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

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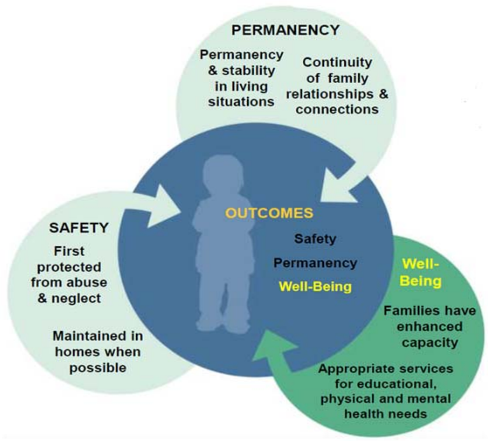
Participants of this presentation will be able to:

- 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

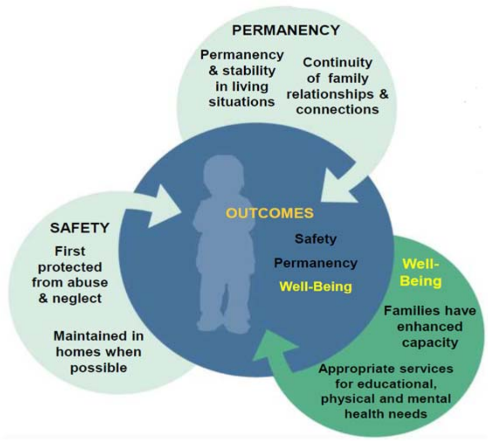
Guardianship

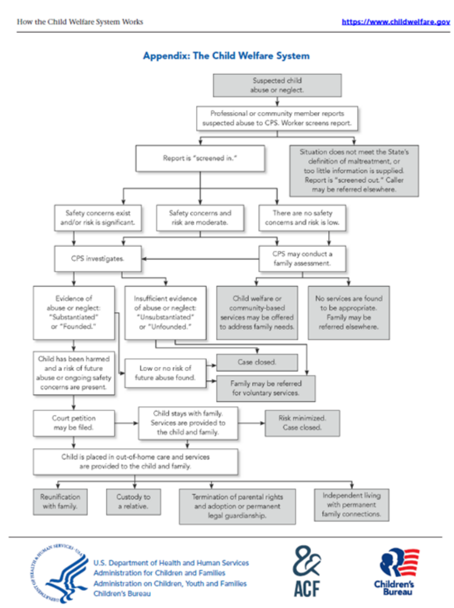
- Legal custody without terminating parental rights
  - Establishes permanency (forever home)
  - Removes youth from child welfare (CW) system
  - Allows guardian to make important decisions on behalf of youth

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





How the Child Welfare System Works https://www.childwelfare.gov

Appendix: The Child Welfare System

U.S. Department of Health and Human Services
Administration for Children and Families
Administration on Children, Youth and Families
Children's Bureau

ACF

Children's Bureau

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%

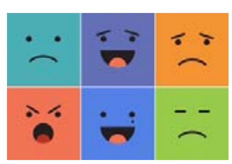
2017 Foster Home Exits

- 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

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

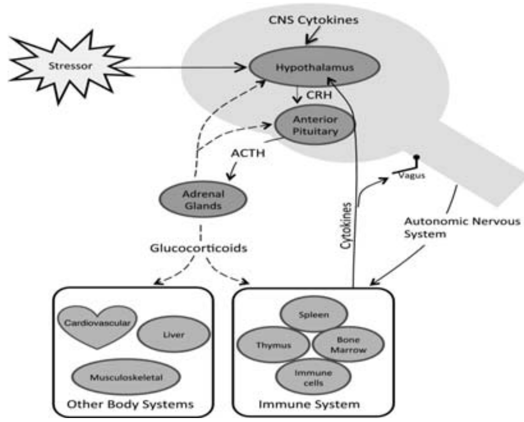
Foster Youth: Behavioral Health Risk Factors

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

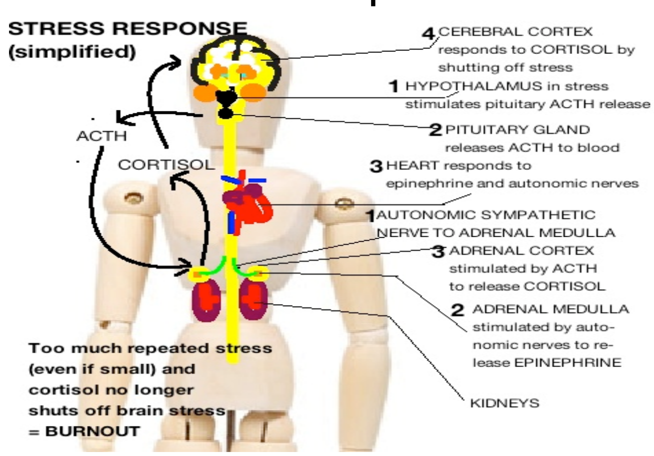
Foster Youth: Behavioral Health Risk Factors

- 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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