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

New York City Children’s Services database (CCRS), 2006
“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

Atkinson, M: Aging Out of Foster Care: Towards a Universal Safety Net for Former Foster Care Youth, http://www.law.harvard.edu/students/orgs/crcl/vol43_1/183-212.pdf
“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”
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
• 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)*
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