



June 13, 2008

Dear Chairman McDermott and Members of the Sub-committee,

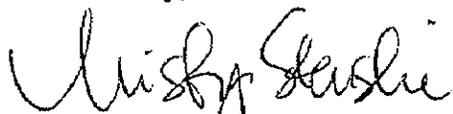
Thank you again for the opportunity to be part of the recent hearings on the use of psychotropic medications among children in foster care. As a part of the national community of alumni of the foster care system, it is a privilege and an honor to share our voices and our experiences with you in the hope of improving the lives of the ones who come after us in foster care.

I especially want to thank you and Congressman Weller for your particular commitment to being 'the godfathers of all foster children'. I was incredibly moved by your comments at the hearing where you claimed that role to us. For me, and for so many others of the 12 million foster care alumni in the United States, it was a powerful experience to hear you take that place in our lives. The further statement made through House Resolution 1208 (sponsored by Congressman John Lewis) actually has brought a great deal of happiness to the national alumni community, many of us moved to tears at the thought that we were loved, supported, and not forgotten.

Attached you will find responses to the additional questions from the Sub-committee. I hope you will find this information helpful in your work.

Again, thank you for the opportunity to share our experiences and please contact us anytime you are working on issues related to child welfare—our community is highly invested in looking after our younger brothers and sisters in care.

Sincerely,



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**RESPONSES TO ADDITIONAL QUESTIONS FROM THE SUBCOMMITTEE ON
INCOME SECURITY AND FAMILY SUPPORT RE: THE USE OF PSYCHOTROPIC
MEDICATIONS AMONG CHILDREN IN FOSTER CARE**

How do youth who age out of the foster care system and who are prescribed psychotropic medications fare once they leave care? Do these youth continue to receive their medications and an appropriate level of medical care to treat their illness once they emancipate from the system?

There have been too few formal studies that look at what happens to young people once they leave the foster care system, particularly as it applies to the use of medication and the access to ongoing health care. The existing evidence, along with the anecdotal evidence within the community of alumni of the system and the professionals who work with us makes clear that this is an area of major concern.

As you heard at the Hearing on May 8, there are extremely high rates of psychotropic medication use with youth in care. For those of us from foster care, we are typically overmedicated during placement and then underinsured upon emancipation. We are in the position to fend for ourselves in regards to accessing—and paying for—ongoing mental health care. Studies of emancipating youth indicate a great risk for unemployment/under employment, which in turn increases the risk that the young person would not have health insurance. Both the overmedication while in care, and the lack of insurance at emancipation can serve as an incentive for the young person to NOT continue to fill medication prescriptions or secure ongoing psychiatric care. A related issue is that there may be dire consequences for sudden withdrawal from certain psychotropic medications.

The Chafee Foster Care Independence Act allows for ongoing health care coverage for youth in transition, but this is only available in some states. In states where the Chafee option is not in place, young people may be able to apply for Medicaid, however, there are often complicated and conflicting rules in place—for instance, in NY, one cannot get Medicaid and be in college at the same time.

There are many layers of consideration in answering this question:

1. Does the young person know about his diagnosed mental health conditions and their treatment? Too often, the answer to this is 'no'. The empowerment of young people in regards to their own lives is absolutely necessary to ensure that they can make informed decisions for themselves upon emancipation.
2. Are there ongoing resources to support the transitioning youth with their mental health care—for instance, is there insurance available? Are there people responsible for ensuring the young person knows how to access those resources? Are there appropriately trained mental health professionals available as service providers?

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3. When young people emancipate into 'independent living', they often find their way back to their birth families, which brings the risk of an increased need for mental health support—possibly including medication intervention—at the very time when access to these supports is taken away.

Do most foster parents and other caretakers generally have the resources that are necessary to monitor the health care needs of children placed in their care who have been prescribed these medications?

There is a broad spectrum of caretaker knowledge, skill, and access to adequate and appropriate mental health resources. While there are some foster parents and kinship caregivers who are well-informed advocates for the young people in their homes, many are extremely unprepared, under-trained, and under-supported in this area. Foster parent training and record-keeping generally requires that licensed foster parents follow specific protocol in the administration of prescribed medications, but there is not a typically a requirement beyond this. Given the instability in placements and professionals responsible for individual youth, it is too often the case that no single person in the child's life has either all of the information they need or the authority they need to meaningfully advocate for the mental health needs of youth in care.

Coordination between the mental health and child welfare systems is lacking—and likely needs to be incentivized to find sustainable and significant improvements.

One area of particular concern in the alumni community is the sense that foster children are frequently misdiagnosed with disorders and/or over prescribed medications when their difficulties are really their attempts to adjust to the very abnormal life situations connected to being in foster care. We often see that children are prescribed medications when caretaker-focused behavioral interventions would likely be safer, more effective, and lead to greater long-term benefit. As we've heard from a member of Foster Care Alumni of America, "pills can not take away what happened to me". Ensuring that the training and supervision of caretakers includes support for these behavioral interventions is a top recommendation from people in and from foster care.

Are states effectively addressing the needs of foster youth who suffer from mental health disorders? If not, what are some of the initiatives that states should undertake to effectively meet the needs of these youth?

Youth in foster care have better access to mental health services than youth in kinship care. Ensuring the passage of the Kinship Caregiver's Support act would be an important way to address this disparity.

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We are really not meeting the psychotropic needs of youth of color in care – especially for African American youth. There's evidence to suggest they are often misdiagnosed AND overmedicated. From the child and family services reviews, we know that the stability of foster care placements is based on the mental health of the child, and the reverse relationship is true as well. So, to help youth manage their mental health in order to encourage permanency, foster parents and kinship caregivers may need additional skills to help youth be successful. Also, children and youth in care have higher rates of mental illness than the general population. If states were effective at addressing the needs of youth with mental disorders, there wouldn't be such a huge disparity.

Based on the literature, conversations with alumni of the system, and consultation with a number of experts in the field, successful system improvements would require a multi-prong strategy with considerations to cultural responsiveness in each area:

1. Increase interventions to promote & maintain mental health prior to the onset of mental health challenges (prevention);
2. Implement more reliable and valid screening instruments (there is some research that shows this is a missed opportunity in states to catch challenges early);
3. Through training, heighten the awareness of mental health needs among child welfare professionals and stakeholders (birth parents, foster parents, social workers, and administrators) especially regarding psychotropic medication, adolescent development, mental health diagnoses & appropriate treatment modalities;
4. Empowerment training and support with young people that increases the resiliency and coping strategies of youth in foster care (protective factors);
5. Create platforms for sharing and implementing the best evidence-based practices among child welfare and mental health professionals (such as Trauma-Focused Cognitive Behavioral Therapy, Multi-Dimensional Treatment Foster Care etc.); and,
6. Establish medical homes for each young person in foster care where they have consistent caregivers over time, their records are kept in a safe and complete manner, and where they have relationships that are empowering and skills-building for youth as individuals.

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