Caring for Children in Foster Care: Managing Care Transitions and Placements

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Participants of this presentation will be able to:

• Describe how the child welfare system works
• Define some common child welfare terms
• Identify potential risks associated with foster care
• Discuss best practice care coordination for this high risk-high needs population
• Identify potential complications from frequent transitions in foster care placement
Child Welfare System Goals

Permanency

- “Forever” family
  - Family preservation
  - Reunification with birth family
  - Adoption by kin or caring adults
  - Legal guardianship
Guardianship

- Legal custody without terminating parental rights
  - Establishes permanency (forever home)
  - Removes youth from child welfare (CW) system
  - Allows guardian to make important decisions on behalf of youth

Dependency

- CW Legal Process
  - Court oversight
  - Protect child
  - State assumes temporary legal custody
  - Youth may remain in-home (in-home dependency)
Child Welfare System Goals

PERMANENCY
Permanency & stability in living situations
Continuity of family relationships & connections

SAFETY
First protected from abuse & neglect
Maintained in homes when possible

OUTCOMES
Safety
Permanency
Well-Being

Families have enhanced capacity
Appropriate services for educational, physical & mental health needs
2017 CW Statistics (AFCARS, 2018)

- On any day 442,995 children are in foster care
- 269,690 children entered foster care
- 247,631 children exited foster care

2017 Foster Care Placements

- Nonrelative foster family homes 45%
- Relative foster family homes 32%
- Institutions 7%
- Group homes 6%
- Trial home visits 5%
- Pre-adopt homes 4%
- Runaway 1%
- Supervised independent living 1%
2017 Length of Stay for Youth Exiting Foster Care

- <1 month 9%
- 1-11 months 34%
- 12-23 months 30%
- 24-35 months 15%
- 3-4 years 9%
- 5+ years 4%

2017 Foster Home Exits

- Reunification 49%
- Adoption 24%
- Guardianship 10%
- Emancipation (“aging out”) 8%
- Living with other relatives 7%
- Other outcomes 2%
**Reasons for Removal (AFCARS, 2018)**

- Neglect 62%
- Parent Drug Abuse 36%
- Caretaker Inability to Cope 14%
- Physical Abuse 12%
- Housing 10%
- Child Behavior Problem 9%
- Parent Incarceration 7%
- Parent Alcohol Abuse 5%
- Abandonment 5%
- Sexual Abuse 4%

**CW: High Rates of Health Care Needs**
Health Care Needs of Foster Youth

- Children in foster care have poor health relative to children in the general population (Turney, 2016)
- Upwards of 80% of CW-involved youth have developmental, behavioral, and/or emotional concerns

Behavioral Health Care Needs of Foster Youth

- High rates of comorbidity
- Depression, anxiety
- Post-traumatic stress disorder (PTSD)
- Disruptive behaviors
- Attention deficit hyperactivity disorder (ADHD)
- Learning problems
- Substance use disorders
- Suicide attempts
Foster Care Adult Outcomes Compared to Non-Foster

- Low academic achievement
- Unemployment, low income, poverty
- Disability
- Lack of insurance
- Pregnancy
- Homelessness
- Justice system involvement
Youth “aging out” of the foster care system have access to Medicaid insurance until age 26

Foster Youth Compared to Non-Foster Medicaid

- 5-8 times mental health service use
- 8-12 times mental health expenditures
- 2-8 times various psychotropic prescribing metrics
Foster Youth: Behavioral Health Risk Factors

- Maltreatment-Trauma
- Conditions leading to removal
- Removal from home and familiar ecology
- Disrupted attachments
- Multiple placements

Foster Youth: Behavioral Health Risk Factors

- Poverty
- Social influencers of health
- Genetic vulnerability
- Assorted mating
- Gestational exposures
Toxic Stress/Adverse Childhood Experiences (Johnson, 2013)

Trauma/Toxic Stress/Adverse Childhood Experiences
Adverse Childhood Experiences (ACEs) and Adult Health (Felitti, 1999)

• ACEs dose-dependent effects
  – Heart disease
  – Cancer
  – Chronic lung disease
  – Bone fractures
  – Liver disease

Reasons for Appropriate Higher Health Care, Psychotropic Utilization

• Higher (behavioral) health care needs
• Gaining access to Medicaid insurance
• CW systematic physical/mental health screenings and assessments
• CW advocacy and follow up for indicated treatments
Potential Factors for Inappropriate Prescribing

• Insufficient information and time to properly evaluate and reassess
• Limited support for collaboration among providers and stakeholders
• Under-recognition of trauma etiology in complex presentations

Potential Factors for Inappropriate Prescribing

• Limited access to effective and specifically targeted psychosocial interventions
• Workforce insufficiently trained in effective psychosocial and psychopharmacologic treatments
• Poor continuity of care
Potential Factors for Inappropriate Prescribing

- Limited integration of care
- Ineffective advocacy
- Unrealistic hope that medication will stabilize a complex psychosocial situation

Potential Factors for Inappropriate Prescribing

- Lack of commitment to indicated parent skills training
- Lack of commitment to or confidence in psychotherapy for complex problems
Potential Factors for Inappropriate Prescribing

- Responding to behavioral crises or urgent situations with pharmacologic interventions
- Problems within the CW and public behavioral health systems, and how they interface

Who Can Consent?

- Varies based on youth status in child welfare system
- Inter-state variability for age of consent and who consents for physical, reproductive, and mental health, and substance use disorder assessment and treatment
- Direct consent questions to child welfare worker
CW Values and Principals

• Value and prioritize family’s right to raise their children
• Children are usually best raised by their families
• Unless there are compelling reasons to terminate parental rights

CW Values and Principals

• Child and Adolescent Service System Principals (CASSP, Stroul and Friedman, 1986)
  – Child-centered
  – Family focused
  – Strengths-based
  – Culturally competent
  – Least restrictive appropriate setting
CW Values and Principals

- Families as full partners
- Access to a comprehensive array of services
- Individualize services to youth and family
- Highlight family voice and choice

Strengths-Based Approach

- Parental resilience
- Parenting and child development knowledge
- Social connections
- Concrete/pragmatic supports
- Social-emotional competence
Culturally-Informed Approach

- Culture
- Ethnicity
- Race
- Language
- Sexual orientation
- Gender identity
- Spirituality

Culturally-Informed Approach

- Some minority groups, such as African Americans and American Indians, are over-represented in child welfare system
  - Indian Child Welfare Act (ICWA) 1978-specific guidelines for American Indian children in foster care to preserve cultural heritage
LGBTQ Youth Also Over-Represented in Foster Care

• Placed for same reasons, as non-LGBTQ youth
• In addition,
  – May face homo- or transphobia
  – Must assess safety in school, social networks, communities, homes
  – Judge whether and to whom to disclose LGBTQ identity

Addressing Disrupted and Fragmented Care

• Federal requirements for states to oversee and coordinate health care services, including behavioral health
  – Medical homes
  – Medication monitoring
  – Health passports/summaries
• Some states have single managed care organization (MCO) for child welfare
Sources of Information

- Family
- Dependency court documents
- Court evaluations
- Initial and subsequent pediatric, development, trauma, mental health, and substance use screens-foster care
- Initial pediatric evaluations-foster care
- MCO utilization management (UM) and case management (CM) records

Sources of Information

- Behavioral health evaluation and treatment notes
- Some states set up additional consenting process for CW psychotropic meds
- School health records, evaluations, and notes
- Juvenile court evaluations and notes
Treatment Principals

• Adequate information to proceed

• Youth should be accompanied to appointments by someone who can describe youth’s recent functioning

• Involve family when appropriate

• Educate family and caregivers

Consider Effects of

• Trauma and maltreatment
• Family separation
• Disrupted attachments
• Separation from familiar ecology (school, neighborhood, teachers, friends, other supports)
• Response to transitions
• Caution in developing new relationships
High Rates of Unmet or BH Needs (NSCAW)

- <6 years old with development or behavioral health needs: <25% received services
- 2-14 years old with strong evidence of clinical needs: ~25% received some care in the previous 12 months
- 2-15 years old out-of-home for 1 year: ~25% with high needs had not received services

Most At-Risk for Underserved BH Needs

- Victims of neglect
- African-American youth
- Young children
- Youth in kinship care or remaining at home
Child Welfare Treatment Assessment Resources

- California Evidence-Based Clearinghouse for Child Welfare (cebc4cw.org)
- Washington State Institute for Public Policy (wsipp.wa.gov), child welfare tab

Effective CW Treatments (not exhaustive list, see websites)

- Attachment and Biobehavioral Catch-up (ABC): for caregivers of children 6 months to 2 years old who have experienced adversity
- Parent-Child Interaction Therapy (PCIT)
- Treatment Foster Care Oregon (TFCO)
- Multidimensional Family Therapy (MDFT)
- Multisystemic Therapy (MST)
Effective CW Treatments (not exhaustive list, see websites)

- Trauma treatments:
  - Child-Parent Psychotherapy (CPP): children 0-5 years old who experienced trauma and their caregivers
  - Trauma Focused Cognitive Behavioral Therapy (TF-CBT): youth 3-18 years old with post-traumatic symptoms, and caregivers
  - Prolonged Exposure Therapy for Adolescents (PE-A): youth 12-18 years old who experienced trauma

CW Treatments with Risk of Harm

- “Rebirthing” or Holding “Therapies”
- Associated with some deaths
Health Care Worker Self-Awareness

• Child-rearing beliefs
• Family functioning
• Abuse
• Neglect
• Disrupted attachments

Questions?

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