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Beyond the System: Nurturing Healing and Belonging for Foster Youth

Child Maltreatment and Violence Committee
AACAP Adoption and Foster Committee
Diversity and Culture Committee

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Structural Issues That Affect Youth in Foster Care

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Overview

- Context – Health/Mental Health Needs
- Challenges
  - Child Welfare Systems
  - Youth Perspective/Engagement
  - Parent Engagement
- Moving the Bar

One Sentence Cases

8-year-old – now in 3rd foster care placement outside county of foster care case. Foster parent says, "I don't know how much longer we can do this – he never sleeps and says scary things." Soon afterwards, admitted psychiatrically and from there moved to different, 4th, foster home.

10-year-old – presented to ED with 2nd foster parent for making a threat to stab parent and take out a foster sibs ET tube. After ED visit, moved to a 3rd foster home in a different county. Discussion about residential.

Health Needs of Children in Foster Care

- 30-80% have at least one physical health problem at entry
- At least 50% have a chronic health condition (dental caries, asthma, obesity, anemia, vision/hearing, mental/developmental disorder)
- 10% medically fragile or complex
- 35% with oral health problems

Health Needs of Children in Foster Care

42.7% at least one mental health problem:

- 9% depression
- 13.9% suicidality
- 23% substance abuse
- 13.5% anxiety
- 18.6% ADHD

Of kids with any problem:

- 52% single problem
- 28% two problems
- 20% three or more problems

Heneghan A, *et al*. *J Adol Health* 52(5): 634-640. 2013

Health Needs of Children in Foster Care

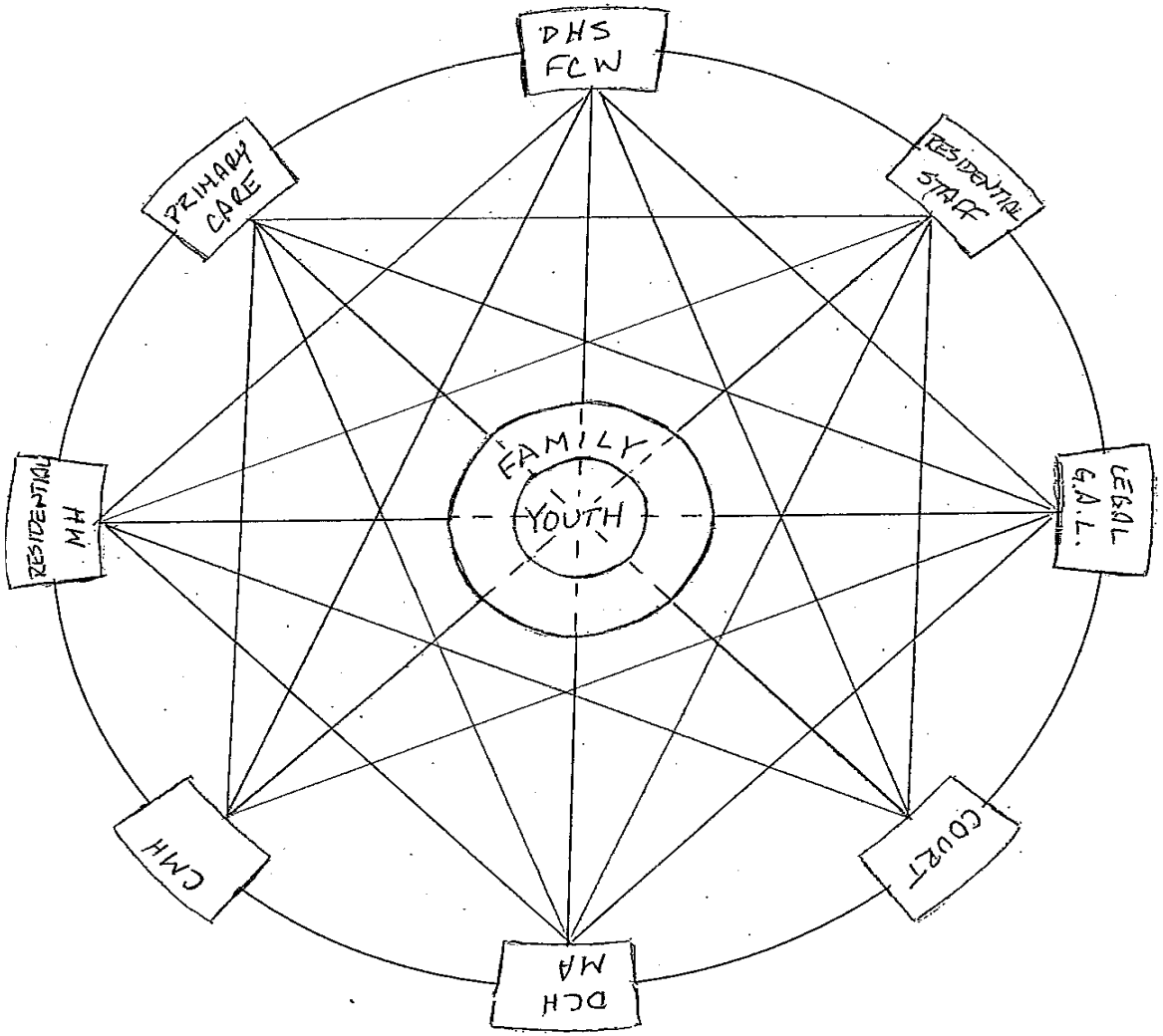
- National and state foster care data:
  - More medications
  - More complex medication combinations
  - Challenges in connecting to full range of treatment resources
  - Challenges in care coordination
  - Challenges recognizing and responding to trauma exposures

Heneghan A, *et al*. *J Adol Health* 52(5): 634-640. 2013

Challenges: Complex Child Welfare Systems

- DHHS and private placement agency foster care (sometimes also juvenile justice)
- School systems
- Courts (family court re: foster care/juvenile justice courts)
- State and federal government (executive and legislative)
- Primary health care systems
- Mental health care systems
- Advocacy organizations

Challenges: Complex Child Welfare Systems



Challenge: Mental Health Access

Insufficient access - universal

- Outpatient psychotherapy services,
- Intensive community-based services
- Psychiatric services

System fragmentation – **varies by state/region**

- Medicaid health plans
- Specialty behavioral health services

Challenge: Child/Youth Engagement

- Pre-System Trauma Exposure
  - Attachment/trust
  - Awareness/expressions of emotions
  - Learned limits on interaction
- Post-System Exposure
  - Adult expectations
  - Transitions in care
  - Relationships with providers/system

Challenge: Parent Engagement

Practical challenges

- Geographic – children and parents both are mobile
- Socioeconomic limitations (e.g., lack of access to communication technology)
- Parental access to mental health/substance use can be dependent on the presence of their children
- Parental challenges in productive communication with medical care providers

Challenge: Parent Engagement

Philosophical challenges – partners vs. obstacles

- Multigenerational nature of maltreatment
- Nearly unavoidable adversarial nature of child protective services
- Parents' strengths/needs
- Evolution of physician role – gradual shift from paternalistic to shared decision making

Challenge: Parent Engagement

Philosophical challenges – partners vs. obstacles

- Prior experienced disrespect associated with doubt of benefit (Kerkorian *et al.* 2006)
- Positive expectations linked to positive experiences and intent – negative expectations not linked as clearly to negative experience (Thompson *et al.* 2013)
- Former marriage, satisfaction with prior services, physical/psychological partner violence, depression correlated with seeking services (Thompson *et al.* 2012)

Desired Outcomes

Demonstrate improvements in:

- Permanency – sustained placements, successful reunification
- Safety – reduced/eliminated recurrent maltreatment
- Wellbeing:
  - Evidence of improved access to well-coordinated care
  - Improved functioning
  - Possibly could see reduction in overall psychotropic medication use

Moving the Bar (solving the Rubik's cube)

Better data on which to base care decisions

- More longitudinal studies – diagnosis and natural history
- More psychotherapeutic treatment studies – expand available approaches

Better access to broader range of treatment **and supporting** activities

- Require adequate case formulation (see McTavish *et al.*)
- Require **full** child and family and system partner engagement
- Require training in fidelity measures, and use of measurement-based care
- Care coordination reimbursement

Moving the Bar (solving the Rubik's cube)

Better informatics systems

- Health information exchange networks
  - Need for secure/confidential systems
  - Full participation by providers (MA Claims/CW Information Systems)
- Ease of information access for all key participants in the system
  - Foster care workers – e.g., immunization data
  - Primary care physicians – prior health care, evidence of existing/chronic conditions
  - Psychiatry – longitudinal history – diagnosis, treatment

What Can CAPs Do?

- Advocate for clinical systems/infrastructure to address needs
- Provide comprehensive case formulation
- Advocate for comprehensive assessment/treatment
  - Comprehensive emotional and behavioral services
  - Parent (foster and birth) education (e.g., foster parent training)
  - Adjunctive services (school, community)
- Recognize and work to fill gaps in communication
- Be a teacher! (will require developing infrastructure)

Summary

- Children in foster care and Juvenile Justice settings are more clinically complex than their community-based cohort counterparts
- Still working towards effective systems of care
- Need to advocate for the expansion on information to guide care recommendations
- Need to account for and address both practical, philosophical and experiential barriers to youth and parent engagement
- Need to make youth and family engagement the required (and measured) default setting

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Foster Care Youth and The Development of Autonomy

A Clinical Teaching Presentation for Child Psychiatrists

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Youth Who Age Out of Foster Care

- Many young people leaving foster care face significant challenges with housing, employment, and food security.
- Adverse outcomes remain common even among youth who participate in independent-living programs.

Autonomy

- More than just decision-making capacity
- Autonomy also includes:
  - Clear sense of self
  - Stable goals
  - Ability to delay gratification
- Autonomy is the capacity to understand oneself, make choices, and pursue personally meaningful goals.

Autonomy Supports

- Education
- Relationships
- Employment
- Preparation for adult life

Development of Autonomy for Youth in Foster Care

- For young people in foster care, opportunities to develop autonomy may be disrupted by trauma, caregiver changes, and limited control over important decisions.

Autonomy - Three Dimensions

Autonomy is the personal experience of self-governance. Three dimensions of autonomy are:

- **Cognitive:** feeling that one has some control over one's life.
- **Behavioral:** being able to make decisions and act on them.
- **Emotional:** developing a sense of self and values that is not wholly dependent on others' approval.

Autonomy Develops Within Relationships

- A secure, reliable relationship can provide a “secure base” from which a young person explores and takes developmentally appropriate risks
- Caregivers help young people build autonomy by offering emotional support and opportunities to practice decision-making
- Support and guidance can coexist with increasing choice and responsibility
- Autonomy should be scaffolded—not demanded before a young person has the skills or support to manage it

Support Practice of Autonomy

- Offer meaningful, bounded choices
- Break larger goals into small, concrete steps
- Use coaching and clear expectations rather than either control or abandonment
- Let young people take ownership of selected tasks or projects
- Include trusted adults, such as caregivers, mentors, coaches, or school staff, where appropriate

Barriers Facing Youth In Care

- Early adversity and trauma
- Difficult or disrupted attachments/frequent changes in caregivers or placements
- Fewer consistent opportunities to practice choice and independence

A Developmental Formulation

- What goals and values matter to the young person?
- What practical or system-level constraints limit their options?
- What choices and responsibilities have they had the chance to practice?
- Who are their dependable adults—and how stable are those relationships?
- How do trauma symptoms or emotion-regulation difficulties affect decisions?

What Can Clinicians Do?

- Build a therapeutic relationship that is dependable, respectful, and collaborative
- Invite the young person’s perspective in treatment and care planning
- Help identify personal values and translate them into achievable goals
- Practice problem-solving and emotion-regulation skills
- Encourage safe, supported decision-making rather than taking over unnecessarily
- Coordinate with caregivers and other adults so that autonomy-supportive approaches are consistent

What Can Caregivers Do?

- Provide predictable routines and reliable emotional availability
- Offer a secure base while allowing age-appropriate exploration
- Help the young person reflect on how past experiences may affect present reactions
- Acknowledge that healing from trauma and difficult relationships takes time
- Support safe opportunities to make choices, learn from outcomes, and try again

Interventions For Encouraging The Development of Autonomy

- **Attachment-focused work:** examples include Parent-Child Interaction Therapy and Circle of Security for young children; other approaches emphasize reflective dialogue and safe relationships
- **Emotion regulation:** skills-based work, including dialectical behavior therapy strategies such as validation and emotion-regulation skills
- **Goal-setting:** motivational interviewing techniques can help youth identify values, set goals, plan steps, and problem-solve setbacks

Clinical Cautions

- Autonomy does **not** mean leaving a young person to manage alone
- Increased choice must be balanced with safety, developmental capacity, and the young person’s circumstances
- Avoid equating independence with success; healthy interdependence and access to support matter

Clinical Takeaway

Consider autonomy development as part of formulation and care planning, alongside safety, mental health, education, relationships, and material needs.

Take-Home Messages

- Autonomy is a developmental capacity supported by relationships, practice, and emotional skills
- Foster-care experiences can create barriers, but do not determine a young person's future
- Child psychiatrists can promote autonomy by listening, collaborating, supporting regulation, and helping youth practice decisions safely
- Pair opportunities for choice with dependable relationships and practical support
- Treat the young person as an active partner in their care and future planning

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