

Mental Health Needs of Children in Foster Care

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OBJECTIVES

- Explore mental health risks and vulnerabilities specific to children in out-of-home placement
- Understand some of the ways that changes in placement compound the risks
- Briefly review AACAP recommendations for providing mental health care to these kids

Paths into Foster Care

- Abuse and neglect (70% to 80% of cases)
- Parent/guardian's death, abandonment, incarceration
- Truancy or other juvenile offenses, when court deems parent/guardian is unable to provide needed structure
- Voluntary decision by parent (unusual)

How Long are Foster Placements?



- 45%: less than 1 year
 - 23%: one to two years
 - 11%: two to three years
 - 10%: three to four years
 - 10%: five years or more
- Adoption and Foster Care Analysis and Reporting System (AFCARS), FY 2011 data*

Characteristics of Foster Children on Entry into State-Sponsored Care

- High incidence of genetic, teratogenic, biological (malnutrition and injury), and environmental risk factors
 - Parental mental illness
 - Fetal substance exposure, low birth weight
 - Brain injury, malnutrition, lack of medical care
 - Trauma and neglect
 - Iatrogenic trauma: removal from home, siblings, school, extended family, community supports

Characteristics of Foster Children on Entry into State-Sponsored Care

- An estimated **80%** have mental health or developmental problems on entry to state-sponsored care
 - **ADHD, ARND**, mood and anxiety disorders
 - 25% or more meet diagnostic criteria for **PTSD**
 - **LEARNING PROBLEMS**
 - Foster children are *3 times as likely* to receive special educational services (Massachusetts data)

Foster Care, Placement Change, and School Achievement

- Research suggest that children *lose an average of 4 to 6 months' educational attainment* with each school change
- 65% of children in foster care experienced *7 or more changes in school* from elementary through high school
 - A loss of *28 to 42 months'* attainment
 - Extracurricular participation is rare
 - Lasting friendships are impossible
 - Mentorship opportunities are curtailed

Paths out of Foster Care

- Reunification
- Placement with extended family
- Foster care (non-family)
- Group home or residential treatment
- Adoption
- Time: 25,000 children **“age out”** of foster care annually

“Aging Out” of Foster Care: What A Long, Strange Trip It’s Been

For all “aging out” of care:

- 24.3% had lived in 1 or 2 placements
- 28.9% had 3 or 4
- 20.5% had 5 or 6
- 26.2% had 7 or more

“Aging Out” of Foster Care: Outcome at Ages 18 to 25

- **65% “age out” without secured housing**
..while 1/2 of the general population continues to live with parents between 18 and 24 yo
- **50% leave the system with < \$250**
..while 2/3 of other adults in their twenties receive some financial help from parents
- These kids are **twice as likely to be parents** as same aged peers

“Aging Out” of Foster Care: Outcomes at Ages 18 to 25, Midwest study

- 33% to 50% do not have a high school diploma or GED
 - <20% attend any college classes, only 3% to 5% graduate
- 25% to 40% will be homeless or “couch-surf” during a year
- At 19 yo, only 40% were employed
 - 90% of those earned <\$10,000
 - 25% had dealt drugs
 - 11% had engaged in prostitution
- 25% - 40% had arrests or incarcerations

Obstacles to Providing Comprehensive Mental Health Care to Foster Children

- Changes in placement interrupt therapy, school adjustment, peer relationships
- Changes in case management can result in “drift” or diffusion of long term goals
- Inadequate resources to provide long-term therapy, adequate level of placement

Obstacles to Providing Comprehensive Mental Health Care to Foster Children

- Legal guardian (usually case manager) must provide consent for care, but is often not familiar with child's day-to-day functioning
- While foster parents can give data on a child's day-to-day functioning, they are not usually the child's legal guardian- so they cannot give consent for care
- Case managers (not foster parents) are the keepers of the child's past psychiatric records, reason for removal from family, and any *known* developmental or medical history
 - Caseloads are heavy and turnover is high
 - Case managers vary in experience, energy, and skill
 - Personal or agency philosophy of care must be considered

AACAP “Best Principles” Guidelines

BASIC PRINCIPLES:

- Every youth should be screened and monitored for emotional and/or behavioral disorders
 - Those with apparent emotional disturbances should have a comprehensive psychiatric evaluation
 - If treatment indicated, a biopsychosocial treatment plan should be developed

AACAP “Best Principles” Guidelines

- Youth receiving mental health care are entitled to:
 - Continuity of care
 - Effective case management
 - Longitudinal treatment planning
- Youth in state custody should have access to effective:
 - Psychosocial, psychotherapeutic, and behavioral treatments
 - When indicated, pharmacotherapy

AACAP “Best Principles” Guidelines

- Psychiatric treatment requires a two-staged, “rational consent” procedure
 - Consent by agency or person acting in loco parentis
 - Assent from the youth
- Medication management should include:
 - Identification of target symptoms
 - Monitoring of response to treatment
 - Screening for adverse affects
- State procedures should be based on these principles, and states should assure that youth in state custody receive treatment in a timely manner

AACAP “Best Principles” Guidelines

- **Guideline 1: States should**
 - Identify the parties empowered to give consent
 - Establish a mechanism to obtain assent from minors when possible
 - Obtain educational materials and medication information to facilitate the consent process (*recommended*)
 - Establish training requirements for child welfare, court personnel, and foster parents to help them advocate for children in their care (*ideal*)
 - Training should include names/indications for use of common meds, how to monitor for response and side effects, maintaining medication logs
 - It should include written “Guide to Psychotropic Medication”

AACAP “Best Principles” Guidelines

- Guideline 2: Juvenile courts or agencies empowered to consent for treatment should design and implement (with consultation from a child and adolescent psychiatrist) oversight procedures that:
 - Establish guidelines for use of psychotropic medication for children in state custody
 - Establish a program administered by child and adolescent psychiatrists to oversee use of medications for youth in state custody (*ideal*), which would:
 - Establish an advisory committee to oversee a formulary and medication monitoring guidelines
 - Monitor rate and type of med usage and adverse reactions
 - Review non-standard, unusual, or experimental interventions
 - Provide quarterly reports to the state, available to clinicians

AACAP “Best Principles” Guidelines

- Guideline 2 (cont’d):
 - Maintain an ongoing record of diagnoses, height and weight, allergies, medical history, problem list, psychotropic medications, and adverse med reactions that is easily **available to treating clinicians 24 hours a day** *(recommended)*

AACAP “Best Principles” Guidelines

- Guideline 3 : State agencies or court empowered to consent for treatment should design a consultation program administered by child and adolescent psychiatrists *(recommended)*, which would
 - Provide consultation by child and adolescent psychiatrists to the person or agency responsible for consenting for treatment
 - Provide consultation by child and adolescent psychiatrists to , and at the request of, physicians treating this population
 - Conduct face-to-face evaluations at the request of the agency empowered by law to consent for treatment when concerns have been raised about the pharmacological regimen

AACAP “Best Principles” Guidelines

- Guideline 4: Agencies or courts empowered by law to consent for treatment should create a website accessible to clinicians, foster parents, and other caregivers, to include *(ideal)*:
 - Policies and procedures governing psychotropic med management
 - Educational materials about medications
 - Consent forms
 - Adverse effect rating forms
 - Reports on prescribing patterns for psychotropic meds
 - Links to reliable websites with information on diagnosis and medications

Different Priorities, Different Pressures

- **Foster parents**
 - Safety in home, minimization of aggressive/destructive behavior
 - Good sleep, continence
 - Vary in their focus on child's long term goals, from minimal investment to adoption
- **Case managers**
 - Time/workload/budget restraints
 - Agency's philosophy re: meds, reunification vs. adoption, etc.
 - Vary in their focus on child's long term goals- often have not known the child over an extended period

Different Priorities, Different Pressures

- School staff
 - Strongest pressures are toward short-term goals- reduce disruptive behaviors, maintain safe school environment
 - School placement changes can interrupt, postpone, or preclude assessment
 - Children often come with incomplete records, and even if there is an IEP the new school may not be aware of it
 - Scarce resources, squeaky wheels get the grease
 - Who is bird-dogging the school if needed?

Comprehensive Assessment for Foster Children

- Allow some extra time for the assessment
 - Developmental history
 - Pertinent medical records
 - Parental substance abuse/family mental illness history
 - Reason for child's removal
 - Placement history since removal
 - Current and past psychiatric meds
 - Psycho-educational test results, current IEP

Comprehensive Assessment for Foster Children

- **EXPLORE GOALS**
 - Is the plan known- reunification, adoption, transition ?
 - Child's goals for placement, independent functioning (for older children)

- **ADVOCATE, ENLIST PARTICIPATION**
 - Has the child had adequate educational assessment?
 - If there is an IEP, has it followed him/her to new school when placement change occurs?
 - Is the child receiving appropriate therapy?

Comprehensive Assessment for Foster Children

- **COMMUNICATE**
 - Case manager
 - Foster parent/group home staff
 - Therapist
 - School staff

Comprehensive Assessment for Foster Children

- **IS THERE A “MAIN” ADVOCATE?**
 - Many children have had multiple discontinuities- case managers, therapists, psychiatrists, schools, and peer groups
 - Who can provide the most continuity?
 - The person who has known the child the longest is often the most effective ‘linchpin’ for the treatment team
 - This may be you, or long-term foster parent

Programs to Help Children “Aging Out”

- The Chafee Foster Care Independence Act of 1999
 - Provides funding to states for transitional youth programs, mainly for ages 16-18. States must put up a 20% match to receive Chafee funds. Up to 30% of a state’s Chafee Act funds can be used for housing for youth aged 18-21, but states may choose to use less for this purpose
 - Arizona allotted \$1300 per participant
 - Youth must participate in an approved educational, vocational, or treatment program, or be employed to receive housing assistance

Programs to Help Children “Aging Out”

- Family Unification Program (FUP)
 - Funded by HUD
 - Provides time-limited housing vouchers to youth aged 18-21 who left foster care after age 16
- YouthBuild USA
 - Funded by the Department of Labor
 - Low-income youth 16-24
 - Obtain GED while building affordable housing

Programs to Help Children “Aging Out”

- JobCorps: for low-income youth ages 16-24, provides housing, a small allowance, and up to 2 years' education, vocational training, and job placement in:
 - GED completion (if needed)
 - Construction
 - Welding
 - Automotive/machine repair
 - Health care
 - Business and accounting
 - Hospitality
 - Renewable resources
 - Information Technology
 - Transportation