Why aren't we doing better in supporting the health of children and youth in care?

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Child welfare agencies encounter a higher percentage of children and youth with reported complex trauma exposure than any other system serving children.

The Adverse Childhood Experiences Study showed a correlation between traumatic exposures during childhood—such as abuse, neglect and household dysfunction—and increased health risk behaviors and poor health outcomes in adulthood. Subsequent research in the last two decades has supported the harmful impacts of childhood adversity and toxic stress on brain development and overall health.

Despite this knowledge and research on protective factors that buffer impacts of childhood adversity, there remains a paucity of supports for the needs of children and youth in the child welfare system. As a result, these children and youth continue to experience poor health, with intergenerational consequences as those poor outcomes can later affect their own children.

The Child Welfare League of Canada recently released eight 'transition pillars' to support equitable transitions from care. Health and well-being transition improvements for youth with complex needs are mirrored by the Canadian Paediatric Association as well.

What do we know?

Researchers in the United States found that 60 percent of children who enter child welfare systems prior to their fifth birthday have a developmental issue. Between 30 and 80 percent enter care with at least one medical condition and up to 80 percent are living with a significant mental health need.

Across Canada, Black, Indigenous, LGBTQ2S+, newcomer and low-income populations continue to be over-represented in the child welfare system. Given this, prioritizing these populations from a health equity perspective could be very beneficial for these children and youth, and could lead to improvements in other government systems, including justice, education and social assistance, where there are also significant

inequities for these populations.

Recent research related to "aging out" of child welfare services in Canada highlights the imminent need for change across the continuum of care for our children and youth. Adverse outcomes in British Columbia are estimated to cost between $222 and $268 million for the cohort of approximately 1,000 youth who age out of care each year.

Beyond adverse mental and physical health effects, this also adversely affects other areas of their lives, including education, housing and homelessness; criminalization; and unemployment, poverty and income support. What's not included is the intangible costs, such as these young people's trauma, hardship and suffering.

What are we calling for?

The complex health and social issues faced by children and youth in care call for a comprehensive cross-sector collaborative approach to health care. However, this population often experiences fragmentation. They often struggle to access comprehensive health care in care homes and may only have access to episodic health care in response to acute illness. Health care is often organized and or provided by a variety of professionals who may not know them well.

Social workers, tasked with the care of these children, may have limited access to children's health-care records and histories; and despite best efforts, they may be unable to provide health-care professionals with the information necessary to deliver safe and excellent care.

When there is a necessary change in a child or youth's continuum of care and residential placement, especially out of their community, they may become disconnected from their primary health-care providers and services. As a result, it becomes difficult to provide the comprehensive

health care necessary to support these often vulnerable children and youth.

That means children and youth with child welfare involvement are at risk of bearing a heavier burden of illness than their counterparts who do not have child welfare involvement, as a result of an inequitable system of health-care provision that fails to address their unique circumstances.

The American Academy of Pediatrics recommends that each child and youth in foster care should have continuity of care and the provision of comprehensive medical, psychological and dental assessments that are co-ordinated by health-care professionals who are well versed in the effects of trauma and neglect on the developing child.

As the legal guardian of children and youth in care, it is critical that governments prioritize a comprehensive, trauma-informed health strategy for children and youth in care that is reviewed and evaluated by a multidisciplinary team. This team needs to meaningfully include members with lived experience in collaboration with families and community.

In addition to our national youth mental health strategy and our Youth Policy, we urgently call for a health strategy for children and youth in care to help bolster cross-system integration and communication. This could enable sharing key health information that would help create unique health and social plans for children and youth in care, which would travel seamlessly with them across their family care, foster/group care and professional care. This specialized focus for children and youth in care is long overdue.

We know better; now we need to do better.

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