuals—a family member or friend,
must take additional time off from work or school to attend another appointment to receive dual services. This places a burden on a person’s financial resources due to extra expenditures for insurance co-pays or out of pocket appointment costs, transportation costs, child-care costs, and potentially lost wages or jobs. Many people will forego seeking the additional healthcare services needed until it becomes a crisis.

Medicaid is the largest payer for behavioral and mental health services not only in Kentucky but nationally (KFF, 2011). There are projections that over 300,000 previously uninsured people in Kentucky will be eligible for the Medicaid expansion and over 350,000 will participate in the marketplace insurance programs (Office of Governor Beshear, 2012). Of those who are newly eligible to enroll in the Medicaid program, an estimated 47.5 percent will have behavioral and mental health needs (Pugh, 2014) creating a strain on the mental healthcare provider market.

Currently, less than 20 percent of Kentucky adults with a serious mental illness receive care through the state’s public mental health system (National Alliance for Mental Illness [NAMI], 2010) and there are currently 90 designated mental health care Health Professional Shortage Areas (HPSA) in Kentucky (KFF, 2013). Mental health HPSAs are areas that have less than one psychiatrist per 30,000 people in a designated area; in comparison a primary care HPSA ratio is 3,500:1.

Background

Kentucky ranked lowest, among all the US states, for emotional health according to the 2011 Gallup-Healthways Well-Being Index Survey (Smith, Cambron, & the State Epidemiological Outcomes Workgroup [SEOW], 2012). In 2012, the Kentucky SEOW
investigated trends in mental health among adults in the state. The SEOW measured frequency of mentally unhealthy days, defined as days with stress, depression, and/or problems with distressing emotions (Smith, Cambron, et al.). Findings suggested that adults, ages 18-64 years, reported having an average of 4.3 mentally unhealthy days per month compared to the national average of 3.5 days. The average number of days in rural areas was as high as 9.3. Based on study findings, the SEOW recommended more behavioral and mental screening and interventions be available and accessible for Kentuckians (Smith, Cambron, et al.).

Serious mental illness (SMI) was reported by 5.4 percent of adults in Kentucky compared to 4.6 percent nationally (Smith, Cambron, et al., 2012). A SMI causes functional impairment that interferes with the ability to perform major life activities such as work, attend school, perform self-care activities, and/or engage in appropriate social functioning (CDC, n.d.). Kentuckians, aged 18 years and older, had more serious thoughts of suicide than the national average (3.9 percent compared to 3.7 percent) and their suicide mortality rate was also higher (13.3 versus 10.8 per 100,000) (Smith, Cambron, et al.). When mental illness is untreated or undertreated, the risk of suicide dramatically increases (NAMI, 2010).

Mental health disorders also have a profound effect on children either through personal illness or through the effects of living with a family member affected by mental illness. The National Center for Children in Poverty (NCCP) reported that 20 percent of children have a diagnosable mental disorder and 10 percent of youths have a serious mental disorder (Stagman & Cooper, 2010). Mental illness can begin as early as 7 years of age and half of lifetime serious mental illnesses start by the midteens (MMWR, 2013;
Stagman & Cooper). Fifty percent of children in the child welfare system have mental health issues (Stagman & Cooper). Mental health disorders influence children’s academic and social success and can have lifelong effects (Mekonnen, Noonan, & Rubin, 2009; Szilagyi, 2012). Preschool children with behavioral disorders are expelled from school three times more than all other ages of children (Stagman & Cooper). In addition, Kentucky students who have serious mental disorders are at high risk for dropping out of school. “During the 2006-2007 school year, approximately 46 percent of Kentucky students aged 14 and older living with serious mental health conditions who receive special education services dropped out of high school” (NAMI, 2010).

A Medicaid policy change is needed so that people of all ages, living in all areas of Kentucky, can have timely and efficient access to both medical and mental healthcare. The limited behavioral and mental health resources could be spared for more serious and chronic issues if patients could be treated efficiently and timely in the primary care setting.

Kingdon’s Theory for Policy Change

Kingdon’s theory of policy process provides the framework for advancing a policy change in Kentucky to remove the same-day billing barrier for people seeking medical and mental health care services. Kingdon’s theory identifies three streams—the problem stream, the policy stream, and the political stream—that determine if a new policy or policy change has a chance of becoming law (Kingdon, 2011). The streams function and operate independently until a critical point in time when coupling or intersecting occurs that gives heightened awareness or importance to the issue or solution
When this coupling occurs there is impetus, energy, and perceived opportunity for advocates to latch onto the issue to supply their solution and thus have their agenda recognized and hopefully adopted (Kingdon). Advanced Practice Nurses (APNs), by virtue of their experience, knowledge, and education, can be powerful advocates and players in healthcare policy design, development, and implementation.

The Problem Stream. In Kingdon’s model, the problem stream focuses on a particular issue. Problems can be framed in terms of societal values, change in the state of a systematic indicator, or a crisis or disaster (Kingdon, 2011; Henry, 2007; Laraway & Jennings, 2002). In order for a problem to get attention and be addressed it must be something that the actors in the politics stream believe they can do something about.

The problem has been brought to the national forefront by the Affordable Care Act (ACA). The ACA has essentially opened the door for healthcare to everyone in the United States. Availability, accessibility, and affordability of health care are societal values—whether it is the government’s responsibility is debatable among politicians and the public. The ACA has mandated behavioral and mental health care as part of the essential benefits that every person should receive (SAMHSA, n.d.). Prior to the implementation of the ACA, the crisis in healthcare was the number of uninsured. The impending crisis, in Kentucky and nationally, will be the newly insured who have limited availability and/or access to mental health providers.

Many people are still reluctant to seek out mental health care in part due to the stigma and misinformation that continues about mental health and mental illness. The National Center for Children in Poverty (NCCP) reports that 40-60 percent of all mental
health care is initiated by a primary care provider (2007). Eliminating same-day billing restrictions would allow more people the ability to have more timely, and possibly more efficient, medical and/or mental health care. The KFF reported, in 2011 and 2012, that there are 146 designated Rural Health Clinics (RHC) and 19 Federally Qualified Health Centers at 92 sites in Kentucky (KFF, 2013). Both RHC and FQHC cover mental health services provided by physicians, APNs, physician assistants, clinical psychologists, and clinical social workers (CMS, n.d.). The ability to receive mental health services in a setting that most people are comfortable in may encourage more people to seek behavioral and mental health care.

APNs can play a crucial role in educating patients, families, and the general public about mental health and its impact on health and well-being to help decrease stigma associated with mental health. The incorporation of mental wellness assessments by APNs into patient encounters can help to “normalize” the integration of body and mind healthcare. APNs also need to be actively involved at the local, state, and national level in educating policy makers, health insurance companies, and employers on the benefits of their constituents, clients, and employees receiving comprehensive and coordinated care in a timely and effective manner. Presenting patient vignettes can be a powerful “real life” influence on decision makers.

The Policy Stream. The second stream in Kingdon’s model is the policy stream. It is composed of ideas that politicians, experts in the field, citizens, and others have related to an issue. The ideas, initially, may not be directly related to a specific problem or issue but eventually the ideas begin to ‘attach’ to the issue as possible solutions. The criteria for selection of an idea include public acceptability of the solution and
congruence with their values, receptivity by the policy makers, and technical feasibility (Kingdon, 2011).

Many ideas about healthcare delivery and benefits have ‘floated’ around in the policy stream for years. For the past 50 years, the president and government leaders in the U.S. have launched ideas for healthcare (Weissert & Weissert, 2006). During the Clinton administration there was a major thrust to have a national health insurance plan; the support was not there to make it a reality. The Obama administration has been able to push the agenda and in 2010 the Affordable Care Act was signed into law. There have been many ideas about how to make the law work. Kentucky became one of the first states to develop and initiate plans that would provide insurance coverage for all citizens in the state. Medicaid eligibility was expanded and a ‘marketplace’ insurance plan was developed for those who did not qualify for Medicaid (Office of Governor Bexhear, 2012; Pugh, 2014). Although Kentucky has made health insurance available to all citizens, it continues to restrict same-day billing placing unnecessary hardship on people seeking services. APNs can be involved at this stage of the policy process by contacting local and state legislators and educating them on the impact of the issue. APNs can share vignettes of the legislature’s constituents and how changes to the policy would benefit not only the constituents but also the community and state.

Same-day billing could be phased in so that the state could monitor billings, reimbursement, and outcomes. Populations at high-risk should be the first to be allowed to have same-day services. Adults and children with serious mental illnesses or serious emotional disorders, based on diagnostic criteria in the Diagnostic and Statistical Manual, 5th Edition [DSM-V], should be the first group to receive services to help
decrease progression and severity of symptoms of both medical and mental health needs. The next phase should address children in foster care and people with chronic medical conditions. Children in the child welfare system have more untreated health issues, chronic health issues, and are at high risk for behavioral and mental disorders (Pires, Grimes, Allen, & Mahadevan, 2013; Richardson, Mark, & Miller, 2013). People with chronic illnesses are at high risk for mental health disorders that can have negative consequences for their physical health (Chapman, et al., 2005; Druss & Walker, 2011). Another alternative would be to allow same-day billing for telemedicine for facilities that have both mental health and medical service providers that may not be on-site. This could be especially beneficial for rural areas of the state.

The Political Stream. The third stream in Kingdon’s model is the political stream. It is composed of the public or national mood, organized political forces, and events within government (Kingdon, 2011). Kingdon provides a very narrow definition of “political” it includes “electoral, partisan, or pressure group factors” (p.145). It is the climate of influence, persuasion, and power by which the elected officials make decisions. Voting constituents, special interest and grass roots groups, and professional organizations need to be involved in framing the problem and potential policy ideas.

Several national organizations are committed to the mission of public education and advocacy for equitable and effective treatment for people with mental health disorders. Most of the organizations have state and or local affiliates. Resources from the National Alliance on Mental Illness (NAMI), the National Institute for Mental Health (NIMH), the American Psychiatric Nurses Association (APNA), the International Society for Psychiatric Mental-Health Nursing (ISPMHN), and the National Council for
Behavioral Health (NCBH) should be utilized to educate and inform those involved in the political stream as to the critical nature of the issues facing Kentuckians who do not receive timely and effective mental health services. State and local mental health agencies could help present constituent stories and testimonials to the legislators. This “softening up” (Kingdon, 2011) helps the politicians become knowledgeable of the issue, make a ‘real’ connection of the problem to their constituents, and provides them with the resources to make decisions.

Politicians typically are to the economic issues of their constituents and therefore need to be educated and informed about the costs of untreated or undertreated mental illnesses and the associated medical problems. APNs can play a prominent role in educating the politicians by presenting vignettes and encouraging patients and clients to give first-hand testimony.

Among the top five reported conditions in 2011 for children less than 18 years, mental health conditions ranked fifth in the number of children affected but was first in expenditures (Soni, 2014). In 2009 mental disorders for adults 40-64 years old ranked fourth for conditions reported, but was the second highest condition by expenditures (Roemer, 2012). Mental health disorders accounted for one-third of people ages 18-64 who received Social Security Disability Insurance (SSDI) benefits in 2012 in both Kentucky and nationally (Social Security Administration [SSA], 2013). The 2012 national monthly average for SSDI payments for all disability recipients was $1,134.86 (SSA).
In 2009, Kentucky’s state mental health agency spending (i.e., state monies) was approximately 50 percent for both community mental health services and state hospital care; the national average was 75 percent for community services. The higher cost of state hospital care could potentially be offset if people received timely services in the community before their symptoms escalated. Kentucky is above the national average for diabetes, cardiovascular disease, and premature deaths (KY Institute of Medicine, 2007). People with severe mental illness have a high prevalence for these health issues thereby incurring further medical expenses.

The use of data from states that have had successful economic results from same-day billing could present a compelling argument for a change in Kentucky’s billing and reimbursement regulations. For example, in Washington state a collaborative care program involving over 25,000 clients across the state was implemented (Unützer, 2013). Clients received medical and mental health care from the same facility, at times on the same day. They found that for every dollar invested in the program they saved $6.50 in healthcare expenses compared to those who received care as usual (Unützer). They also found that the effectiveness of depression care was doubled. Clients reported improved physical functioning. Providers and clients were very satisfied with the program. Kentucky could glean valuable information from Washington by studying how they designed, implemented, and evaluated their program.

Conclusion

Kentucky’s mental health service system received an “F” in 2006 and 2009 from the National Alliance on Mental Illness (NAMI, 2009). Kentucky was the only state to
receive a failing grade during both review periods. Kentucky was the first state to initiate statewide community mental health centers when President Kennedy passed the Community Mental Health Act in the 1960s (Schuster, 2012). Kentucky has slipped from being first in the nation to 42nd in funding for mental health services (Schuster). NAMI stressed that for progress to be made the state has to have political leadership and sustained investment into the mental health system. Kentucky needs to restructure and invest more in community based services (versus in-patient and residential) and evidence-based programs (NAMI).

Progress has been made for more people to have healthcare insurance through the expansion of Medicaid and the marketplace insurance programs. Kentucky stands to increase its state coffers with federal monies through the Affordable Care Act’s (ACA) match and incentives (Miller, Lentz, Maududi, & Harding, 2013). There are incentives in the ACA for service delivery to become integrated. Same-day billing restrictions prevent Kentucky from having integrated healthcare services available throughout the state.

It appears as though the policy process streams have converged. The current health care environment present an ideal opportunity for those who support same-day billing to make their case and push for action. The political stream could change in the next year when a new governor will be elected. Governor Beshear has been aggressive in promoting, and obtaining, his vision and plans for health insurance coverage for all Kentuckians. Now is the time for him to continue to pursue legislation that would put “the head back on the body” (National Council for Behavioral Health, n.d.) so that Kentuckians can have access to safe, effective, holistic, timely, and evidenced-based care. The Primary Care Association, FQHCs, RHCs, and Community Mental Health
Association need to join forces to advocate for all Kentuckians to receive comprehensive health care.

APNs should be actively involved throughout the policy process. Active APN involvement can include participating in the state nurse practitioner coalition government policies committee, joining with other professional groups to form coalitions, working with lobbyists to promote the agenda, volunteering to be an expert witness, serving as a content expert for the development and design of the policy, and contacting their representatives or senators to provide education on the issue and to represent constituents’ needs.

Initially, expenditures for both medical and mental health care will increase; primarily due to the numbers of newly insured in the state. Eventually, as people receive the health care they need, the overall expenditures should decrease due to issues being addressed at an earlier stage, and not progressing to the more expensive critical state. “Advancing the health status of Kentuckians will improve productivity and economic viability of the state. Kentucky cannot realize economic gains nor improve quality of life without a healthy populace” (KY Institute of Medicine, 2007, pg.8).

Once the policy is passed by the Kentucky legislature, APNs need to continue to be involved in the design and implementation of the policy changes so that the APN scope of practice is upheld and included in the plans. APNs should also help with data collection and analysis to monitor the process of the policy implementation. APNs do not have to stop at the advocacy state of involvement; those who have a passion for the
political aspects of the healthcare system should run for office so that they can be a visible voting voice for healthcare reform.

Mental health and well-being are fundamental to our collective and individual ability as humans to think, emote, interact with each other, earn a living and enjoy life. On this basis, the promotion, protection and restoration of mental health can be regarded as a vital concern of individuals, communities and societies throughout the world (WHO, 2014).
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Manuscript 3:

Foster Parents’ Perceptions about Social-Emotional Development in Infant and Toddlers

Susan R. Noel, PPCNP-BC, PMHNP-BC, MSN
Abstract

Infants and toddlers placed in foster care are at increased risk for social-emotional (SE) development dysregulation. Foster parents, as surrogate parent, play a critical role in a young child having the potential for healthy SE development. The transactional model supports the complex and intricate interplays and transactions of the child, the foster parent, and the environment that influences a healthy SE development. This qualitative descriptive study explored foster parent knowledge, behavioral cue recognition, and role perception regarding a young child’s SE development. Although the sample size was small, the study provides relevant information, from the on-going experiences of foster parents, for healthcare providers to assimilate into their practice concerning SE development of young children in foster care.

Key Words: social-emotional development, foster care, foster parent, transactional model, qualitative descriptive
Foster Parents’ Perceptions about Social-Emotional Development in Infant and Toddlers

Every year thousands of children in the US are placed in out of home care due to the inability of their family of origin to provide a safe, secure, and healthy living environment. Children who enter the child welfare system have endured not only the trauma of separation from their primary caregivers, they may have also experienced one or several traumatic experiences such as personal physical or sexual abuse, neglect, exposure to domestic violence, unsafe living conditions, or the inability of their caregiver to provide care due to mental illness, substance abuse, or an unsafe living environment.

Infants and toddlers who are removed from their primary caregivers suffer disruptions during a critical phase of their brain development that impacts their social-emotional (SE) development (Dozier, Zeanah, & Bernard, 2013; National Scientific Council, 2012). SE development is the base for mental health development in infants and toddlers; it includes their ability to experience, express, and manage their emotions, their ability to form relationships, and their ability to explore and engage in their environment (Cohen, Onunaku, Clothier, & Poppe, 2005). Through relationships with their caregivers, infants and toddlers learn to develop trust and a sense of security (attachment), emotion regulation, behavior regulation, and socialization skills. Disruptions in caregiver relationships and trauma can lead to SE distress or dysregulation which can result in long-term consequences impacting a child’s future emotional and mental health, academic success, relationship building, socialization skills, and physical health (Shonkoff, Garner, et al., 2012; CDC, n.d.).
Foster care, by federal regulations (45CFR1355.20), 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” (www.dhs.mn.us). Foster care, by nature, is a temporary arrangement. Foster parents are given the responsibility to provide a safe, secure, and nurturing environment in which a child can grow and thrive in all aspects of their development.

Foster parents, as surrogate parents, have the responsibility to develop a relationship with the foster child that will enable the child to thrive and develop social and emotional health. Buehler, Rhodes, Orme, and Cuddeback (2006) identified twelve competency domains for effective and successful foster parenting that included promoting social and emotional development. Several studies have addressed motivations of foster parents to engage in relationships with young children (Ackerman & Dozier, 2005; Cole, 2005), interventions to promote healthy relationships (attachments) between foster parents and young children (Spieker, Oxford, & Fleming, 2014; Bick & Dozier, 2013; Bernard & Dozier, 2011), and helping foster parents interpret behavioral cues of young children (Kelly & Salmon, 2014; Dozier, Lindhiem, Lewis, Bick, Bernard, & Peloso, 2009). To date, no research has specifically studied foster parent knowledge of SE development or the foster parent’s perceived role in the young child’s SE development. The researcher believed this information was foundational in determining how healthcare providers, and child welfare workers, assess, screen, and intervene with foster parents to insure the young child in their care is experiencing positive social-emotional development. Through the researcher’s experiences, in a medical clinic focused specifically on providing primary care for children in foster care, concerns arose
about the gap between the scientific knowledge about the effects of stress and trauma on the developing brain and the application of the knowledge as it pertained to the social-emotional development of young children. To gain a better understanding of what foster parents were being taught during their training, specifically related to social-emotional development and trauma, the researcher attended the 11-week course required of all prospective foster parents. The researcher found social-emotional developmental issues, mental and behavioral health issues, and trauma related issues were interwoven throughout the training resulting in a base of theoretical knowledge. The amount of information presented and the homework required was overwhelming; it was information overload even for someone who was not being evaluated to become a foster parent but just focusing on the course content. Therefore, it is reasonable to assume that much critical information about trauma and social-emotional development was lost amidst all the other information presented.

The purpose of this qualitative descriptive study was to investigate foster parent knowledge of social-emotional development and their perception of their role in the social-emotional development of young children in their care. The specific aims were to 1) describe foster parents’ understanding and knowledge of SE development, 2) identify cues foster parents use to monitor SE development in children 7 months through 3 years of age, 3) describe what foster parents perceive their role to be specifically related to the child’s SE development, and 4) identify resources foster parents utilize for information, support, and intervention. The findings from this study will be the foundation for future research addressing foster parent knowledge, cue monitoring, and participation in trauma interventions for young children in foster care.
Significance of the Problem

According to the Adoption and Foster Care Analysis and Reporting System (AFCARS), 28 percent of the over 400,000 children in out of home care in FY 2013 in the US were children three years of age and younger, representing the largest group of children in the child welfare system (AFCARS, 2014). This age group also accounted for 37 percent of the 255,000 children who entered out of home care during that same period. Nationally, the total number of children in out of home care has declined in the past 10 years however, the three year and under age group (and especially those under 1 year) has continued to rise (AFCARS). In spite of all the prevention and intervention practices put into place by social and public health agencies, a significant number of young children continue to be removed from their families and suffer from trauma.

Over the last several decades there has been an increase in scientific data about brain development and the effects of stress and trauma on a child’s brain. Studies have shown detrimental effects from severe, prolonged, and uncontrollable stress (DeBellis, 2005, 2001; DeBellis, Keshavan, Shifflett, et al., 2002). The normal stress response is an adaptive system that enables a person to activate ‘survival’ responses to brief, mild stressors. The normal stress response enables a child to grow and develop emotionally and intellectually. However, when a child is subjected to chronic stress-producing events or situations in which they do not have support from a caring adult, a toxic, or detrimental, stress response is elicited (National Scientific Council, 2005). Toxic stress can cause both functional and structural changes to occur in the brain. The normal stress response can be altered by toxic stress resulting in a lowered threshold for reactivity that can increase the child’s risk for developing stress-related illnesses. Toxic stress can also
change the architecture of the brain resulting in deficits in the affected areas. (National Scientific Council, 2007, 2005).

DeBellis (2001) and colleagues (Watts-English, Fortson, Gibler, Hooper, & DeBellis, 2006) found structural and functional brain changes in children who had suffered traumatic life experiences. Brain imaging showed smaller intracranial, cerebral, and cerebellar volumes in traumatized children. These children also demonstrated compromised cognitive and psychosocial functioning.

Perry (2008) found smaller head circumference (measure of head size and indicator of brain size in infants) and abnormal brain scans in 67 percent of children who had global neglect. Perry observed that once a child was removed from the detrimental environment, brain function and relative brain-size recovered; this was inversely proportional to the age when the child was removed.

The Adverse Childhood Experience (ACE) Study, a retrospective epidemiological study of over 17,000 adults, assessed eight areas of childhood adverse experiences including abuse, neglect, and family dysfunction (CDC, n.d.). Two-thirds of the participants identified at least one ACE and 20 percent identified three or more ACEs. According to the CDC ACE study site, over 50 scientific studies have yielded data, from the original study in 1995-1997, revealing overwhelming proof that childhood trauma increases the risk of health, social, and economic problems.

In the classic work of Shonkoff and Phillips (2000), *From Neurons to Neighborhoods*, they asserted that development in the early years is very active and also very vulnerable to the environment and the relationships young children encounter. They
also emphasized that a young child’s regular caregiver plays an active role and influences the child’s development; children must have at least one close and dependable relationship or there will be long-term consequences from disrupted development.

The scientific evidence—ranging from behavioral genetics and neuroscience to policy analysis and intervention research—on the significant developmental impacts of early experiences, caregiving relationships, and environmental threats is incontrovertible. Virtually every aspect of early human development, from the brain’s evolving circuitry to the child’s capacity for empathy, is affected by the environments and experiences that are encountered in a cumulative fashion, beginning early in the prenatal period and extending throughout the early childhood years (p. 388).

Foster parents play a critical role in decreasing the young child’s exposure to toxic stress, helping the child establish a secure relationship with a caring and consistent adult, and thereby supporting the child’s brain development.

Methods

Design

A qualitative descriptive research methodology design was selected for this study. Qualitative descriptive design allows participants to share their personal experiences and perceptions in their language and in reference to their life situation without being filtered through a structured and stringent set of predetermined data constructs or variables (Sandelowski, 2000). Qualitative descriptive methods do not require a pre-determined conceptual or theoretical framework (Sandelowski) however a conceptual or theoretical underpinning may provide a foundation for the initial inquiry. The transactional model of
development (Sameroff, 2009) was adopted as a theoretical base as it recognizes the interplay and transactive (effective and affective) nature of the complexity of social-emotional development in young children. “The development of the child is a product of the continuous dynamic interactions of the child and the experience provided by his or her social settings” (Sameroff, pg.6). There is a bidirectional and interdependent relationship of the child to people, events, and situations in their environment. Healthy SE development is dependent on the effective and affective nature of the transactional premise:

A child is born with little ability to regulate stressful or challenging events, relying almost entirely on the caregiver for security and regulation of infant emotional states and behavior. As the infant develops, the parent must adapt to the infant’s emerging physical, cognitive, and emotional capacities. The ability of the care giver to provide the infant with a continuing sense of organization, stability, and security that can be internalized over time into a coherent regulatory strategy is vitally important for successful development (Sameroff, p. 41).

Thus, foster parents play a critical role, as a surrogate parent, in a young child’s ability to have successful development. There is a dearth of information about what foster parents know about social-emotional development in young children therefore the researcher was interested in obtaining information related to first-hand, real-life experiences of people who are currently providing foster care to children less than four years of age. The qualitative descriptive design allowed for unencumbered collection of this information.

“Qualitative descriptive studies have as their goal a comprehensive summary of events in the everyday terms of those events” (Sandelowski, 2000, p 334). Qualitative descriptive studies do not have predetermined variables to assess or evaluate but they
usually have a semi-structured format for information collection. The depth and richness of descriptions provided by the participants are dependent on their willingness to share information and their perceptions of an event or situation (Sandelowski). Qualitative descriptive methodology focuses more on the facts or the statements from the participants and less on an interpretation of the information although “all description entails interpretation” (Sandelowski, p. 335). A consensus on data interpretation in descriptive methodology is facilitated among researchers due to the focus on the statements or facts from the participants (Sandelowski).

A semi-structured interview guide was used in this study to obtain participants’ perceptions, experiences, and beliefs about the social-emotional development of young children. Additional questions were used by the interviewer to probe for examples and clarification in order to further expand the participant’s descriptions. A copy of the interview guide is located in Appendix A.

Institutional Review Board Procedures

This study was approved by the University of Kentucky Medical Institutional Review Board. Written informed consent was obtained from all participants. Study participant confidentiality and anonymity was assured by assigning a pseudo-name to each participant so they were not identified on the taped interview. All study documents were stored either in a locked file or on a password protected external storage device.

Inclusion and exclusion criteria

Inclusion criteria for participants in this study were: a) adults 21 years or older who are foster parents in a large urban area of a state in the south central area of the U.S.,
b) current status as a foster parent currently with a foster child in their home who is at least 7 months old and less than 4 years old, c) the foster child has been in their home for at least 1 month, d) ability to speak English, and e) willingness to participate in audiotaped interviews that would be transcribed by another person. Exclusion criteria for participants were: a) foster child has medically fragile status, b) foster child is a relative, and c) foster child was placed in their home before they were 6 months old.

Participant Recruitment

Participants were recruited from the enrollment of a pediatric primary care clinic that specifically provided medical care for children in foster care in a large urban area of a state in the south central area of the U.S. Fliers were distributed at the clinic outlining the criteria for participation. In addition, the researcher continually reviewed potentially eligible participants and once criteria were met they were invited to participate. Some foster parents expressed interest in participating but the reference child had not been in their home for the required length of time; however, once eligibility requirements were met, the foster parent was invited to participate. All eligible foster parents who expressed interest in the study were contacted via phone by the researcher to confirm their eligibility and provided an overview of the study. Arrangements for an interview were made with the foster parents who agreed to participate.

The participants were allowed to choose the site for the interview. Seven interviews were conducted at the clinic site in the researcher’s office after regular clinic hours. Two interviews were conducted at the participants’ work offices, and one interview was conducted at a restaurant. The interviews began with the researcher
reading aloud the “Consent to Participate in a Research Study” form while the participant read along. Participants were given the opportunity to ask questions and to decline to continue with the study. The consent form was signed and dated by the participant and the researcher. The participant received a copy of the signed consent form that included contact information in the event they had questions or concerns following the interview.

The interview was audio-taped in its entirety excluding the reading of the consent form. Each participant had one face-to-face interview that lasted approximately 30 minutes. At the conclusion of the face-to-face interview each participant received $20. As the interviews progressed, new issues of interest developed and some of the earlier participants were contacted via phone; after giving verbal consent, they were asked follow-up questions. Recruitment continued until data analysis and interpretation indicated data “saturation” had occurred (Creswell, 2007, p.160) defined as the point at which data obtained from later participants did not provide further insight into the inquiry.

Sample

Purposive sampling was used to select participants such that they could “purposefully inform an understanding of the research problem” (Creswell, 2007, p.125). The sample consisted of 10 foster parents who had a foster child in their home that was at least 7 months old and less than 4 years old and had been in their home at least 1 month at the time of the interview. The selected participants had received their foster care training through a regional social service department. They were experiencing similar situations in taking care of young children in foster care.
Data Collection

Data for the study were collected between June 2013 and December 2013. The data included audio-taped interviews, selected demographic data, and general observation field notes. Demographic information was also obtained from the participants. During the first five interviews additional questions for inquiry were elicited that were included in the last five interviews. The first five participants were contacted by phone to ask the additional questions. The audio-taped interviews were transcribed verbatim by a person with no connection to the clinic or the foster care program. The researcher took notes for the information from the follow-up phone calls.

Data Analysis

The participants’ responses during the interviews were the focus of the data analysis. Each transcribed interview was initially read while listening to the taped interview to confirm the accuracy of the transcript. Data analysis began with the first interview. Content analysis in qualitative studies is data derived (Sandelowski, 2000) therefore each transcript was read multiple times to ‘listen’ for overall themes and patterns. The responses were organized by question and topic. As the data were read and re-read it became apparent to the researcher that the overall pattern of the responses fell into two categories: foster parents who were experiencing issues with social-emotional development and those who were not. Data were then categorized by the foster parents’ responses in which there were or were not expressed concerns and descriptions of social-emotional developmental issues.
The value of the information obtained from the participants is consistent with their knowledge, perceptions, and concerns precisely as they expressed. Per Sandelowski (2000), a descriptive summary of the information obtained, organized in a way that is relevant for the intended audience, is the expected outcome of a qualitative descriptive study.

Scientific Rigor

In qualitative descriptive research, the trustworthiness of data interpretation is the degree of truth or credibility reflected in the descriptions of the participant’s perspective (Sandelowski, 1993). In this study, trustworthiness of the data analysis was addressed using guidelines from Lincoln and Guba (1985) that include credibility, dependability, and confirmability. Credibility and dependability, used to establish the truth in the data, were addressed with the use of member checks in which participants review the findings and comment on the degree to which the findings accurately reflect their experiences (Lincoln & Guba). In this study, five of the participants reviewed the summary of their interviews and confirmed with the researcher that the information collected and the researcher’s interpretation accurately represented them. Three of the participants were lost to follow-up and two of the participants did not return written comments or phone calls to discuss the write-ups. Credibility was also established through prolonged engagement in the field (Lincoln & Guba). The researcher had spent 5 years working in the foster care medical clinic providing direct medical healthcare services to foster children and providing support and services to foster parents. The researcher attended the foster parent training classes in order to better understand foster parent preparation. The researcher, during training for the psychiatric nurse practitioner certification, had also
worked in a program treating children who suffered from traumatic stress. These experiences along with the data from the participants provided multiple data sources (triangulation) that resulting in a rich and robust account of the data (Creswell, 2007).

Confirmability, the objectivity of the data analysis based on the participants’ responses and not the researcher’s biases or interests (Lincoln & Guba, 1985), was carried out through peer debriefing. The researcher met several times with 2 colleagues, psychiatric nurse practitioners with qualitative research experience, to review transcripts, perform data clustering, and identify themes. The peer debriefings were a sounding board for the researcher to explore ideas, examine alternative ways of understanding the data, and discuss personal biases, motivations, and interests that might cloud or overshadow the reporting of the data.

Results

There were two primary questions this study set out to explore: 1) What do foster parents know about social-emotional development in young children in foster care? and 2) What do foster parents perceive their role to be in helping young children achieve a healthy social-emotional development? The first inquiry included both the foster parents’ knowledge of what social-emotional development encompasses and recognition of signs or symptoms of dysregulation. The second question, although a straight-forward inquiry, also included the foster parents’ preparation for assuming their role as a foster parent and their resources for ongoing parenting information.

A demographic overview of the foster parents who participated in the study is provided in Table 3. Seventy percent of the participants had been a foster parent for two
years or less. The initial purpose for becoming involved in foster care was identified as adoption for 60% of the participants. However, three of the four study participants who initially became involved in foster care for the purpose of providing care for children until they could be reunited with their birth parents, are now planning to adopt and the fourth family is considering adoption. The child referenced in the study was the first placement for 60% of the study participants. All but one child had been in the study participant’s home since their initial out of home placement. The children referenced in the interviews ranged in age from 24 to 41 months of age at the time of the interview with length of time in placement ranging from 6 to 28 months.

The study participants were asked for their definition of social-emotional development as it pertained to children six months through three years of age (Table 4). The participants’ definitions included at least one aspect of the concept. Most of the definitions were very simplistic, such as Ms. E., “I would say bonding with the care giver,” and Ms. G., “Being able to adapt to situations.” Other definitions included relationship formation, getting along with peers, ability to communicate needs, and security. Ms. A. provided the most comprehensive definition:

“I think of kind of their whole makeup; their emotions that they express, their personalities, the way they deal with things, maybe the way they process things, sensory process, how they deal with transitions, all kinds of their social and emotional makeup.”

The study participants were provided a working definition for social-emotional development and given a card with the definition to reference during the interview:
Social-emotional development is the foundation for mental health and begins the day a child is born and develops throughout their life. It includes their relationships with others, their ability to experience, manage, and express their emotions, and their ability to explore and engage with their environment. (Cohen et al., 2005).

All the participants stated they initially had concerns about the reference child’s SE development. Some of the concerns were related to how the child interacted with the foster parent(s). Other concerns were related to behaviors following visits with the child’s biological family. Table 5 lists the behaviors the foster parents observed that initially made them concerned about the child’s social-emotional development. The majority of the responses were descriptions of external or overt behaviors such as head banging, putting their hands over their ears, decreased response to their environment, and rocking movements. A couple of the foster parents recognized internal symptoms of distress including a flat affect and withdrawal. None of the participants identified any concerns with disruptions in sleeping, eating, toileting, or sensory issues until specifically inquired by the researcher.

Five of the participants reported their reference child had difficulty with sleep issues ranging from refusing to be put in a crib to frequent waking and crying during the night.

Ms. A. noted, “in the beginning she had a lot of trouble sleeping. Sometimes it would take a couple of hours for her to calm down—even with me staying in the room with her, patting or rubbing her back, or rocking her—to go to sleep. She would cry out and scream randomly during the night also. …any time after something distressing, such as visits with her family or major changes in her routine, she has a harder time sleeping.”
Six of the participants reported the child had difficulty with eating when they were first placed in their home. One of the children had difficulty with food textures preferring liquids or pureed foods although she was old enough to be eating solids. Three of the children acted as though they were constantly hungry and would eat overly large amounts of food at meals and snacks.

Ms. E. reported, “he had hoarding of food. He also wanted to eat all the time and sometimes would gorge himself to the point of getting sick. He always wanted there to be something to drink with him or a snack constantly.”

None of the participants identified any issues with toileting routines. One of the participants reported she is having difficulty with potty training at the present time but she perceived this to be normal for the child’s age and development.

Four of the participants identified sensory processing concerns for their child. Ms. A noted that her child becomes distressed whenever her clothes are not “just right in how they fit or feel.” Ms. A. also reported her child initially would become very distressed with loud sounds and would put her hands over her ears; this behavior has diminished but still occurs especially if she hears sirens. Ms. A. also reported her child appears to have a high pain threshold as evidenced by pulling out handfuls of her hair without wincing. Ms. B. also reported her child seems to have a very high pain threshold as evidenced by her head banging and walking barefoot on rough, hot surfaces without acknowledging any discomfort; “I would not be able to tolerate what she walks on.” Ms. B. reported when her child becomes distressed, she becomes very “oral” and puts non-food items (toys, clothes, etc.) in her mouth. Ms. E. and Mr. H. both identified food textures as an issue for their children.
Through repeated review of the audio-tapes with the transcriptions and grouping or clustering the responses to the individual questions (Table 6), two major divisions of responses emerged. The first group was the participants who had a child with on-going SE dysregulation. The second group was the participants who had a child who is no longer (per their perception) having any SE dysregulation. The behaviors reported by the first group were not much different than the initial behavioral concerns however, most of the participants reported a decrease in intensity and frequency.

For half of the participants, concerns about their foster child’s SE development have diminished over the time that the child has been in their care and they do not perceive the need for any behavioral or mental health interventions. The other five participants have ongoing concerns about their child’s SE development and four of the children are currently receiving behavioral or mental health interventions. One child receiving services is on a waiting list for intensive trauma-related therapy. One of the participants has been unable to locate services for her child because the child does not qualify for any federal or state funded IDEA-Part C early intervention services; she has been unable to find someone who will see children younger than three years old to “do anything besides parenting play therapy.”

The participants’ perceived role in the social-emotional development of young children is listed in Table 7.

Mr. D. stated, “My role is the same as a biological parent would have. As the primary caregiver and the primary support to make sure that development is appropriate and safe.

Mr. H., responded, “I feel the more love that you give a foster child, or any child, it’s going to help them. If
you put them in a good situation and teach them family values and how to act when around people, help them with their social skills, then you will be helping them to develop.”

Ms. B. reported, “I always say that my role is to give the children the tools to be successful in any environment, and especially as a foster parent your goal is to return to parent or return to a family member, and so you want to make sure you have given them the tools to be able to cope and to handle and articulate their needs.”

All the participants received their foster parent training from the same state agency. Four of the participants gave a resounding “No” when inquired about being adequately prepared in their training for what they have encountered in dealing with SE developmental concerns for young children. Six of the participants stated they felt they received adequate training and were prepared “as much as possible.”

Ms. C. stated, “I think I was as prepared as much as you can be until you are placed in the situation. Not having had any children prior to being a foster parent, we didn’t know for sure what we were getting into, but I felt that the training we got was pretty good.”

Ms. F. responded, “I was prepared for many situations but I don’t think you can ever prepare for life. I mean stuff just comes along. You never know what you are going to get. The initial training is good but it is a lot. You get that first child and like with mine, I finished the classes and the next week I got my first child. It’s kind of like you get thrown into the open waters.”

Ms. A. reported, “Not at all. They do touch on the emotional distress and you know going in that these children have been through trauma but I know you’re not taught strategies. We were not taught what the trauma causes, how long that stays with them. You know, what are some things that even if they haven’t been through trauma that they could still display because of it. A lot of things we didn’t have a clue what was going to happen.”
Besides the initial foster parent training, the participants reported they have attended required continuing education. Only one participant recalled attending a training focused on SE development or trauma-related.

Most of the participants reported they have relied on friends and family for information in regards to parenting tips and strategies related to the child’s SE development. However, most of the participants acknowledged that unless someone has also been a foster parent, they did not seem to fully understand the issues they were facing and that ‘typical’ parenting advice did not fit their situation.

Ms. G. stated, “I accept the advice they give but I don’t know that it applies to my children sometimes. Not that they’re special needs or anything like that but I don’t know that a child that’s been loved and given everything they need, nurtured through their life, could be comparable to mine.”

Other resources the participants identified for information regarding SE development included their personal education (either formal or informal), their experiences working with young children, and other foster parents. Professional resources included the child’s social welfare worker, the child’s health care provider, the child’s early childhood/daycare provider, and other professionals they may have contact with such as occupational therapists, speech therapists, and psychologists. None of the participants reported having a formal mentor to guide them through the experience with their first child (per the foster parent training this is an available resource).
Discussion

This descriptive qualitative study explored foster parents’ knowledge of and perceived role in the social-emotional development of a young child in their care. Ten foster parents were interviewed and shared their personal experiences with a young foster child currently placed in their home. The information that was shared in the interviews provides real-life data for healthcare providers, child welfare workers, and early childcare workers to consider and incorporate into their assessments, plans, and interventions with foster parents of young children.

The foster parents in this study described a limited understanding of social-emotional development. None of the foster parents included all three of the major components of SE development in their definition during the interview; the major components are relationship formation, expression and management of emotions, and exploration and engagement with their environment. Social-emotional development may be an unfamiliar term for most foster parents; had the correlate term—mental health—been used in the interview their descriptions might have been different. However, the term ‘mental health’ has a tendency to evoke thoughts of illness and detrimental behaviors versus wellness and normal development (Corrigan, Druss, & Perlick, 2014).

All the foster parents identified concerns about their foster child’s SE presentation when the child was first placed in their home. The researcher inferred from their responses, and validated through member checks, that the foster parents expected the child to have an adjustment period and emotional lability for at least the first few weeks the child was in their home due to their separation from their caregivers. Ms. E. reported
she was concerned when her 16 month-old foster child did not “bond” with her immediately and expressed concern that it took 6 to 8 months before he reciprocated any affection. The American Academy of Pediatrics’ Committee on Early Childhood, Adoption, and Dependent Care, addressed this issue in their statement on *Developmental Issues for Young Children in Foster Care*,

> Abused and neglected children (in or out of foster care) are at great risk for not forming healthy attachments to anyone… Separations occurring between 6 months and about 3 years of age, especially if prompted by family discord and disruption, are more likely to result in subsequent emotional disturbance (AAP, 2000, p. 1146).

This child referenced by Ms. E. was in foster care from birth to 6 months, was reunited with his biological parents, and was subsequently removed at 16 months of age due to substantiated physical abuse of his 3 year old sister, exposure to domestic violence, and parental substance abuse. In view of this history, it would be unreasonable to expect this child to “bond” with another adult until he has the opportunity to feel reassured that his needs are being met consistently over a prolonged period of time (AAP). When foster parents have unrealistic expectations there is increased risk for development of an insecure attachment and placement disruption (University of California, 2008). In a study investigating new attachment behaviors during the first 2 months of placement between foster parents and infants 5 to 28 month old, Stovall-McClough, and Dozier (2004) found that infants less than 12 months old were able to display attachment behaviors within two weeks of placement whereas older infants were more likely to withdraw and display avoidant behaviors. Ms. E. could have benefited, prior to or at the least at the beginning
of the child’s placement, from psychoeducation about trauma and attachment along with being supported in her efforts to provide consistent and nurturing caregiving.

Mr. H. described his child exhibiting behaviors that are indicative of SE distress however he did not perceive the child as having any on-going SE disruptions. Mr. H. described the child as being “easily overwhelmed” in new situations, being “easily frustrated,” and having a difficult time interacting with other children and preferring to play by himself. The National Child Traumatic Stress Network’s report on Early Childhood Trauma (NCTSN, 2010) affirms that young children’s behaviors provide clues on how they are affected by and trying to deal with trauma and stress since they cannot express verbally what they are feeling. Children aged 3 to 6 years old may demonstrate behaviors such as inability to trust others or make friends, act withdrawn, and be anxious, fearful, or avoidant as ways of expressing how they are dealing with their current or past history of traumatic stress (NCTSN). Mr. H. could benefit from psychoeducation and trauma interventions for young children suffering from traumatic stress to help him identify and appropriately respond to the behavioral cues the child is exhibiting.

The parenting roles the participants described included ‘typical’ parenting roles such as providing a safe, secure place to live and thrive, love and nurturance, and teaching the child values and social skills. The participants also described being an advocate for the child to receive services for developmental and behavioral needs and concerns. Foster parents have roles that are unique from biological or adoptive parenting roles. The foster parents must contend with the shared authority role of parenting with the child welfare agency and the child’s family of origin (Haugaard and Hazan, 2002). This shared parenting role can place limitations on what the foster parent is able to, or
wants to, initiate and provide for the child if the child welfare agency or biological family
is not in agreement. Ms. B reported her child needed early intervention services for
speech and motor skills delay but the biological mother would not sign the consent forms
so the child did not receive services for several months until the child welfare agency
overrode the biological mother’s refusal. Another unique role that foster parents are
expected to play is to be supportive of visitation arrangements for the child with their
family, regardless of how they feel about the child’s family or their purpose for fostering.

People become foster parents for various reasons. Some people have an altruistic
desire to help a child in need and to assist their community. Other people become foster
parents to have children (or more children) in their home with the goal of adoption.
According to the Casey Family Foundation, 21 percent of children in foster care in the
US were adopted during FY2013 and 31 percent of children in foster care in Kentucky
(study site) were adopted (casey.org, n.d.). The director of a mentoring program for
foster parents in Kentucky noted, from his personal records and observations, 60 to 70
percent of people enter foster care for the purpose of adoption (personal communication,
October 2014); this is consistent with the participants’ goals in this study.

The participants in this study demonstrated a commitment to their child of
reference as evidenced by their expressed desire to help their child be successful, the
length of time some of the children with the more severe SE dysregulation had been in
the foster home, and the foster parents’ persistence in advocating for their child.
“Commitment allows for a supportive relationship within a stable environment, which
has implications for later adjustment” (Bernard & Dozier, 2011, p.253). A longitudinal
study by Ackerman and Dozier (2005) found that toddlers in foster care who had a foster
mother who showed early investment in the toddler-parent relationship, through commitment and acceptance of the child, had a positive self-representation and more constructive coping responses at age five.

What most people know and believe about being a parent is a reflection of their own parenting (Sigel & McGillicuddy-DeLisi, 2002). It comes as no surprise that people rely on family and friends as a major source for information on parenting. People supplement their information about parenting from their social networks that include health professionals and educational professionals (Cochran & Niego, 2002). The study participants cited the foster care training classes as a source of information, however the overall perception of being adequately prepared to care for a child with traumatic stress was not affirmative. The participants identified family and friends as resources but also noted that, due to the unique circumstances of their foster child’s life, they also relied on professionals and other foster parents for parenting information as these resources had knowledge and experience that was perceived to be more relevant to their situation.

Applications to Clinical Practice

All disciplines involved in the well-being of young children in foster care should be ‘trauma-informed’ in order to provide effective services and support to foster parents and the young children in their care. The National Child Traumatic Stress Network defines trauma-informed as a system in which all parties involved recognize and respond to the impact of traumatic stress on those who have contact with the system including children, caregivers, and service providers. Programs and agencies within such a system infuse and sustain trauma awareness, knowledge, and skills into their organizational cultures, practices, and policies.
They act in collaboration with all those who are involved with the child, using the best available science, to facilitate and support the recovery and resiliency of the child and family (NCTSN.org, n.d.).

The findings of this study offer insights into what foster parents know and understand about the social-emotional development of young children. Although foster parents receive training, healthcare providers (HCP) should not assume that they fully understand the impact of separation and trauma, recognize cues of SE distress, or will alert the HCP if there are any concerns. Cues of social-emotional distress can be subtle or enmeshed with somatic symptoms requiring HCPs to be thorough in their screening and assessment of young children in foster care to avoid over-looking potential signs of distress or dysregulation. HCPs should include social-emotional screenings and assessments as part of the comprehensive health assessment when a child is first placed in foster care and should also perform periodic assessments for early detection of distress or dysregulation so interventions can be initiated as soon as possible to minimize, and hopefully prevent, further mental health deficits. The foster parents who participated in the study viewed their role as essential to the well-being of the child placed in their care. Healthcare providers should capitalize on this attribute and include the foster parent in the child’s healthcare case plan.

The integration of mental healthcare providers into primary healthcare could facilitate timely entry into services and provide the avenue for collaboration to effect comprehensive care. Advanced practice nurses (APN) who are dual certified in primary care and psychiatric-mental health care could play a pivotal role in providing comprehensive services. The relationship and rapport developed between the APN, the
foster parent, and the young child could facilitate acceptance and willingness to participate in interventions and services to address SE developmental needs and traumatic stress.

Study Limitations

There are several limitations of this study. The small sample size cannot be considered representative of all foster parents across the US or even in the state in which the study was conducted, however data saturation was obtained which indicates the sample size was sufficient. The majority of the participants had limited experience as a foster parent; this could contribute to limited knowledge about SE development and the cues they should monitor. As might be expected, those participants who had a child with overt SE distress and dysregulation were more attuned to the availability, or lack thereof, of resources. Also, they perceived their preparation and training to be inadequate to deal with traumatized children. Had the other participants identified their child to have SE distress and be in need of additional services, their perceptions about resources and training might have been different.

The researcher being known by the participants could be a major study constraint. The willingness of the participants to be part of the study could have been influenced by their professional relationship with the researcher. The researcher was also constrained to abide by the data from the interviews and not interject information known about the reference child through contact with them in the medical clinic. The researcher attempted to use probing strategies to encourage the participants to elaborate and share more
information without leading and straying away from their story and perceptions in order to stay true to the method of inquiry.

Implications for Future Research

The African proverb, “It takes a village to raise a child” (www.quotes.net), becomes ‘a village raises a child’ for children in foster care. Multiple people involved in overseeing the upbringing of a child in foster care. Child welfare workers, biological family, foster family, and multiple professionals and service providers all play a role in the child’s life. This study points to the need for further research involving a multidisciplinary focus and approach in addressing the young foster child’s SE developmental needs through a trauma-informed model.

A study is needed to assess the influence of trauma-informed training on foster parents’ knowledge and parenting strategies related to the SE development of young children. Studies are also warranted to assess the knowledge and understanding of professionals and service providers about trauma-informed care.

A longitudinal study is needed to look at the long-term influence of a multidisciplinary trauma-informed approach on the well-being of children placed in foster care at a young age. Most of the available studies of the impact of trauma and/or foster care have been with school-aged children and adolescents (Irish, Kobayashi, & Delahanty, 2010; Lansford, Miller-Johnson, Berlin, Dodge, Bates, & Petit, 2007; Cohen, Deblinger, Mannarino, & Steer, 2004); to date, there have not been longitudinal studies involving trauma-informed care for young children. Studies that utilize the research and scientific data on the impact of trauma on brain development and function should be done
to develop intervention methods and strategies to enhance the neuroplasticity of the young child’s neuronal pathways to stimulate positive SE development.

Another avenue of study would be to look at the ‘culture’ of foster care. An ethnographic study focused on foster parent attitudes, beliefs, and experiences about parenting may illuminate ways to better select a good fit between child and foster parent for stability of placement and enhancement of the child’s SE development. Dozier et al. (2009) found that a young child’s attachment to their foster parent was more dependent on the characteristics of the foster parent than to the child’s age at placement.

Conclusions

The participants in this study provided relevant information for practice enhancement for medical and mental healthcare providers. The participants described a lack of a thorough understanding of SE development in young children placed in foster care. They also were not fully attuned to the connection between physiological and psychological manifestations of distress or dysregulation. Medical and mental healthcare providers must utilize every opportunity of contact with the child and foster parent to assess for healthy SE development, provide support and practical parenting strategies, and provide for or facilitate provision for specialized SE services and interventions.

“In many important ways, more is asked of foster parents and families than of birth, adoptive, or stepfamilies” (Buehler, Rhodes, Orme, & Cuddeback, 2006, p. 549). Foster parenting is perhaps one of the most challenging forms of parenting. The child welfare system, in the state of Kentucky, has recently recognized the importance of foster
parents being trauma informed. A Kentucky state regulation will mandate all foster parents receive trauma-informed training beginning the fall of 2015; child welfare workers are being trained by the University of Kentucky’s Center on Trauma and Children to provide trauma-informed training for foster parents (personal communication with Dr. Ginny Sprang, Executive Director, December 2014). Practical parenting strategies for healthy SE development of the young child in foster care and the effects of trauma should also be included in the required continuing education for the foster parents.

The researcher perceived the participants in this study took their role as foster parent seriously and were committed to developing a relationship with, nurturing, and advocating for the young child in their care. Foster parents need to be able to help their young child develop secure and trusted relationships, learn how to express and manage their emotions, and learn to explore and engage with their environment in order to have a healthy SE development. A healthy SE development will set the foundation for positive mental health development setting the stage for the child to have optimal success in academics, relationships, and social interactions and roles.

The transactional model for SE development recognizes the complex interplay of the child with their socioenvironmental and familial (both birth and foster) factors for short- and long-term outcomes related to their maltreatment. How the child responds to, effects, and is affected by relationships, stress, health, and cognitive responsiveness will determine their trajectory for their SE development. Foster parents play a critical role in helping young children in their care develop secure relationships and adaptive coping skills for future mental wellness.
References


### Table 3.

<table>
<thead>
<tr>
<th>Study Participant</th>
<th>R’ship Status</th>
<th>Bio or Adopted Children</th>
<th>Foster Purpose</th>
<th># yrs Foster Carer</th>
<th># placements</th>
<th>Current placement (reference child [RC] for the study)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms. A</td>
<td>Married</td>
<td>1 bio 6 yr boy</td>
<td>Foster; now will adopt</td>
<td>3 yrs</td>
<td>5 (RC—2nd child placed for the home)</td>
<td>F</td>
</tr>
<tr>
<td>Ms. B</td>
<td>Married</td>
<td>0</td>
<td>Foster; now will adopt</td>
<td>2 yrs</td>
<td>2 for respite; 3 for foster (RC—1st child placed for the home)</td>
<td>F</td>
</tr>
<tr>
<td>Ms. C</td>
<td>Married</td>
<td>1 adopted 5yr boy</td>
<td>Adopt</td>
<td>4.5 yrs</td>
<td>7 (RC—5th child placed for the home)</td>
<td>M</td>
</tr>
<tr>
<td>Mr. D</td>
<td>Partner</td>
<td>0</td>
<td>Adopt</td>
<td>2 yrs</td>
<td>3 (RC part of sibling group; 1st placement for the home)</td>
<td>F</td>
</tr>
<tr>
<td>Ms. E.</td>
<td>Partner</td>
<td>0</td>
<td>Adopt</td>
<td>~1.5 yrs</td>
<td>2 (RC part of a sibling group; 1st placement for home)</td>
<td>M</td>
</tr>
<tr>
<td>Ms. F</td>
<td>Single</td>
<td>2 adopted girls, 9yr &amp; 5yr</td>
<td>Adopt</td>
<td>6 yrs</td>
<td>19 (10 within age range of 6mo-3 yrs) (RC—16th placement)</td>
<td>F</td>
</tr>
<tr>
<td>Ms. G</td>
<td>Partner</td>
<td>0</td>
<td>Adopt</td>
<td>1.5 yrs</td>
<td>2 (RC part of sibling group; 1st placement for the home)</td>
<td>M</td>
</tr>
<tr>
<td>Mr. H</td>
<td>Married</td>
<td>0</td>
<td>Adopt</td>
<td>1 yr</td>
<td>2 (RC part of sibling group; 1st placement for the home)</td>
<td>M</td>
</tr>
<tr>
<td>Ms. I</td>
<td>Married</td>
<td>2 bio 5yr boy, 8yr girl</td>
<td>Foster; may adopt</td>
<td>1.5 yrs</td>
<td>2 (RC—2nd placement for the home)</td>
<td>M</td>
</tr>
<tr>
<td>Ms. J</td>
<td>Single</td>
<td>1 bio 17yr boy</td>
<td>Foster; now will adopt</td>
<td>6 mo</td>
<td>2 (RC part of sibling group; 1st placement for the home)</td>
<td>F</td>
</tr>
</tbody>
</table>

*Child was placed in foster care at birth, placement disruption at 6 months of age
**Table 4.**

<table>
<thead>
<tr>
<th>Study Participants’ Definitions of Social-Emotional Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Ms. A.: “I think of their whole makeup; their emotions that they express, their personalities, the way they deal with things, maybe the way they process things, sensory process; how they deal with transitions, all kinds of their social and emotional makeup.”</td>
</tr>
<tr>
<td>• Ms. B.: “I think it’s the ability to communicate their needs, the ability to connect with people and to build relationships, whether it be with their caretakers or with other peers their age.”</td>
</tr>
<tr>
<td>• Ms. C.: “How a child changes and learns as they are growing.”</td>
</tr>
<tr>
<td>• Mr. D.: “How well the child interacts with peers and others and the attachment that the child has to other people.”</td>
</tr>
<tr>
<td>• Ms. E.: “Bonding with the caregiver.”</td>
</tr>
<tr>
<td>• Ms. F.: “How they form relationships and attachments and bonding.”</td>
</tr>
<tr>
<td>• Ms. G.: “Being able to adapt to situations.”</td>
</tr>
<tr>
<td>• Mr. H.: “How each child interacts in different ways to different things; it could be good, it could be bad. How they show emotion; anger or getting excited about things or even crying over something.”</td>
</tr>
<tr>
<td>• Ms. I.: “Security first of all, they should be secure and willing to learn things and just it come naturally to them, to want to learn without difficulty.”</td>
</tr>
<tr>
<td>• Ms. J.: “Their emotions and how they get along with other people.”</td>
</tr>
</tbody>
</table>
Table 5.

<table>
<thead>
<tr>
<th>Child’s Behaviors Related to Study Participants’ Initial Concerns About Social-Emotional Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Head banging</td>
</tr>
<tr>
<td>• Putting hands over ears</td>
</tr>
<tr>
<td>• Rocking movements</td>
</tr>
<tr>
<td>• Pulling out their hair</td>
</tr>
<tr>
<td>• Hiding from “strangers”</td>
</tr>
<tr>
<td>• Asking strangers to hold them</td>
</tr>
<tr>
<td>• Flat affect—no smiling</td>
</tr>
<tr>
<td>• Limited reaction to things going on in the environment (pets, people, sounds)</td>
</tr>
<tr>
<td>• Acted uncomfortable with bonding activities (hugs, kisses, cuddling)</td>
</tr>
<tr>
<td>• Clingy with foster parent—didn’t want to separate to play with other children</td>
</tr>
<tr>
<td>• Lack of response to stimulation, almost lethargic</td>
</tr>
<tr>
<td>• Easily frustrated</td>
</tr>
<tr>
<td>• Preferred to play by himself while other children his age were playing together in the same area</td>
</tr>
<tr>
<td>• Defiance; temper tantrums; aggressive behaviors</td>
</tr>
<tr>
<td>• “Zoning out,” staring into space</td>
</tr>
<tr>
<td>• Inability to self-soothe</td>
</tr>
<tr>
<td>• Always whiny</td>
</tr>
<tr>
<td>• Regression in development</td>
</tr>
</tbody>
</table>
Table 6.

<table>
<thead>
<tr>
<th>Clustering of Behavioral Cues</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>On-Going Concerns about SE Development per Foster Parent Report</strong></td>
</tr>
<tr>
<td>• Withdrawn</td>
</tr>
<tr>
<td>• Plays alone</td>
</tr>
<tr>
<td>• No boundaries</td>
</tr>
<tr>
<td>• Clingy</td>
</tr>
<tr>
<td>• Bangs head</td>
</tr>
<tr>
<td>• Pulls their hair out</td>
</tr>
<tr>
<td>• Difficulty with sleep</td>
</tr>
<tr>
<td>• Whinier than other kids their age</td>
</tr>
<tr>
<td>• Temper tantrums—more than other kids their age</td>
</tr>
<tr>
<td>• Difficult time with transitions; does not tolerate change</td>
</tr>
<tr>
<td>• Easily frustrated</td>
</tr>
<tr>
<td>• Fearful of new places—wants foster parent by their side</td>
</tr>
<tr>
<td>• No fear—runs off</td>
</tr>
</tbody>
</table>

*this study participant did not perceive their child to be having any SE distress although the child’s speech therapist had voiced concerns per the participant’s report.
Table 7.

<table>
<thead>
<tr>
<th>Study Participants’ Perceived Role in SE Development of Young Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Be their advocate</td>
</tr>
<tr>
<td>• Provide tools for child to be successful in any environment</td>
</tr>
<tr>
<td>• Support</td>
</tr>
<tr>
<td>• Love consistently</td>
</tr>
<tr>
<td>• Primary caregiver</td>
</tr>
<tr>
<td>• Nurture</td>
</tr>
<tr>
<td>• Provide safe place to live, learn, and develop</td>
</tr>
<tr>
<td>• Positive reinforcement</td>
</tr>
<tr>
<td>• Monitor behaviors, emotions, reactions to situations</td>
</tr>
<tr>
<td>• Initiate intervention services</td>
</tr>
<tr>
<td>• Teach values</td>
</tr>
<tr>
<td>• Teach social skills</td>
</tr>
</tbody>
</table>
Figure 1

Transactional Model of Social-Emotional Development of Young Children in Foster Care

Sameroff, 2009; Sprang, Clark, Kaak, & Brenzel, 2004
DNP Practice Inquiry Project Conclusion

Susan R. Noel, PPCNP-BC, PMHNP-BC, MSN
DNP Practice Inquiry Project Conclusion

Young children in foster care are not ‘typical’ children. They have experienced trauma through neglect, abuse, and/or exposure to violence; at the very least they have been separated from significant relationships. Many children have physical health issues due to their trauma history. The young child’s immature cognitive development makes it impossible for them to make sense of the violation of their basic needs for trust and security. Their social-emotional development, the foundation for mental health and well-being, becomes arrested or stalled at very critical points in development that interfere with their progression along the continuum of mental wellness. This effects not only their current state of being but can have lifelong effects on their ability to have a healthy self-esteem and self-worth, develop meaningful relationships, achieve academic success, and be functional in society. Early recognition and intervention for social-emotional developmental dysregulation in young children could help prevent long-term sequelae.

All children in foster care should be considered to have emotional, psychological, or mental health needs, by virtue of their life history, until proven otherwise. It is imperative that primary healthcare providers (PHPs) have a keen awareness and are attuned to the effects of trauma on the SE development of young children in foster care. PHPs are the most frequent and main point of contact for children in the healthcare system. Screening for SE developmental issues should be an ongoing part of a young child’s healthcare while in foster care. This will enable early identification for areas of concern. The first manuscript provided an overview of potential signs of SE distress and parenting strategies for foster parents to incorporate into their repertoire of parenting skills and interventions to help prevent, and hopefully stop the cycle of, SE distress.
Pediatric PHPs’ knowledge and experience working with families concerning child development and parenting strategies can help fill the gap for early childhood mental health providers. Early identification and intervention can help prevent further dysregulation that might progress into a more serious mental health issue as the child becomes older. These strategies can also help strengthen and support the stability of the placement further decreasing risk of SE distress and dysregulation.

Children requiring more intensive and specialized SE interventions would be best served through an integrated health model. Removing the Medicaid same-day billing restrictions, for primary care clinics in Kentucky, would encourage the incorporation of mental health specialists into the primary care setting. This would enable children to receive mental health and medical care services on the same day. This would increase accessibility and collaboration for comprehensive and timely healthcare. The second manuscript addressed the same-day billing barrier through demonstrating how John Kingdon’s political ‘streams’ of problem (Kentucky has an “F” in providing mental health services; severe mental illness increases society’s burden), policy (the Affordable Care Act increased the number of insured seeking health services and mandates mental health parity), and politics (Governor Beshear’s success in providing health care insurance for everyone; the Governor is completing his final term in office) have merged and the setting is possible for a policy change.

I wanted to develop a plan for incorporating mental health into the primary care setting based on the needs of the foster parents and children in their care, with a special focus on infants and toddlers. Although I perceived that foster parents were not fully attuned to SE developmental issues for young children, I did not want to develop a plan
based on personal observations and assumptions. The third manuscript provides results from a qualitative descriptive study, with a small purposive sample of foster parents, describing what they know about SE development and what they perceive their role to be for a young child in their care to have a healthy SE development. The information gleaned from the study provides insight into the need for psychoeducation about SE development and the effects of trauma on the developing brain and the potential long-term sequelae.

This DNP Practice Inquiry Project has reinforced my desire to provide mental health services for young children in the foster care system with a special focus on the effects of trauma. Young children need the support of a safe, secure, and trusted relationship with a caregiver. The primary caregiver must be informed and involved in order for a young child to have a healthy SE development that will provide them with optimal opportunities for academic, social, relational, and physical and mental health successes.

The DNP course of study prepared me for an inter-professional leadership role working with clinical social workers, psychologists, and psychiatrists. The degree provides parity with other doctorally prepared professionals in the delivery of evidenced-based and on-going research-driven mental health care for children and adolescents. The transactional model, the theory base in the qualitative study, underscores the open system that healthcare truly is—we are all effected and affected by one another (both patients/clients and providers) and the multiple systems within which we live, work, and play. The DNP provided the means for me to advance my clinical scholarship through applying scientific principles, conducting and integrating research into practice,
proposing and developing a policy change, and utilizing technology to expedite, enhance, and inform not only my knowledge base but also patient care.
APPENDIX A

Study Interview Guide

1. Define social-emotional development

2. Source(s) of information and knowledge about SE development
   a. Describe role of family and friends
   b. Describe role of healthcare provider, service providers, etc.

3. Ever have a young child (<4 years old) with concerns about SE development
   a. Describe what was occurring caused concern

4. Describe signs/symptoms indicative of healthy SE development

5. Describe signs/symptoms indicative of child struggling with SE development

6. Describe resources utilized when concerns of SE developmental distress/dysregulation
   a. Resources needed
   b. Need for mental health services; availability

7. Describe current perceptions of child’s SE development
   a. Describe correlation of signs/symptoms to child’s life events
   b. Changes or effects on sleep, eating, toileting, sensory issues

8. Describe comfort level or confidence in ability to recognize red flags pertaining to SE distress/dysregulation

9. Describe how your foster parent training in regards to SE development and trauma
   a. Describe on-going training
b. Describe resources provided (mentor, support group, etc)

c. How do you think you would have responded had child welfare training provided detailed information about effects of trauma on young children?

10. Describe your role as foster parent as it pertains to child’s SE development

11. Describe your greatest challenge as a foster parent

12. What advice do you have for other foster parents
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