Extension of Foster Care Beyond Age 18

To find statutes information for a particular State or Territory, go to the State Statutes Search.

Young people leaving foster care are often at different levels of development in their transition to adulthood. With the growing recognition that most young people are not fully prepared for self-sufficiency by age 18, States offer a variety of programs, including foster care, to this population.

The Federal Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351) amended the title IV-E foster care program to give States the option of allowing youth to remain in foster care after reaching age 18, provided they have not yet reached ages 19, 20, or 21, as the State may elect. The conditions for continued title IV-E foster care payments apply to youth over age 18 and require the youth to be completing secondary school (or the equivalent), enrolled in postsecondary or vocational school, participating in a program or activity that promotes or removes barriers to employment,

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employed 80 hours a month, or incapable of school and/or work requirements due to a documented medical condition.[1] The act also amended the definition of a child care institution in 42 U.S.C. § 672(c)(2) to include a supervised setting in which an individual who has reached age 18 is living independently.

States also extend foster care services and supports to youth in their foster care system after age 18. State-funded extended foster care programs are not required to meet the requirements of the Federal extended foster care program, but many follow the school and work requirements of the Federal program.

AVAILABILITY OF FOSTER CARE BEYOND AGE 18

In approximately 48 States, the District of Columbia, and American Samoa, youth who are in out-of-home care at the time they reach their 18th birthday are allowed to extend that placement and continue receiving services from the social services agency.[2] In most cases, youth may remain under agency supervision until age 21—in situations that can include foster care, a supervised independent living arrangement, or the provision of transitional living services— while they continue working on educational or vocational goals and further develop their independent living skills and transition to independence.[3]

In 33 States, youth who leave foster care when they reach age 18 may request, at any time prior to their 21st birthday (or as otherwise specified in State law), to return to foster care (which may be in the form of a supervised independent living situation or a resumption of transitional living services).[4] A return to foster care is permitted when a youth has attempted to live independently but now needs continued assistance and support. In these States, youth can return to care and/or supervision to pursue educational or job training goals, to ensure their personal safety, or to further develop the skills needed to achieve self-sufficiency.

REQUIREMENTS FOR REMAINING IN PLACEMENT

Youth who elect to remain in or return to foster care are required to meet specific eligibility requirements that are articulated in Federal and State law, regulation, or policy. In most cases, youth also need to work actively with their caseworkers to develop and implement case plans that help them reach their education and career goals and work toward self-sufficiency.

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[1] See 42 U.S.C. § 675(8)(B)(iv) (2018).

[2] The word "approximately" is used to stress the fact that States frequently amend their laws and applies to all data in this publication. The information in this publication is current only through March 2022. The following States allow an extension of foster care up to age 21, except as noted: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii (to age 19 or age 20 for a youth still in high school who is receiving special education services), Idaho, Illinois, Indiana, Iowa (to age 22), Kansas, Kentucky, Louisiana (to age 26 for youth receiving services through the John H. Chafee Foster Care Program for Successful Transition to Adulthood program), Maine, Maryland, Massachusetts (to age 22), Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire (to age 23), New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont (to age 22), Virginia, Washington, West Virginia (to age 23), Wisconsin, and Wyoming. Oregon and Utah do not offer continued foster care and supervision but do provide support services to former foster youth to age 21.

[3] The sources of funding for these programs, whether Federal or State, are not identified in the statutes and regulations reviewed.

[4] The following States permit a return to foster care: Alabama, Alaska, Arizona, Arkansas, California, Connecticut (to age 23), Delaware, Florida, Georgia, Illinois, Indiana, Iowa (to age 22), Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Missouri, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Oklahoma, Pennsylvania, Rhode Island, Tennessee, Texas, Vermont (up to age 22), Virginia, Washington, West Virginia, and Wisconsin.

In 23 States and the District of Columbia, the eligibility requirements in State law include at least one of the following:[5]

- The youth is working to complete a high school diploma or an equivalent credential.
- The youth is enrolled in a postsecondary or vocational program.
- The youth is participating in a program designed to remove barriers to employment.
- The youth is employed for at least 80 hours per month.
- The youth is incapable of any of the activities listed above due to a documented medical condition.

State laws in Vermont require youth who are receiving services to be engaged in 40 "productive hours" per week, which includes time devoted to any combination of classes, study, work, internships, volunteer work, training, apprenticeships, or treatment activities.

PLACEMENT AGREEMENTS

Extension or return to foster care may be accomplished through a court order, although it is usually accomplished through a written agreement between the youth and the department that it is voluntary on the part of the youth. In 27 States, a youth who requests extended foster care services must enter a specific, written voluntary placement agreement with the child welfare agency that will be providing the services.[6] In 24 States and the District of Columbia, the youth must agree to work with the agency to develop a written service plan.[7] In 25 States, the District of Columbia, and American Samoa, placement agreements and service plans are subject to court review.[8]

The voluntary placement agreement or service plan serves as a contract between the agency and the youth. The agreement specifies the services and resources that will be provided to the youth, the responsibilities of the youth regarding the services, and the consequences for failing to meet those responsibilities. The service plan is designed to reflect the youth's strengths, needs, and circumstances and to promote their successful transition to independent adult living and emotional and economic self-sufficiency. The plan should be developed in partnership with the youth and other persons who are significant to the youth and be a mutual agreement between the youth and program staff.

Elements that often are addressed in the plan include the following:

- Specific measurable goals
- Items that are appropriate for the individual youth, particularly with regard to the following:
  - The youth's education, including postsecondary education
  - The youth's employment and vocational training
  - Personal and emotional support for the youth

[5] Arizona, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Indiana, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Nebraska, New Hampshire, North Carolina, North Dakota, Pennsylvania, Rhode Island, Tennessee, Texas, Washington, and West Virginia

[6] Alaska, California, Connecticut, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Nebraska, Nevada, North Carolina, North Dakota, Ohio, Rhode Island, Vermont, Virginia, Washington, West Virginia, and Wisconsin

[7] Alabama, Arizona, Arkansas, Colorado, Delaware, Hawaii, Kansas, Kentucky, Missouri, Montana, New Hampshire, New Jersey, New Mexico, New York, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, and Virginia

[8] Alabama, Alaska, California, Colorado, Florida, Georgia, Idaho, Illinois, Indiana, Kansas, Kentucky, Mississippi, Missouri, Nevada, New Mexico, New York, North Carolina, North Dakota, Ohio, Pennsylvania, Rhode Island, Texas, Washington, Wisconsin, and Wyoming

In the agreement, the youth has certain responsibilities to working toward meeting the goals and objectives of their service plan and working on becoming semi-independent and self-sufficient. The department has the responsibility to provide the youth with assistance in meeting those goals and objectives.

TRANSITION SUPPORTS PROVIDED

States offer an array of services and resources designed to support youth in extended foster care as they work toward self-sufficiency. The services and resources provided are intended to help youth achieve their service plan goals and may include any of the following:

- Academic support, including tutoring, study skills training, literacy training, and help accessing educational resources[9]
- Career preparation, including the following:
  - Vocational and career assessment
  - Job-seeking and job-placement support
- Budgeting, financial management, and consumer-skills training and support
- Housing education and home-management skills, including homemaker skills and basic home maintenance
- Health education, including on topics such as family planning, sex education, healthy relationships, parenting, risk prevention, and substance use prevention
- Transitional housing, such as group homes, foster homes, or subsidized apartments, with gradually decreasing levels of supervision
- Mentoring and counseling
- Referrals to community supports
- Short-term financial assistance
- Assistance obtaining a driver's license
- Room and board financial assistance, including rent deposits, utilities, and other household start-up expenses
- Developing and maintaining relationships with individuals who are important to the youth
- Assistance accessing the youth's credit report and resolving any inconsistencies[10]
- Assistance enrolling in Medicaid or other State-sponsored medical insurance coverage
- Assistance designating another person to make health-care decisions on behalf of the youth and executing a health-care power-of-attorney

Before a youth exits care, the agency also must ensure the youth has essential personal documents in their possession, including their birth certificate, Social Security card, driver's license or State-issued identification card, and copies of all health and education records in the agency's possession. In 19 States and the District of Columbia, the agency also must provide the youth with a letter or other official documentation that verifies the youth's placement in out-of-home care.[11]

[9] For a detailed description of the academic supports provided to youth who have been in foster care, including support for postsecondary education, see the Child Welfare Information Gateway publication *Educational Supports for Youth in Foster Care*.
[10] The Child and Family Services Improvement and Innovation Act (P.L. 112-34), enacted in September 2011, amended title IV-E to provide this credit support for foster youth who are age 16 and older. See 42 U.S.C. § 675(5)(I).
[11] California, Colorado, Connecticut, Delaware, Florida, Georgia, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Hampshire, North Carolina, Ohio, Oklahoma, Rhode Island, Utah, Washington, and West Virginia

This publication is a product of the State Statutes Series prepared by Child Welfare Information Gateway. While every attempt has been made to be complete, additional information on these topics may be in other sections of a State's code as well as agency regulations, case law, and informal practices and procedures.

SUGGESTED CITATION:

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

Name: _____ Date: _____

Quiz: Extension of Foster Care Beyond Age 18 (2 hours)

True or False- circle one

1. Most young people are fully prepared for self-sufficiency by age 18. **True** **False**

2. Federal law requires all States to extend foster care services beyond age 18. **True** **False**

3. Youth may remain in extended foster care while completing education or employment-related activities. **True** **False**

4. In some States, youth who leave foster care at age 18 may later return to care before turning 21. **True** **False**

5. Placement agreements for extended foster care are always ordered by a court. **True** **False**

6. Which federal law gave States the option to extend foster care beyond age 18?

   A. Adoption and Safe Families Act

   B. Fostering Connections to Success and Increasing Adoptions Act of 2008

   C. Child Abuse Prevention and Treatment Act

   D. Individuals with Disabilities Education Act

7. Which of the following qualifies a youth to remain in extended foster care?

   A. Being employed at least 80 hours per month

   B. Enrolled in postsecondary or vocational school

   C. Completing secondary education

   D. All of the above B. 20

8. In most States, youth may remain under foster care supervision until age:

   A. 19

   C. 21

   D. 25

9. A voluntary placement agreement primarily serves as:

   A. A disciplinary contract

   B. A court order

   C. A contract outlining responsibilities and services

Name: _____ Date: _____

D. A housing lease

10. Which is NOT a transition support provided to youth?

A. Budgeting and financial management training

B. Housing and home-management skills

C. Mandatory military service

D. Career preparation and job-placement support

11. Why do States offer foster care services beyond age 18?

_____

_____

12. Name two eligibility requirements to remain in extended foster care.

_____

_____

13. Give one reason a youth might return to foster care after leaving at age 18.

_____

_____

14. List two documents youth must receive before exiting care.

_____

_____

15. Briefly explain the purpose of a service plan in extended foster care.

_____

_____

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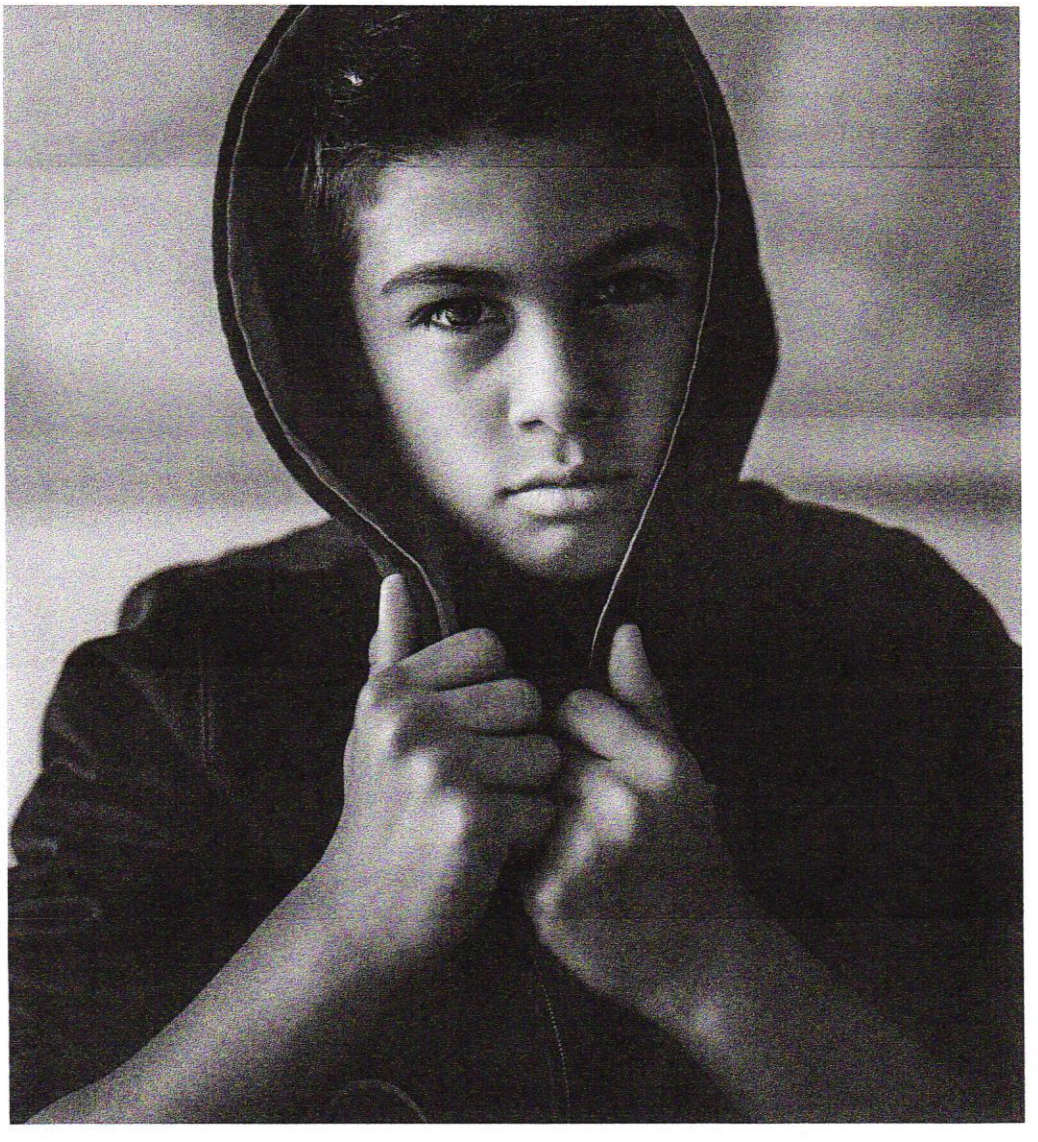
The 3-5-7 Model—Helping Children Work Through Grief

Contributed by:
Darla Henry



Children and youth in the child welfare system want a life free of pain and full of love. If possible, most want to live with their parents. We in the system cannot discount or minimize the power of love between children and their birth parents. While parents may have had inadequate parenting capacity, most have loved their children and have conveyed this love to their children in some way. Acknowledging these basic facts—and the

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resulting grief children experience at the loss of their parents—is the basis for helping children prepare for permanency.

A Series of Losses Results in Grief

The losses children experience don't begin at the point of referral for abuse, neglect, or dependency. Many children are in care because their parents struggle to cope with their own traumatic backgrounds and are challenged by substance abuse and domestic violence. These challenges compromise parents' ability to meet their children's needs, which contributes to the first loss for their children—the lost opportunity for normal child development. When early nurturing needs are inconsistently met, infants may experience feelings of abandonment and rejection, and these feelings will show up again each time the child or youth have experiences reminiscent of their early challenges.

Over time, children and youth in troubled families may experience other losses if their parents have difficulty building and sustaining healthy relationships. Many parents also have deeply embedded grief and loss of their own, with generational losses in family systems where parents' needs were not met and now they have the inability to parent safely. Children and youth then lose solid relationships and normal childhood experiences.

The ultimate experience of loss occurs when children and youth enter foster care. Although foster care often ensures a safe environment, children frequently experience the move into care as a loss from their permanent family.

With all of these losses come significant grief. The child welfare system must support children's and youth's work to grieve their losses. And we must ensure that professionals and parents understand how grief and loss affect children and youth and may lead to challenging behaviors. We must approach the behaviors caused by grief as normal, not as a pathological diagnosis.

Addressing Grief

As child welfare professionals, foster parents, and adoptive parents, our first role is to respond as the comforter to children's grief, establishing a feeling of safety. When we start where the children are, we listen to their perceptions and experiences of life events and can begin to help them heal. All of our interactions with children and youth in the system must be guided by the understanding that we must address grief as we work toward permanency.

Without efforts to address their grief, children often experience divided loyalties between the many adults and parenting figures in their lives. When we acknowledge that they are loved by their parents, but that those parents may have poor parenting abilities, we make it easier for children to accept the possibility of being parented by others. We must start where the children are—missing their families—and give them opportunities to grieve these losses so that they engage in tasks for integrating all family relationships into their lives. Permanency can then be achieved through reunification or adoption or guardianship.

As professionals and families, we cannot "fix" children and youth. But we can help them do their own grief work effectively. When encouraged to tell their stories, children and youth, in time, will integrate biological, foster, and adoptive families into their lives.

So how do we support grief work for children and youth and their families? It is not talk therapy and is not initially a cognitive process. In fact, a simple inquiry into their feelings may leave teens feeling interrogated. Youth are often reluctant or unable to share with professional strangers who ask probing questions but aren't able to provide relief from the

pain and hurt they are experiencing. When we try to get them to talk about abuse or their parents' shortcomings, young people often become defensive in an effort to protect the parents whose loss they are grieving.

Foster and adoptive parents can provide an environment that supports children in grieving their losses by helping them understand what has happened to them and get ready for permanency. Every moment counts for the child who is grieving. They are often missing their birth families and are fearful of the unknown before them. They need adults to acknowledge that they are in pain. By affirming children's losses, adults support children as they address and resolve their grief. Through this process, adults also create the foundation of establishing healthy relationships through permanency.

The 3-5-7 Model©

The 3-5-7 Model is designed to help professionals and parents work with children and youth to address these issues of grief and loss. It is an evidenced-informed, guided practice approach that supports the work of children and parents in grieving their losses and rebuilding their relationships in an effort to achieve well-being, safety, and permanency. The model incorporates theoretical underpinnings from child development, attachment, separation and loss, trauma, family systems, and relationship development.

The 3-5-7 Model has several beliefs at its core:

- Human beings grow, heal, and develop a sense of self in relationships.
- Relationships are a continual process that give rise to both hurt and wholeness.
- Healing is a relational process honoring the whole person—life story, life experiences, traumas, strength, and resiliency.
- Children, youth, and families have the ability to resolve their needs if provided the support and time to do so.

I initially developed the 3-5-7 Model to prepare children and youth in the foster care system for adoption. Now it is being used to help all types of families build a committed relationship with their children, whether through reunification, extended family parenting, guardianship, or adoption. The model can be used at various times, from intake to permanent placement and beyond, and can be woven into family search and engagement and family group decision-making activities.

In recent years, the child welfare system has begun to pay a lot of attention to family engagement approaches. But we don't pay as much attention to, or offer sufficient training on, the underlying issues of grief and loss that family members are often dealing with—losses such as loss of control, loss of dignity, loss of security, loss of identity, and loss of belongingness in a family. These issues of grief and loss can have a substantial impact on the family engagement process. Using the 3-5-7 Model in the context of family work helps children, youth, and parents recognize and grieve losses, so that the trust, security, and openness needed for successful family engagement will be more readily achieved.

The 3-5-7 Model can be used by anyone who interacts with children, youth, and their families in support of their grief work. With training and coaching, caregivers are able to respond in the moment to behaviors as responses to loss, affirming the importance of the child's feelings and the caregiver's availability to support them as they express their feelings. The model ensures caregivers understand their role as comforters of grief. Professionals using the model engage children and youth in activities that support their grief work.

The Model's Core Components

The model is based on three tasks, five conceptual questions, and seven skills. Professionals and caregivers use the seven skills and a series of concrete activities to help children answer the five questions and thus accomplish the three tasks.

Three Tasks

The model's three tasks determine where each individual child or youth is and what she needs to do to reconcile and grieve losses and move toward rebuilding relationships. The tasks help children and youth:

1. Understand the events of their lives and reconcile the losses they have experienced (clarification)
2. Rebuild relationships in their lives and understand they can be members of more than one family (integration)
3. Visualize belonging to a permanent family (actualization)

Five Questions

Through a series of specific activities and techniques including lifebooks, life maps, life/loss lines, and collages, professionals using the model help children and youth explore the answers to five conceptual questions that address specific issues (noted in parentheses below):

1. What happened to me? (exploring issues of loss)
2. Who am I? (identity)
3. Where am I going? (attachment)
4. How will I get there? (relationships)
5. When will I know I belong? (claiming and safety)

Seven Skills

The model identifies seven skills or interpersonal abilities that guide the efforts of professionals and caregivers to support the work of children, youth, and their families. These are:

1. Engagement
2. Listening
3. Recognizing that behaviors indicate the pain of losses
4. Affirming and responding to these behaviors from a grief perspective
5. Remaining present to the expressions of grief and responding in the moment
6. Creating opportunities for the perception of safety within the relationship
7. Recognizing that grief work and relationship building can be done only by those who have experienced the losses

While working through these tasks and questions (see box at right for an example of the model in practice), children and youth may experience anxiety, regression, physiological symptoms, denial of feelings or events, confused attachments to rejecting or unreliable parents, rebellious behaviors, delayed expression of feelings, self-blame for being in placement, and conflicting loyalties to all parent figures in their lives. Using the model and its various activities and techniques, professionals and parents can help children and youth respond to these reactions and move toward resolution of the painful events and relationships of their lives.

Using the Model

The 3-5-7 Model is currently being used or introduced in about 25 places in the U.S. and Canada. Mississippi, Arizona, Delaware, North Carolina, Alaska, and many California communities have integrated the model into their family finding efforts. A federal project using the model to help teens address pregnancy, parenting, and pregnancy prevention is completing its third year in Clark County (Las Vegas), Nevada. Overall, the programs identify positive outcomes in helping children and youth engage in grief work and understand their life events.

Those interested in implementing the model can receive training, coaching, implementation strategies, and evaluation and outcome studies. Other tools available to support implementation include a readiness continuum, readiness inventory, skills development guide, pre- and post-tests for children and youth, a resource parent curriculum, and a group development program. The *3-5-7 Model© Workbook: Supporting the Work of Children, Youth and Families Toward Permanency* provides ideas and activities for professionals helping children and youth become ready for permanency. The book, *The 3-5-7 Model©: A Practice Approach to Permanency*, provides information on how programs have implemented activities, such as lifebook work, safety nets, and life maps.

Training programs are a minimum of three days, depending on agency size and needs. Coaching and consultation help agencies ensure fidelity to the model and support for practicing the model.

Conclusion

As we are challenged by the difficult task of successfully achieving permanency for children and all of their families, we need to be vigilant about children's pain. Children just want adults to make the pain go away. As professionals and caregivers, we must prevent additional losses (by reducing moves and honoring birth family members) and accept our role of addressing ongoing grief and providing comforting relationships.

Related

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Therapy Plays an Important Role in Adoptive Families' Lives
February 9, 2002
In "Parenting"

About Darla Henry:

A social worker, trainer, teacher, and consultant with extensive experience in child welfare, Darla established and authored the 3-5-7 Model©. She is president of Darla L Henry &

Name: _____ **Date:** _____

3-5-7 Model Quiz- 3 hours

Multiple Choice Questions

1. Who authored the 3-5-7 Model?
   A) Elisabeth Kübler-Ross
   B) Darla Henry
   C) Sigmund Freud
   D) John Bowlby

2. The 3-5-7 Model was initially developed to prepare children in the child welfare system for what outcome?
   A) Foster care only
   B) Adoption
   C) School success
   D) Group therapy

3. Which of the following best describes the purpose of the model?
   A) To diagnose mental illness
   B) To help children work through grief and rebuild relationships
   C) To teach academic skills
   D) To replace family therapy

4. What does the first of the three tasks, **clarification**, help children do?
   A) Build new friendships
   B) Understand life events and reconcile losses
   C) Complete school assignments
   D) Move into a new home

5. Which theoretical areas underpin the 3-5-7 Model?
   A) Nutrition and exercise
   B) Child development, attachment, trauma, and family systems
   C) Economics and policy
   D) Sports psychology

6. List **two beliefs at the core** of the 3-5-7 Model.

7. What is the significance of recognizing behaviors from a grief perspective?

8. Describe what the **integration** task helps a child accomplish.

9. What does the **actualization** task involve?

10. Name **three of the seven skills** professionals and caregivers use in the 3-5-7 Model.

11. Why is it important for adults to acknowledge children's grief in the child welfare system?

12. What types of activities might be used in the model to help children answer the five questions?

13. Explain how the model supports building permanency in relationships.

14. The 3-5-7 Model is described as a form of talk therapy that begins with detailed cognitive questioning.
    True / False

15. The model emphasizes that healing is a relational process that honors the whole person's life experiences.
    True / False

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Preventing, Identifying, and Treating Substance Use Among Youth in Foster Care

Youth in foster care often face multiple challenges that place them at increased risk of using substances, making it imperative that caseworkers understand how to prevent substance use, identify possible usage, and, if needed, support youth in their treatment and recovery. This work, however, cannot be undertaken by the child welfare field alone. It requires close collaboration with substance use treatment providers, families, the community, and others.

This bulletin provides child welfare professionals with information about the extent and effects of substance use among youth in foster care, ways to identify substance use, how to support youth in care who currently use or are at high risk for using substances, and strategies for prevention. It also addresses why and how you can collaborate with professionals in other fields.

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PREVALENCE OF SUBSTANCE USE AMONG YOUTH IN FOSTER CARE

Because of their history of maltreatment, stressful home circumstances, and other trauma, youth in foster care are at significant risk for using substances (Substance Abuse and Mental Health Services Administration [SAMHSA], 2011). Studies show that youth in foster care use substances, including alcohol, marijuana, or other drugs, at rates similar to (Braciszewski & Stout, 2012; Greeno et al., 2019; Kim et al., 2017) or higher than (Siegel et al., 2016) their peers who had not been in foster care. Furthermore, youth in foster care appear to begin substance use at an earlier age than their peers who had not been in foster care, which places them at a higher risk for developing a substance use disorder (SUD) (Braciszewski & Stout, 2012). According to data from the National Youth in Transition Database, 27 percent of 17-year-olds in foster care had been referred for substance use treatment (Administration for Children and Families, 2020).

The high risk of substance use also continues as they exit care, with youth formerly in foster care having higher lifetime use rates than their peers who were never in foster care (Greeno et al., 2019; Braciszewski & Stout, 2012). Additionally, the diagnostic rates for SUDs are much higher among youth in or formerly in foster care (Braciszewski & Stout, 2012).

UNDERSTANDING THE CAUSES AND IMPACTS OF SUBSTANCE USE DISORDERS

Repeated instances of substance use can lead to changes in the brain that cause SUDs (National Institute on Drug Abuse [NIDA], 2018b). This section describes the effects of substance use on the brain, including how it can lead to an SUD, and risk and protective factors related to youth substance use.

SUBSTANCE USE DISORDERS

The term "substance use disorders" covers a range of issues related to substance use or misuse. Clinical diagnosis of an SUD can be made by trained professionals using the criteria outlined in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5). This diagnosis is different than those in previous editions of the DSM. In the DSM-5, SUD, which is measured on a continuum from mild to severe, is a combination of the DSM-IV categories of substance abuse and substance dependence (American Psychiatric Association, 2013). Although many people use the term "addiction" when referring to an individual's SUD diagnosis or situation, addiction is not a formal diagnosis in the DSM-5. However, some individuals or groups, such as NIDA, use the terms synonymously (NIDA, 2018a).

SUDs are greatly influenced by brain chemistry. The human brain is wired to make decisions and actions (e.g., eating, exercise) based on rewards. This reward system is

driven by the chemical dopamine, which is released during pleasurable activities. For example, when you eat something delicious, your body may release dopamine, which makes you feel good. Your brain then associates eating this food, regardless of whether it is healthy for you or not, with pleasure and encourages you to eat it again.

When someone takes a drug, it can cause a rush of dopamine to be released. The amount of dopamine released is often much higher than that of other rewards, which creates the "high" of taking drugs (NIDA, 2014). This can cause the person to seek out the drug to replicate the high. As the drug use continues, the brain may not achieve the same high, and so larger amounts of the drug may be required to trigger the reward system. Rather than an SUD being a character flaw, as it has historically and even presently been portrayed, it is a chemical response in the brain that can direct an individual's behaviors.

For more detailed definitions and descriptions related to substance use, refer to NIDA's Drugs, Brains, and Behavior: The Science of Addiction.

IMPACT OF SUBSTANCE USE ON YOUTH

Substance use can have myriad effects on an individual's health and can lead to other negative outcomes due to changes in behavior and decision-making. Short-term health effects of substance use include changes in appetite, wakefulness, heart rate, blood pressure, and mood as well as heart attacks, stroke, psychosis, overdose, or even death (NIDA, 2017). Long-term health effects of substance use include heart or lung disease, cancer, mental illness, hepatitis, and other health problems. Other effects of substance use include increased impulsivity and poor judgement, troubled relationships, risky sexual behaviors, early pregnancy, difficulty obtaining housing and employment, stress, and criminality as well as decreased education levels and memory (NIDA, 2017, 2018b; Kim et al., 2017).

RISK AND PROTECTIVE FACTORS FOR YOUTH SUBSTANCE USE

Although anyone who uses drugs is at risk of developing an SUD or even becoming addicted, not everyone does. Just as there is no single risk factor for child maltreatment, there is no single risk factor for an SUD. Factors affecting an individual's likelihood for developing an SUD include biology or genetics (e.g., presence of a mental health issue) and their environment (e.g., peer pressure, family circumstances, exposure to stress) (NIDA, 2018b). This includes experiencing adverse childhood experiences, which can lead to substance use among youth, including earlier initiation of use (Duke, 2018).

Although not an exhaustive list, the following are risk factors for substance use by youth in the general population (Centers for Disease Control and Prevention [CDC], 2019):

- Family history of substance use, including parental substance use
- Positive parental attitudes toward substance use
- Limited parental supervision
- Association with peers who use substances or have a history of delinquent behaviors
- Lack of connection to school
- Low academic performance
- Childhood sexual abuse
- Mental health challenges

Co-Occurrence of Substance Use Disorders and Mental Health Problems

SUDs and mental health problems frequently co-occur, with national surveys showing that approximately half of all individuals experiencing one will also experience the other (NIDA, 2020). Symptoms of an SUD can be similar to those of a mental health disorder, and vice versa (Child Mind Institute & Center on Addiction, 2019). Additionally, the disorders may have developed at the same time, or one disorder may have contributed to the other. For example, a youth may self-medicate to reduce their overwhelming feelings of anxiety. Since selecting the proper treatment is dependent on a correct diagnosis, it is critical to refer youth exhibiting symptoms of either disorder for a comprehensive assessment with a trained professional.

For additional information, refer to NIDA's Co-Occurring Disorders and Health Conditions webpage and *Substance Use + Mental Health in Teens and Young Adults: Your Guide to Recognizing and Addressing Co-Occurring Disorders* by the Child Mind Institute and the Center on Addiction.

Additionally, exposure to any potentially traumatic event as a child—including experiencing or witnessing maltreatment or other interpersonal violence, having a serious accident or illness, and others—can increase the risk an adolescent will use substances (Carliner et al., 2016).

Unfortunately, many of the same circumstances that are risk factors for youth substance use are the same circumstances faced by youth in or at risk of entering foster care (Brook et al., 2015). Of particular note is that youth who have been maltreated, when compared to their nonmaltreated peers, are more likely to use substances earlier, use more types of substances, and have more severe usage (Gabrielli et al., 2016).

Additionally, adolescents' brains are wired for engaging in risk-taking behaviors and new experiences, and using substances may fulfill that drive in an unhealthy way (NIDA, 2014). Furthermore, the adolescent brain is still maturing and is malleable, including in areas responsible for evaluating situations, making decisions, and regulating emotions and impulses.

Protective factors can help prevent youth from using substances or help them cope if substance use has already begun. For youth, examples of protective factors for substance use include social, emotional, behavioral, cognitive, and ethical competence; self-efficacy; parent or family engagement; spirituality; resiliency; family support and stability; parental disapproval of substance

use; parental supervision; and connectedness to school and community or faith-based groups (Office of the Surgeon General, 2016; SAMHSA, 2011; CDC, 2019). For additional information about protective factors, read Child Welfare Information Gateway's *Protective Factors Approaches in Child Welfare*.

The Role of Peers in Substance Use

Peer relationships play a key role in decision-making and behaviors among youth. Peer approval of substance use can increase the risk for substance use, but conversely, peer disapproval can decrease that risk (Mason et al., 2014). A large study of youth in foster care found that they considered characteristics of their peer group to be the strongest risk and protective factor for substance use (Brook et al., 2015). Family factors are still important to youth substance use, but agencies and professionals should keep in mind the importance of peer influence as they develop prevention and treatment programs.

IDENTIFYING SUBSTANCE USE AMONG YOUTH IN FOSTER CARE

Due to their close contact with youth and their families and intimate knowledge of their histories, child welfare caseworkers can play a key role in identifying youth in foster care who may be using substances. By identifying these youth as soon as possible after they come into contact with the child welfare system, caseworkers can help them access services and supports that can assist them in ending the use and stemming the possible short- and long-term effects.

Two key components of identification are screening and assessment. Screening for a possible SUD is a way to determine if a problem may be present, while assessments are more comprehensive and allow a professional to determine more conclusively if a problem is present and develop a plan to address it. Even if a screen identifies the possibility of a substance use issue, that does not mean the youth has been diagnosed as such. An assessment by a trained professional is required to make that diagnosis. Screening and assessments may be conducted as part of regular practice, or they may be used when others notice signs of possible substance use. (See the "Signs of Substance Use in Youth" box in this section for more information.) Since conducting assessments requires a level of experience and training beyond that of most caseworkers, this section focuses on the basics of conducting substance use screening.

The American Academy of Child and Adolescent Psychiatry and the Child Welfare League of America (2003) recommend that all children be screened for substance use, as well as mental health needs, within 24 hours of being placed in out-of-home care. Agencies also may want to screen or assess youth whose families have child welfare involvement but have not been removed from care (SAMHSA, 2011). Additional screening should also be provided on a regular basis, particularly after significant transitions and when there is a change in the youth's psychosocial functioning, as usage could

begin or worsen during a youth's involvement with the child welfare system.

Caseworkers will need to determine who will provide the information for the screen: the youth or a parent or other caregiver. Although research has shown that parents and caregivers tend to provide more accurate information than adolescents for substance use screening, the unique situations of youth in foster care present challenges to collecting information from parents or caregivers (SAMHSA, 2011). Parents may not be available or able to provide accurate information, perhaps due to their own substance use or wanting to give responses that may expedite reunification, and caregivers may not have had enough contact with the youth to differentiate their normal behaviors from behaviors that may indicate substance use. Screening can still be conducted with the parents, caregivers, or youth, but you should interpret the results with these issues in mind. If you believe the situation is high risk, you may want to send the youth directly to a qualified professional for assessment.

Caseworkers should only use scientifically validated screening instruments that are recommended for use by their agencies. Screening instruments are developed for particular populations, so you should make sure the screen is appropriate for the person being screened and the person taking the screen, if different. For example, the screen should be appropriate for person's age, language, culture, and reading level.

You will also need to be aware of how the child's custody status affects who, if anyone, needs to provide consent for the screen (or assessment). If the youth is in the care of the State (i.e., has been removed from home and placed in out-of-home care), the agency will likely have decision-making authority about whether a youth should be screened or assessed. The results should be shared with the caregivers to help them better understand the youth's situation and needs, as allowed by State and Federal regulations regarding the disclosure of confidential substance use information. For youth still in their parents' custody, the parents may need to provide consent for the screenings or assessments, but the age at which youth can consent for those may vary by State.

Staff involved in screening should be trained about how to administer and interpret the results as well as what steps should be taken after the screening is completed (e.g., referring youth for services). When you administer a screen, it is crucial to read it to the informant exactly as written. Deviating from the wording at all can affect the informant's response and, therefore, the results. After the screen has been completed, caseworkers should seek the assistance of a substance use, medical, or other relevant professional to interpret the screen and determine what services or supports may be needed by the youth and their family (SAMHSA, 2011).

For additional information, refer to NIDA's Screening Tools for Adolescent Substance Use webpage.

Signs of Substance Use in Youth

The following are possible signs of a youth's substance use and warrant adults in the child's life taking steps to address any issues (NIDA, 2014):

- Changes in behavior for no apparent reason (e.g., withdrawal, frequent exhaustion or depression, hostility)
- Changes in peer groups
- Carelessness with grooming
- Decreased academic performance
- Skipping classes
- Loss of interest in preferred activities
- Adjustments in eating or sleeping habits
- Declining relationships with family and friends

The presence of these signs, however, is not proof that a youth is using substances, and they may also indicate other factors affecting the youth (e.g., normal developmental stages, mental health issues).

SUPPORTING TREATMENT AND PREVENTION FOR YOUTH IN FOSTER CARE

SUDs can be treated, but similarly to other chronic diseases such as diabetes or heart disease, there is not necessarily a cure (NIDA, 2018b). This section describes the availability and usage of treatments by youth and describes some of the evidence-based and promising treatments designed specifically for them. It also describes strategies for preventing the use of substances by youth.

TREATMENT AVAILABILITY AND USAGE

According to the 2018 National Survey on Drug Use and Health, only 11 percent of youth ages 12 to 17 in the general population who needed substance use treatment received any treatment at a specialty facility (i.e., hospital [inpatient], drug or alcohol rehabilitation facility, or a mental health center) (SAMHSA, 2019b). Of the youth in the general population who needed treatment but did not receive it at a specialty facility, nearly all (98 percent) did not perceive they had a need for treatment. Given that youth in foster care generally have less access to services and supports, this gap between service need and access may even be larger for them compared with the general population (Braciszewski, Tzilos Wernette, Moore, Tran, et al., 2018).

One critical barrier to obtaining treatment is the lack of facilities that offer programs tailored for youth. Results from the 2018 National Survey of Substance Abuse Treatment Services (N-SSATS) found that only 25 percent of facilities offered such programs (SAMHSA, 2019a), and the 2012 N-SSATS showed that only 48 percent of facilities even accepted youth clients (SAMHSA, 2014a). Programs geared toward youth are crucial to positive treatment outcomes because the treatment needs of youth and adults are different. For example, youth tend to use different substances than adults (e.g., many more youth receive treatment for marijuana use than alcohol, but it is the opposite for adults), and youth are less likely

to experience withdrawal symptoms (NIDA, 2014). Additionally, some schools may offer substance use treatment services, as well as screening or prevention programs, for youth (Ladegard et al., 2017).

Even when programs may be available, youth in foster care still face barriers to receiving treatment. Compared to their peers not in foster care, youth in care are less likely to view substance use as harmful or have negative opinions of other substance users (Siegel et al., 2016). Additionally, youth in care also may fear the consequences of seeking help for substance use (e.g., being expelled from a program), have difficulty bonding or trusting individuals or institutions, and experience a lack of continuity or coordination of their care (Braciszewski, Tzilos Wernette, Moore, Tran, et al., 2018). They may also confront challenges common to all youth. Youth in general may have difficulty believing treatment is necessary or seeing their own behavior patterns or consequences (NIDA, 2014). They also may not know where to find help or fear the stigma of being labeled with a substance use problem.

TREATMENT CONSIDERATIONS

When youth in foster care require treatment for an SUD, caseworkers can help ensure they receive treatment that meets their specific needs, which can help optimize outcomes. Caseworkers can help find service providers that have programs that focus on youth treatment in general, and they can also ensure providers are familiar with the specific needs of youth in foster care. They can also support youth during and after treatment. Since youth generally have less access to services after they transition out of care, it is important to ensure they receive services for any substance use issues before that occurs.

Adolescent Community Reinforcement Approach (A-CRA)

A-CRA is an intervention that seeks to support youth in recovery by increasing family, social, and educational/vocational reinforcement. Sessions are conducted with the youth alone, the caregiver alone, and the youth and caregiver together. The therapist reviews the youth's needs and self-assessment and chooses from among 17 A-CRA procedures that address areas such as coping skills, problem-solving, and social activities in order to help eliminate substance use. A-CRA is designated as being evidence supported or based by NIDA, the Alcohol & Drug Abuse Institute, and the California Evidence-Based Clearinghouse for Child Welfare.

NIDA (2014) provides guidance for treating SUDs in youth, including the following:

- Treatment should be tailored to the unique needs of each youth and address their overall needs (e.g., physical health, housing, school, transportation).
- Behavioral therapies have been shown to be effective in treating youth SUDs. They can strengthen their motivation to change, offer incentives, build skills to resist or refuse substances, help the youth replace substance use with other activities, and promote positive relationships.

- Youth with SUDs also frequently have mental health conditions, and so it is critical that any co-occurring conditions are identified and treated as well.
- Since any use by youth is cause for concern, even youth without a diagnosed SUD may benefit from some type of intervention.
- Youth should remain in treatment for an adequate period of time and receive appropriate follow-up care. (This is further addressed later in this section.)
- Although addiction medications have been shown to be effective and are commonly prescribed for adults, they are not generally approved for youth by the Food and Drug Administration.
- Legal interventions and sanctions or family pressure may be an important factor in entering or completing treatment, especially given that youth with an SUD often do not see the need for treatment. In publicly funded substance use facilities, the juvenile justice system is the top referral source.

The University of Washington Alcohol and Drug Abuse Institute (2016) lists six treatment interventions for youth as being evidence based:

- Adolescent community reinforcement approach (see text box)
- Brief intervention/motivational interviewing
- Cognitive behavioral therapy
- Functional family therapy
- Motivational enhancement therapy and cognitive behavioral therapy
- Multidimensional family therapy

Culturally Responsive Interventions

When referring youth to treatment, caseworkers should make sure the proposed treatment, as well as the provider itself, are culturally responsive for that individual. Treatments that are tailored for a particular culture can help with client engagement and attendance and promote improved provider-client relationships (Gainsbury, 2016).

Treatment Resources

For a more complete review of treating SUDs in youth, including descriptions of evidence-based programs, refer to NIDA's *Principles of Adolescent Substance Use Disorder Treatment: A Research-Based Guide*.

The following resources offer additional information about substance use treatment approaches for youth:

- *Treating Youth Substance Use: Evidence Based Practices & Their Clinical Significance* (University of Washington Alcohol and Drug Abuse Institute)
- FindTreatment.gov
- Program Search (Blueprints for Healthy Youth Development)

RECOVERY SUPPORT

Relapse (i.e., resuming substance use after an attempt to stop) is common and does not mean the treatment is not or will not be successful (NIDA, 2014). Multiple rounds of treatment may be necessary, and additional supports will be necessary even after the treatment has been completed. During and after treatment, caseworkers should help monitor youth for continued substance use or potential triggers for use, such as high levels of stress or contacts with peers who have previously promoted substance use. They can also follow-up with other caring adults in the youth's life, such as their current caregivers, other family members, teachers, and coaches, to see if they have observed any risk factors and help determine how they can promote continued abstinence from substances. During a series of focus groups, youth reported the following five major reasons for relapse: feeling unable to cope with negative emotions without substances, stress relief, cognitive factors (e.g., poor motivation, urges to use substances, low confidence), social issues (e.g., peer pressure), and environmental issues (e.g., access or availability of substances) (Gonzales et al., 2012b).

Access to recovery supports is a key factor to averting future substance use. Components of recovery support may include aftercare (e.g., support groups), relationships with peers and family, and substance-free activities (e.g., work, school, hobbies) (Acri et al., 2012). Although an SUD is a chronic disease, many youth do not view it that way (Gonzalez et al., 2012a). Rather, they view substance use as being about lifestyle or individual choice, something they can stop at any time, and not putting them at risk for negative

Mobile Interventions to Treat Substance Use

Mobile interventions have become more popular and shown promise in multiple fields, including treatment for physical and mental health problems (Braciszewski, Tzilos Wernette, Moore, Tran, et al., 2018). Advantages of mobile interventions include increasing the likelihood of honest responses, the prevalence of mobile devices among youth, and youth preferring computerized or paper forms to face-to-face interactions (Braciszewski, Tzilos Wernette, Moore, Tran, et al., 2018; Pilowsky & Wu, 2013). iHelp (Interactive Healthy Lifestyle Preparation) is a mobile intervention designed for youth exiting foster care. It includes a computer-based intervention that utilizes motivational interviewing principles and is individualized based on user responses. Youth then receive daily text messages tailored to their readiness for change, with themes changing over time based on participants' responses to poll questions. In a pilot study, iHelp showed positive scores for youth satisfaction, engagement, and retention and moderate effects on use of marijuana, which was the substance the pilot focused on (Braciszewski, Tzilos Wernette, Moore, Bock, et al., 2018).

outcomes. Therefore, caseworkers and others supporting youth in recovery may want to focus on strategies that mesh with youth views of substance use. For example, youth views about substance use and recovery do not necessarily align with 12-step programs, which are a commonly referred aftercare support (Gonzalez, 2012a). Rather, they may want to highlight activities that support lifestyle improvement (e.g., improved decision-making, employment, education, new positive activities).

PREVENTION

Although youth in foster care often have a host of risk factors for substance use, it can be prevented. Substance use prevention efforts can be applied at three levels, similar to maltreatment prevention interventions: universal interventions aimed at all members of a given population; selective efforts aimed at a subgroup at high-risk for substance use; and indicated interventions targeted to individuals already using substances but who have not developed an SUD (Office of the Surgeon General, 2016). Communities will need to determine the mix of strategies that works best for them.

Results from NIDA-funded research show that programs involving families, schools, communities, and the media are effective for preventing substance use in youth (NIDA, 2018b). Outreach and education are critical in these efforts, particularly when they demonstrate the harmful effects of substance use. Examples of evidence-based prevention programs that have shown positive results for decreasing substance use in youth include LifeSkills Training and Project Towards No Drug Abuse, two school-based programs, and Strengthening Families Program: For Parents and Youth 10–14, a family-focused program (Office of the Surgeon General, 2016).

Not all evidence-based prevention programs have been tested for effectiveness on foster care populations, and agencies and communities may need to make adjustments to fit their needs. For example, many prevention programs take place in school and family settings, but given the transitional nature of the lives of many youth in foster care, this could pose a barrier to full participation. Additionally, many programs highlight parent training and family management, but for youth in foster care, family may represent increased risk for use (Brook et al., 2015). Youth in foster care are also less likely to talk with parents or guardians about substance use issues than those living with their biological or adoptive parents (SAMHSA, 2014b). Since parent or family engagement is a protective factor, though, programs that help develop the caregiver-youth relationship may be a valuable means of preventing substance use.

Prevention efforts can begin well before children reach adolescence. However, few substance use prevention programs for children under age 10 have been evaluated for their effect on usage, in part because that requires expensive long-term follow-up on use that may not begin until years or decades later (Office of the Surgeon General, 2016).

Agencies and communities will need to assess the needs of their children, youth, and families—as well as seek their input—to determine the prevention strategy and programs that will best serve them. For additional information about best practices in substance use prevention, refer to *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health* as well as NIDA's *Drug Facts: Lessons From Prevention Research*.

Preventing Substance Use in Foster Care by Improving the Caregiver Environment

KEEP SAFE is a prevention program designed to address problem behaviors, including substance use, in youth in foster care by improving the caregiving environment and improving the youth-caregiver relationship. Foster parents and kinship caregivers attend 16 weekly 90-minute group support sessions in which they learn parenting techniques (e.g., positive reinforcement, increased supervision) and are given an opportunity to practice the acquired skills (Buchanan et al., 2019). A randomized controlled trial showed that youth in foster care participating in the program had significantly less substance use than those in the group receiving standard services (Kim et al., 2017).

COLLABORATION TO SUPPORT YOUTH

To best prevent, identify, or treat substance use among youth in foster care, it is critical for the community to come together as one. No single individual or agency can provide the support youth need to thrive and avoid the inappropriate use of substances. Child welfare agencies should seek out opportunities to work with substance use treatment providers, educators, mental health professionals, juvenile justice professionals, court staff, and others who work with youth in foster care. By working together, they can develop a comprehensive and consistent message to support youth at risk of or already using substances. For example, agencies can institute an adolescent-focused framework to help all parties better agree on who the client is and what the goals are; develop joint accountability and outcomes that link the services together; establish data and information-sharing measures; and provide training for staff beyond child welfare, such as substance use treatment, education, and mental health (Traube, 2019). They can also work together to support youth in engaging in prosocial activities that may help reduce the risk of substance use. Additionally, agencies should work in partnership with parents and other caregivers as well as the youth themselves. They can provide valuable information about youths' needs and help shape programs.

Use of Psychotropic Medications

Children in foster care are much more likely than children in the general population to use psychotropic medications, which are prescribed to address emotional and behavioral problems (Stambaugh et al., 2012). According to data from the National Survey of Child and Adolescent Well-Being II, between 27 and 47 percent of youth in foster care ages 11 to 17 use psychotropic medications, with the rate increasing the longer the child has been in care (Fernandes-Alcantara et al., 2017). Even if a medication is prescribed for a youth, caseworkers should ensure that the medication is being used as prescribed, and it is best practice for agencies to have medical providers review prescribed medications to determine if they are still required or if the dosages or number prescribed are appropriate. Caseworkers should also see if nonmedication interventions, such as therapy, are available and appropriate for the youth. For additional information, refer to two Children's Bureau publications: *Making Healthy Choices: A Guide on Psychotropic Medications for Youth in Foster Care* and *Supporting Youth in Foster Care in Making Healthy Choices: A Guide for Caregivers and Caseworkers on Trauma, Treatment, and Psychotropic Medications*.

CONCLUSION

Youth in foster care are at a heightened risk for substance use. Since they may not recognize their own problems with substances, it is critical for adults in their lives, including child welfare professionals, to help them identify any substance use problems and seek assistance from treatment professionals. It is also incumbent upon the child welfare field to work with other systems touching the lives of these youth to develop and implement evidence-based prevention strategies.

ADDITIONAL RESOURCES

- *Substance Use Disorders and Addictions Series* (American Psychological Association)
- Online Tutorials (National Center on Substance Abuse and Child Welfare)
- Substance Use in Adolescence (HHS, Office of Population Affairs)
- Screening and Assessment Tools Chart (HHS, NIH, NIDA)
- *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health* (HHS, Office of the Surgeon General)

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Name: _____ Date: _____

Quiz: Preventing, Identifying, and Treating Substance Use Among Youth in Foster Care- 3 hours

1. Which factor places youth in foster care at *higher risk* for early substance use?
A. Higher socioeconomic status
B. History of maltreatment and trauma
C. Fewer peer relationships
D. Increased access to treatment programs

2. Youth in foster care begin substance use at *later* ages than their peers. **True / False**

3. What percentage of 17-year-olds in foster care had been referred for substance use treatment, according to the National Youth in Transition Database?

4. Explain how repeated drug use changes the brain's reward system and contributes to substance use disorders.

5. Which of the following is **NOT** a short-term effect of substance use listed in the article?
A. Changes in appetite
B. Stroke
C. Increased heart rate
D. Improved memory

6. Name one **risk factor** and one **protective factor** for substance use among youth.

7. Substance use disorders (SUDs) in the DSM-5 are diagnosed on a continuum from mild to severe. **True / False**

8. Which group's influence is described as a major risk AND protective factor for youth substance use?
A. Teachers
B. Extended family
C. Peers
D. Community leaders

9. According to the article, what are two key components used to identify substance use among youth?

10. Which of the following youth behavioral signs may indicate potential substance use?
A. Increased interest in school activities
B. Significant changes in peer groups
C. Improved sleep habits
D. Increased communication with family

11. Describe one barrier that prevents youth in foster care from accessing substance use treatment.

12. Which of the following treatments are considered **evidence-based interventions** for youth substance use? (Select all that apply.)
☐ Cognitive Behavioral Therapy
☐ Multidimensional Family Therapy
☐ Aromatherapy
☐ Motivational Interviewing

13. Medications for addiction treatment are commonly approved and prescribed for adolescents with SUDs. **True / False**

14. The KEEP SAFE prevention program focuses primarily on:
A. Teaching youth to self-monitor their substance use
B. Improving caregiver–teen relationships and supervision
C. Increasing school-based substance screenings
D. Reducing access to technology and social media

15. In your own words, explain why cross-system collaboration (child welfare, treatment providers, schools, courts, etc.) is essential for addressing youth substance use in foster care.

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Supporting the Well-Being of Children With Disabilities

Children with disabilities and their families face the stress of living in a society that focuses on the needs of people without disabilities. A lack of services, high demands on caregivers, social isolation, communication barriers, and other factors place children with disabilities at higher risk of being maltreated than their peers without disabilities. As a result, they are more likely to become involved with child welfare, where they experience longer stays in foster care and lower rates of permanency.

With tailored supports and strength-based approaches, child welfare agencies can help support the safety and well-being of children with disabilities. This bulletin offers child welfare professionals information about supporting children with disabilities and partnering effectively with their families.

WHAT'S INSIDE

Child Welfare Information Gateway
PROTECTING CHILDREN ■ STRENGTHENING FAMILIES

Children's Bureau
An Office of the Administration for Children & Families

DEFINING DISABILITY

There are many ways to define and describe disability.

A STARTING POINT

The Centers for Disease Control and Prevention (CDC) define disability as "any condition of the body or mind that makes it more difficult for the person with the condition to do certain activities and interact with the world around them" (Centers for Disease Control and Prevention, 2025). Related conditions may affect the way a person sees, hears, moves, learns, remembers, communicates, and manages daily tasks. Such conditions may be present from birth or develop over time.

APPROACHES FOR VIEWING DISABILITIES

Two distinct models capture how society views disabilities:

- The **medical model** characterizes disability as a "defect" (Office of Developmental Primary Care, n.d.). In this view, disabilities are problems that need to be fixed. The focus is on perceived shortcomings or limitations. This attitude can be dehumanizing toward people with disabilities.
- The **social model** frames disability as a discrepancy between a person's functional needs and their environment (Helton & Bruhn, 2013). This model focuses on an individual's strengths and abilities. The "problem" is not with the person; rather, the issue is an environment not designed for them. For example, the social model of disability asks, "Why aren't there ramps?" instead of "Why does that person need a wheelchair?" (Office of Developmental Primary Care, n.d.).

It's important that child welfare professionals focus on a child's strengths and environment, as emphasized in the social model of disability (Kay, 2019). However, it is still important to address a child's holistic needs, and diagnoses are helpful for accessing some medical, legal, and educational services.

> **"Disability is a natural part of the human experience and in no way diminishes the right of individuals to participate in or contribute to society" (Individuals With Disabilities Education Act, 2004).**

LEGAL, POLICY, AND RESEARCH DEFINITIONS

Specific definitions of disability (and disability types) may vary by organization and affect a person's eligibility for services, support, and protection from discrimination. For example, the following Federal laws and programs contain specific definitions and requirements:

- Americans With Disabilities Act (prohibits discrimination)
- Individuals With Disabilities Education Act (IDEA) (makes available appropriate education services)
- Social Security Act for Supplemental Security Income (SSI) (provides financial assistance)

Keep in mind the definition used by the organization with which you are working. Some children may meet the criteria of one definition but not another. Also, some programs may require demonstration of how the child's disability affects specific areas of functioning.

Definitions of disability may also vary for research and reporting purposes. For data collection, the Children's Bureau considers children to have a disability if they have been identified as having or have been diagnosed with an intellectual disability, emotional disturbance, visual or hearing impairment, learning disability, physical disability, behavior problem, or some other medical condition (Children's Bureau, 2024).

ADDITIONAL TERMINOLOGY AND CONSIDERATIONS

Some entities also use the term "**special health care needs**," which means that a child has or is at increased risk for a chronic health condition and may need more health services than most children their age. Additionally, in recent years, the term "**invisible disabilities**" has gained use to describe conditions such as diabetes, asthma, autism, and depression. Although they may not be obvious on the outside, invisible disabilities nonetheless are associated with stigma and other challenges (McLeod, 2023).

Some people may consider the term "**special needs**" to be patronizing. As such, it generally should not be used in the context of disability. However, the term has a different meaning in child welfare law, where it is used to describe children who need additional considerations for foster care placement. In this context, "special needs" could refer to a child who is part of a sibling group, older, has a disability, or requires other considerations.

People prefer different ways of talking about or referring to people and their disability. Some prefer **person-first language** (e.g., person with a disability), and others prefer identity-first language (e.g., disabled person). This publication uses person-first language to better reflect an individual's holistic identity while acknowledging that everyone has the right to choose how they would like to be referred to or identified.

Prevalence of Disabilities

According to 2019 Census Bureau data, more than 3 million children in the United States had a disability, representing about 4.3 percent of the population under age 18 (Young, 2021). A National Survey of Children's Health found that approximately one in five children (19.4 percent) had a special health-care need (Maternal and Child Health Bureau, 2022). Such needs cover a wide range of chronic physical, developmental, behavioral, and emotional conditions that require elevated health, mental health, education, or related services.

Data in the Adoption and Foster Care Analysis and Reporting System (AFCARS) suggest that about one-quarter of children in foster care have a special health-care need (Sepulveda et al., 2020). The true number may be higher because many children do not receive clinical assessments (Sepulveda et al., 2020; Children's Bureau, 2024). Other sources estimate that 30–80 percent of children in foster care have a disability (Kay, 2019). Children with disabilities may be vulnerable to child maltreatment while child abuse and neglect may also lead to a child's disability.

RECOGNIZING RISK AND PROTECTIVE FACTORS FOR CHILD MALTREATMENT

Children with disabilities and special health care needs have a greater likelihood of experiencing child maltreatment (Fang, et al., 2022) and enter foster care at higher rates than their peers without them (Sepulveda, 2020). The following section presents information on selected risk and protective factors for child maltreatment that can be particularly relevant for children with disabilities.

Reminder

Having a disability does not cause a child to be maltreated. Instead, social and environmental factors put them and their caregivers in vulnerable positions or at greater risk. Family resilience and other protective factors can help alleviate many of the external risk factors.

Understanding risk and protective factors can help inform interventions. For example, children who have behavior issues, as is common in emotional or externalizing disorders (e.g., attention-deficit/hyperactivity disorder, conduct disorders), are more likely to experience physical abuse (Vanderminden et al., 2023). Some parents and other caregivers may become frustrated with children's behavior and respond harshly (Centers for Disease Control and Prevention, 2024). In these cases, education, training, and social support can help caregivers cope with their emotions and learn other behavior management and discipline strategies.

RISK FACTORS

Multiple factors may contribute to challenges and increased risk of child maltreatment among children with disabilities, including the following:

- **Stress in families and communities.** Raising a child with disabilities can come with added costs, high caregiving needs, and emotional demands that may leave parents feeling overwhelmed and isolated (Legano et al, 2021). These factors may contribute to high rates of stress, depression, and anxiety among parents (Pinquart, 2019; Gilson et al., 2018). Unresolved parental mental health issues may add to the risk of abuse or neglect (Lopes et al., 2021).
- **Lack of knowledge and support.** Not understanding a child's disability may lead to unrealistic parental and caregiver expectations and reactions (Legano et al., 2021).
- **Reliance on adults for care**. Children with some disabilities rely heavily on adults for care, putting them at risk for medical neglect and other nontypical forms of abuse (e.g., withholding aid). Children may also need help with hygiene and toileting, which creates opportunities to be groomed for sexualized touching (Barron et al., 2019). This is of particular concern when children are placed in isolating environments (e.g., group homes, long-term care facilities) with high staff turnover.
- **Lack of sex education.** Many children with disabilities do not receive sex education. This makes it difficult for them to identify inappropriate behavior by others. Loneliness and social difficulties might make children with disabilities more vulnerable to unhealthy relationships (Jones et al., 2017).

- **Emotional vulnerability and communication challenges.** Many children with severe or complex disabilities are taught to be compliant rather than challenging the adults who direct their care (Barron et al., 2019). In addition, isolation and communication styles can make it difficult for children with disabilities (especially nonverbal children) to tell others about maltreatment (Legano et al., 2021).
- **Poverty.** Nearly one in four children from low-income households have a disability, compared with one in seven from high-income households (Vanderminden et al., 2023). Living in poverty can make it hard for families to access the specialized care and health services their children need. Likewise, children may be affected by challenges of poor housing, poor neighborhood quality, or food insecurity.
- **Barriers to services.** A variety of factors may limit families of children with disabilities from accessing needed services and support. These include limited awareness of available services and registration processes, cultural barriers, shortages of skilled staff, and accessibility issues (e.g., distance from the family's home, limited service hours, children cannot physically access the service facility, or there is a lack of adaptive equipment appropriate for the child) (Sapiets et al., 2020). Barriers also reflect limited opportunities that include families of children with and without disabilities and a lack of welcoming environments that foster a sense of belonging for children with disabilities and their families.

PROTECTIVE FACTORS

Protective factors are conditions or attributes in individuals, families, and communities that can strengthen the health and well-being of children and families and lower the risk for maltreatment (Child Welfare Information Gateway, 2020). Building the following protective factors can help families better handle life's challenges:

- **Knowledge of parenting and child development**. Parents benefit from information and support to better understand their children's abilities and adopt strategies that foster healthy development while being appropriate to the child's age, developmental status, and disability (Legano et al., 2021). Building realistic expectations for their children's capabilities can help reduce parental frustration that sometimes leads to inappropriate physical punishment (Legano et al., 2021).
- **Nurturing and attachment**. Strong bonds with caring and responsive adults in early life can lead to healthier behaviors and positive outcomes for children later in life (Child Welfare Information Gateway, 2020). Parents create secure attachment by listening and being attentive to their child's interests and needs, showing affection, and creating a predictable environment.
- **Concrete support for families.** When families can meet their concrete needs—safe and stable housing, health care, food, and reliable transportation—they are better able to support their children's healthy development. Families of children with disabilities often face additional needs and expenses, such as ongoing medical care and therapies, assistive technology and

specialized equipment, home or vehicle modifications, special dietary requirements, personal care, and other services.

- **Parental resilience**. Resilience enables parents to draw on their particular strengths and resources to handle stress and bounce back when things are not going well. In turn, this helps parents protect their children from stress and models problem-solving skills.
- **Social connections**. Social connections—with friends, neighbors, faith communities, colleagues, and interest groups—can provide valuable emotional, informational, and concrete support to parents. Connecting parents of children with disabilities with other parents can help them build community among others who share similar experiences.
- **Social and emotional competence of children**. Children's abilities to form bonds and interact with others, self-regulate their emotions and behavior, and communicate their feelings are important to how they interact with the world. Some children with disabilities may require tailored interventions and ongoing support to strengthen social and emotional competence and skills.

Child welfare professionals and their system partners can build on existing protective factors and identify areas for improvement. Many families of children with disabilities develop resilience, faith-based coping skills, and strong family bonds. These strengths not only buffer the adverse effects of trauma but can also be a crucial part of prevention, intervention, and treatment. For more information on protective factors, see Information Gateway's *Protective Factors Approaches in Child Welfare* and the Protective Factors Conversation Guides.

PARTNERING WITH FAMILIES

Partnering with families is essential to promoting protective factors, reducing risk factors, and supporting the safety and well-being of children with disabilities. This section describes helpful strategies and resources for working with families of children with disabilities, including families of origin, foster families, and adoptive families. As part of prevention efforts and after families are receiving child welfare services, child welfare professionals can encourage these strategies in collaboration with community partners that work with children with disabilities and their families.

BUILD RELATIONSHIPS FOR BETTER ENGAGEMENT

To build trusted relationships with families of children with disabilities:

- Ask family members to tell you about their child's and family's strengths, needs, goals, and concerns.
- Show respect for the family's perspectives and expertise.
- Ask parents what supports would be helpful to them and from whom.
- Collaborate in making plans appropriate for their child.
- Connect families with resources and help them advocate for their child.
- Establish clear and reliable ongoing communication.

For more information on engaging families, see Information Gateway's Parents and Caregivers webpage.

In getting to know families, recognize that family members might have many different, sometimes contradictory, emotions about and reactions to their child's disability. These may include grief over a diagnosis and relief that the child does not have a different type of disability perceived to be more severe (Rosenzweig et al., 2018). It may have been a long journey to where they are today. Because of this, some families may feel a loss of privacy from telling their story repeatedly to different professionals (Currie & Szabo, 2019).

LEVERAGE CONNECTIONS AND INFORMAL SUPPORTS

In working with families, build on their strengths and promote social connections. Consider their extended family, faith community, trusted community leaders or elders, clubs or shared-interest groups, and others with whom they have strong bonds. Social and emotional support from friends and family buffers the effects of stress and acts as a key protective factor against child maltreatment (Austin et al., 2020). Support groups for families of children with disabilities allow parents to share their experiences and lessons learned, trade information on resources, and create informal support networks.

STRENGTHEN PARENTING, PROBLEM-SOLVING, AND COPING SKILLS

Strong coping and problem-solving skills can help parents overcome challenges. Consider the following interrelated strategies and discuss them, as appropriate, with parents and service providers:

- **Parent education:** Educating parents about how certain disabilities may delay developmental milestones (e.g., toilet training) and how to cope with associated challenges can help alleviate parental stress and promote developmentally appropriate caregiving strategies (Stirling et al., 2024).
- **Problem-solving skills training:** Such training for parents of children with chronic health conditions has been shown to improve both children's and parents' mental health, well-being, and quality of life (Zhou et al., 2024). It can also reduce conflict and encourage positive interactions between children and parents.
- **Safety planning:** Parents and caregivers may need information on steps to take to help keep their children safe while they encourage them to explore the world. For example, parents may teach different ways for children to communicate—using whistles, bells, or electronic devices—when they feel they are in danger. For more information, see the CDC's Keeping Children With Disabilities Safe webpage.
- **Stress-reduction interventions:** Parents may turn to a variety of strategies to recharge, including mindfulness practices, meditation, physical exercise, or spending time in nature. Studies have shown, for example, that parent training for caregivers of children with autism can lower parental stress and depression, improve children's behavior, and build stronger family interactions (Iadarola et al., 2018; Iida et al., 2018).
- **Self-care and therapy:** Some family members may benefit from support groups or individual, family, or group therapy (e.g., parent-child interaction therapy, trauma systems therapy). When possible, identify therapists with experience working with families of children with the relevant disability and who share the family's culture, background, and values.

- **Disability screening for parents:** As appropriate, encourage disability screening and accommodations for parents for their own disabilities.

ASSIST CAREGIVERS IN TAKING A BREAK

Family caregivers often need breaks from ongoing caregiving demands and the following services can help:

- **Respite care:** Taking a break from caregiving not only reduces parental stress and social isolation but also benefits the child, siblings, and overall family dynamics (Whitmore & Snethen, 2018). Respite can include in-home or out-of-home services (e.g., in a family care home, daycare center, after-school program, camp, or other location). The ARCH National Respite Network offers a respite services locator tool and related resources, including, for example, *Nine Steps to Respite Care for Family Caregivers of Children and Adults With Intellectual and Developmental Disabilities*.
- **Crisis nurseries:** Also referred to as crisis care or emergency care, crisis nurseries offer temporary respite to families experiencing challenging circumstances and a safe place for their children who may be at risk for abuse or neglect. Crisis nursery services are offered in daycare centers, licensed private homes, or emergency shelter facilities and are often accessible 24 hours a day, 7 days a week. For information, see ARCH's *Crisis Nurseries: Respite for Children at Risk of Abuse or Neglect*.

HELP FAMILIES ACCESS HEALTH, EDUCATION, AND SUPPORT SERVICES

Access to health, educational, and social services is a key protective factor against child maltreatment (Austin et al., 2020). Families of children with disabilities may need access to general supports as well as those directly related to their child's disabilities. The following are examples of supports that may be beneficial:

- **Medical care:** First, check with the family to see if they have comprehensive health insurance. If not, consider options such as Medicaid and the Children's Health Insurance Program. Then, check to see that children are getting consistent medical care. Children, especially those with disabilities, should have regular appointments with a pediatrician and other specialists as needed. Pediatricians are valuable partners who can help families develop improved understanding of their child's abilities and needs, refer families to needed services, help advocate for continued and coordinated care, and work with insurance companies during placement changes. Strong relationships with a trusted team of interdisciplinary providers are necessary for building a medical home, a comprehensive health-care approach that can promote positive outcomes for children with special health-care needs (Mattson et al., 2019) and support coordination of health care for children in foster care.
- **Educational services:** Collaborate with schools and early intervention programs to provide appropriate educational supports for the child. Children ages 3 to 21 are eligible for school-based services through

IDEA and other Federal and State laws. Families, educators, and other members of the child's support team must agree on appropriate services, which are outlined in a child's individualized education plan (IEP), individualized family service plan, or 504 plan. These plans can facilitate specialized instruction, transportation, therapies, transition care, and other needed services.

- **Economic supports:** Supplemental Security Income (SSI) can help families access helpful financial resources. For more information, see the U.S. Social Security Administration's *Benefits for Children With Disabilities*.
- **Home visiting and early childhood programs:** Some families may benefit from home visiting programs that match expectant or new parents with trained home visitors. Programs such as Child First and Home-Based Early Head Start, which are designed for families of young children with emotional, behavioral, or developmental concerns, have been shown to reduce child maltreatment (Duffee et al., 2017).
- **Informal supports:** Parents can be connected to national organizations, such as Parents Anonymous or Circle of Parents, and support groups specific to their children's disabilities.

SUPPORT COORDINATION OF SERVICES

Children with disabilities and their families have multiple needs, so effective coordination and collaboration are essential for their well-being. Include families in meetings with multidisciplinary professionals to share updates and make decisions. When making recommendations, keep in mind that a family's background, culture, and beliefs can impact caregiving preferences.

Many services have complicated eligibility requirements, forms, and rules. These barriers can overwhelm or confuse families. To reduce this stress, help parents coordinate supports across multiple systems and explain how each service works. Consider how different systems may interact and how those interactions and potential service changes might affect the child. Children with disabilities may be more sensitive to disruptions, such as those associated with changing schools and new IEPs, for example (Slayter, 2016). Give families information that can help them continue with support services and programming after a child welfare case ends.

OFFER TRAINING AND SUPPORT FOR FOSTER AND ADOPTIVE PARENTS

Foster and adoptive parents must go through training, but the curriculum often lacks comprehensive information on how to identify and support children with special health-care needs (Kay, 2019; Barnett et al., 2017). This lack of preparation may contribute to the fact that children with such needs, particularly emotional disturbances, are more likely to experience adoption disruptions (Sepulveda et al., 2020; Hernández Baullosa et al., 2022b). As such, it is important to offer foster and adoptive parents skill-based programs, learning opportunities, and support groups that address health, mental health, and developmental needs (Slayter, 2016).

Child welfare professionals should provide foster and adoptive parents with as much information as possible about the child's medical, social, and behavioral history and help them set expectations based on the child's strengths and needs. Families of origin can help provide this information and should be kept up to date with the child's health status. Involve them in decision-making whenever possible.

Resources for Families of Children With Disabilities

The following are additional supports and resources that may help families of children with disabilities:

- **ARCH National Respite Network and Resource Center** offers caregivers information on finding, selecting, and paying for respite care.
- **Center for Parent Information & Resources** is a resource hub for parents of children with disabilities through which parents can find training and resource centers in their State.
- **Families Rising** supports children in foster care and their families and offers a resource hub to help parents understand different disabilities and challenges.
- **Family-to-Family Health Information Centers** and **Family Voices Affiliate Organizations** are family-led organizations in most States and Territories that support families of children with special health-care needs and the professionals who serve them.
- **Kidpower International** offers information and programs on safety skills for people with disabilities.
- **Parent to Parent USA** is a mentorship program that helps parents of children with disabilities connect with other parents who have had similar experiences.

STRENGTHENING COLLABORATIVE RESPONSES TO IDENTIFY DISABILITIES AND MALTREATMENT

Child welfare agencies adopt different approaches to supporting children with disabilities. Some agencies have caseworkers with specialized training or disability units that are designed to support the unique needs of children with disabilities and their families. Other agencies may assign these children a child welfare caseworker and a disability or public health professional. Others partner each child with a multidisciplinary team. This section describes considerations for child welfare professionals related to the identification of disabilities and assessment of maltreatment among children with disabilities.

SCREENING AND ASSESSMENT TO IDENTIFY IF A CHILD HAS A DISABILITY

Child welfare professionals collaborate with parents, caregivers, and system partners to identify disabilities and developmental delays in children and connect them with needed services. State and local policies may vary on requirements, timing, and collaborative protocols. In general, they rely on complementary processes, including:

Developmental screening. Screening is a brief process using a standardized tool that provides a snapshot of a child's health and development (Moodie et al., 2014). Screenings do not result in a diagnosis but can point to potential issues where more comprehensive assessment is needed. Individuals trained in using selected tools conduct screenings, including child welfare professionals,

healthcare providers, early childhood professionals, and others. Key points for screening include when a child first comes into contact with the child welfare system, when concerns arise, and at specified age intervals. (For more information, see the American Academy of Pediatrics' *Assessing Developmental Delays in Children*.)

Assessment. Assessment is an indepth and ongoing process of observing, gathering detailed information, documenting, and interpreting results (Moodie et al., 2014). Comprehensive assessments paint a more complete picture of a child's functioning, skills, abilities, and needs. Conducted by specialists, assessments inform diagnoses of specific disabilities and help with service planning to meet a child's strengths and needs. Some programs also use comprehensive evaluation processes to determine if an individual meets eligibility criteria for specific services.

Child welfare professionals should work closely with parents and caregivers to explain the benefits of screening and assessment, gain consent, encourage ongoing monitoring of children's development, and discuss any concerns they may have. When a parent, caregiver, or child welfare professional suspect a child has a disability, it is important to consult with qualified disability and medical professionals. They can best identify signs and symptoms, diagnose conditions, and recommend treatments. They can also help develop case plans and strategies that would be most helpful to the child and family. Once a disability is diagnosed, child welfare professionals can support efforts to connect families with accessible, culturally responsive services.

Early Intervention Legislation

In recognition that infants and toddlers who are maltreated are at greater risk of developmental delays and disabilities, the IDEA Part C and the Child Abuse Prevention and Treatment Act (CAPTA) require States to implement procedures for referral to early intervention services. IDEA Part C requires child welfare professionals to refer children under age 3 who are the subject of substantiated maltreatment or directly affected by substance use for screening, evaluation, and assessment to determine the presence of developmental delays and eligibility for early intervention services. For more information, see Information Gateway's *Addressing the Needs of Young Children in Child Welfare: Part C—Early Intervention Services*.

Although required only for children under age 3, disability screening and assessment can benefit children of all ages with child welfare involvement. For children eligible for Medicaid, child welfare professionals can make referrals under the Early and Periodic Screening, Diagnostic, and Treatment benefit.

Training Resources

Training and development can help prepare child welfare professionals to partner with other professionals, identify children with disabilities, and connect children and their families with needed services. The following organizations have helpful training and practice resources:

- **Association of University Centers on Disabilities** supports network members in each State to provide training, education, and research that promotes the well-being of people with disabilities.
- **Center for Adoption Support and Education** (C.A.S.E) hosts the C.A.S.E training institute to meet the needs of professionals supporting children and their foster, kinship, and adoptive families.
- **Center for Advanced Studies in Child Welfare** has a variety of relevant resources and training modules for promoting well-being in children with disabilities.
- **The National Child Traumatic Stress Network** offers resources for supporting children with intellectual and developmental disabilities who have experienced trauma.
- **SAFE Alliance Disability Services** has an online guide for child protection and law enforcement professionals about working with children with disabilities who have experienced maltreatment.

COLLABORATING TO ASSESS MALTREATMENT IN CHILDREN WITH DISABILITIES

It is sometimes difficult to distinguish between signs of maltreatment and disability. For example, children with blood or bone disorders may have frequent bruising or fractures that may resemble signs of physical abuse (Palusci et al., 2015). Likewise, it may be easy to mistake disability-associated behavior issues or injuries, including self-injury, for signs of abuse (Barron et al., 2019). On the other hand, maltreatment and other traumatic experiences can cause anxiety and withdrawal, which can also be signs of an emotional disturbance (Barron et al., 2019). These similarities complicate the assessment and reporting of suspected maltreatment.

Ideally, child welfare professionals should obtain expert advice from disability professionals, physicians, or other consultants *before* interviewing children with disabilities about possible maltreatment. This may be particularly helpful in cases where it is difficult to distinguish between maltreatment and disability.

When determining whether injuries were caused by abuse, consider the following factors (Palusci et al., 2015):

- The child's developmental and mobility abilities
- The severity of the injuries
- Any underlying medical conditions that could have contributed to the injuries
- Factors that might hamper the child from disclosing what happened (e.g., communication issues for nonverbal children)

Regardless of the type of maltreatment experienced or the disability a child has, it may be hard for them to describe their experience. The right supports can help them share what happened and how they feel. Depending on the child's needs, you may need to adapt the structure or location of the interviews. Keep in mind that every child is different and may have different communication needs, such as sign language or drawing. Having an adult present who understands the child's communication preferences might be helpful. However, it could also skew the child's intended messages and be problematic if the adult is involved in the maltreatment (Robinson et al., 2023). Ask a disability professional for tips on communicating with children with a specific disability (see, for example, *Communicating With People With Disabilities* from the Villanova University College of Nursing.)

SUPPORTING CHILDREN WITH DISABILITIES IN CHILD WELFARE

Child welfare professionals and their partners can directly support children with disabilities in various ways, including implementing child-focused prevention and engagement strategies, identifying appropriate placement options when needed, and supporting young people in their transition to independent living.

IMPLEMENT CHILD-FOCUSED PREVENTION AND ENGAGEMENT STRATEGIES

Following are some specific ways child welfare and other professionals can engage, educate, and otherwise support children with disabilities:

- **Develop trusting relationships with children.** Children with disabilities need trusted adults to talk to and safe places where they feel comfortable expressing their needs. Start conversations with open-ended questions about things that are important to them. Incorporate their values and priorities into decision-making and interventions. Instead of focusing solely on areas where children need support, find opportunities to build on their strengths—consider hobbies, special interests, and skills. Building children's strengths over time can help reduce trauma symptoms and poor outcomes, helping them to develop long-term resilience (Kisiel et al., 2017).
- **Include children in decision-making processes.** Children deserve to have a voice in decisions that affect them. Be flexible and creative when engaging children. Their participation might not be verbal. You can try strategies such as picture cards, flow charts, decision-making aids, or games. It can be helpful to explicitly outline their options and invite them to choose (Adams et al., 2017).
- **Teach children with disabilities about maltreatment.** Consider enrolling children in group-based educational opportunities about abuse and neglect. These opportunities cover information on body parts and their functions, healthy relationships, what constitutes abuse and neglect, and the difference between appropriate and inappropriate social interactions (Barron et al., 2019). This can help children identify abuse, respond to it, and tell others. Look for programs appropriate for the child's abilities, instruction needs, and culture.
- **Strengthen communication and advocacy skills.** Improving children's communication skills can help them advocate for their own needs and report maltreatment if it occurs.

Support children in expressing themselves and accessing tools appropriate for their communication needs.

- **Reduce social isolation.** Involvement with communities and organizations can help lessen the loneliness often experienced by children with disabilities (Jones et al., 2017). Child welfare professionals can help children with disabilities and their parents find activities that are physically and socially accessible and support children with developing relationships with peers and trusted adults. These relationships are a strong protective factor against maltreatment (Child Welfare Information Gateway, 2020).
- **Collaborate with other organizations.** Required by CAPTA, cross-sector collaboration is an important strategy for improving services and outcomes for children with disabilities. Partnering with State and local organizations can help expand children's access to services and facilitate coordination of care. Identify potential partners through resources such as the Center for Parent Information and Resources and Family-to-Family Health Information Centers.

IDENTIFY APPROPRIATE CHILD WELFARE PLACEMENT FOR CHILDREN WITH DISABILITIES

Although it is best practice to keep children with their families whenever possible, sometimes family separation is necessary. Children with disabilities, particularly emotional disturbances, are more likely to be placed in congregate care than their peers without disabilities (Hernández Baullosa et al., 2022b). In addition, some children experience initial temporary placements (e.g., hospital emergency rooms, emergency shelters) in crisis situations and when other placements are not available or appropriate. While congregate care (including group homes, child care institutions, residential facilities, and in-patient hospitals) is sometimes needed to meet complex behavioral and mental health needs, it is generally recognized that most children and young people do better in less restrictive and more family-like settings (Capacity Building Center for States, 2017).

If a child has to enter out-of-home care, consider **treatment foster care**. This specialized type of foster care combines a therapeutic family environment with individualized treatment. Trained caregivers participate in the child's daily care and treatment under the close supervision of agency staff. Treatment foster care is less restrictive and more cost-effective than congregate care, and several models have been shown to improve child welfare outcomes. The following models are considered promising by the California Evidence-Based Clearinghouse for Child Welfare: Treatment Foster Care Oregon, Pressley Ridge's Treatment Foster Care, and Together Facing the Challenge. Treatment foster care also can be adapted for kinship care. Learn more by reading the Foster Family-based Treatment Association's *The Kinship Treatment Foster Care Initiative Toolkit*.

Placement and Length of Stay in Child Welfare for Children With Disabilities

In addition to being more likely to be in foster care, children with disabilities often have different child welfare experiences compared to children who do not have disabilities:

- **More restrictive placement settings.** Children with disabilities are less likely to be placed in kinship care and more likely to be placed in institutions or group homes, particularly if they have an emotional disturbance (Hernández Baullosa et al., 2022b).
- **More frequent placement moves.** Young people with disabilities, especially behavioral and emotional conditions, experience more placement moves and are less likely to find permanency than young people without disabilities (Hernández Baullosa et al., 2022a). Such placement changes can create disruptions in health and education services and interrupt valuable connections that affect child well-being.
- **Longer time in care.** Children with disabilities tend to have longer stays in care (Hernández Baullosa et al., 2022a). In one study, children with disabilities in foster care spent an average of 915 days in foster care compared to 514 days for peers without a disability (Platt & Gephart, 2022).
- **Less reunification.** Children with disabilities are less likely to have a case plan goal of reunification (Hernández Baullosa et al., 2022a) and to be reunified with their families of origin (Sepulveda et al., 2020).
- **More frequent termination of parental rights.** Child welfare agencies are twice as likely to seek termination of parental rights for families of children with disabilities, and these cases have a higher completion rate (Slayter, 2016).

Many of these challenges are exacerbated for children with more than one diagnosis (Hernández Baullosa et al., 2022b). For more information on child welfare outcomes, read the Children's Bureau's *Special Health Care Needs Data Brief 1*.

SUPPORT YOUNG PEOPLE AS THEY TRANSITION TO INDEPENDENT LIVING

Young people with disabilities who age out of foster care are at even higher risk than their peers without disabilities for poor economic, social, employment, educational, physical, and mental health outcomes (Kay, 2019). To ease their transitions from foster care and improve outcomes, child welfare professionals can connect young people with mentoring programs, disability organizations, and other services. This process must start by age 16, in line with IDEA requirements for educational planning, although conversations should begin sooner depending on the individual's personal and developmental needs. Keep in mind that in some States, young adults can choose to remain in extended foster care until age 21 if they meet certain conditions, such as needing to develop life skills or having a documented medical condition that prevents them from working.

Use the following strategies to support a young person with a disability who is making a transition to independent living (Capacity Building Center for States, 2017; White et al., 2018):

- Directly engage with the young person in addition to communicating with other professionals.
- Prepare the young person with the knowledge and skills needed to care for their health and mental health and advocate for themselves.
- Discuss supported decision-making options as alternatives to legal guardianship or custodianship.
- Organize important paperwork (e.g., formal letter of transfer of care, medical records and detailed summary of care, readiness assessment, transition checklist).
- Make plans for emergencies and provide the young person and family members with contact information for crisis mobilization teams.

The following resources can help child welfare professionals and service providers in supporting young people through the planning process as they exit foster care:

- *Working With Youth to Develop a Transition Plan* (Child Welfare Information Gateway)
- Youth Transition Services (Federal Partners in Transition Workgroup, U.S. Department of Labor)
- *A Transition Guide to Postsecondary Education and Employment for Students and Youth With Disabilities* (Office of Special Education and Rehabilitative Services, U.S. Department of Education)
- Center for Transition to Adult Health Care for Youth With Disabilities (Family Voices and partners)
- Supported Decision-Making (Center for Public Representation)
- A to Z of Disabilities and Accommodations (Job Accommodation Network)
- Got Transition® (The National Alliance to Advance Adolescent Health)

CONCLUSION

Children with disabilities are more likely to be maltreated than their nondisabled peers. Many factors contribute to this disparity: the stress and isolation experienced by families, the lack of comprehensive supports, increased opportunities for sexual grooming, communication challenges in reporting abuse, and more. Child welfare professionals can play a key role in developing support networks for children with disabilities and their families, identifying and addressing strengths and needs, and connecting families with wraparound services that meet the child's and family's needs. In turn, these strategies can help improve safety and well-being outcomes for children with disabilities and their families.

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Austin, A. E., Lesak, A. M., & Shanahan, M. E. (2020). Risk and protective factors for child maltreatment: A review. *Current Epidemiology Reports*, 7(4), 334–342. https://doi.org/10.1007/s40471-020-00252-3

Name: _____ **Date:** _____

Supporting Well-Being of Children With Disabilities – Quiz (2 hours)

1. Which law prohibits discrimination against individuals with disabilities?

   a) IDEA b) ADA c) SSA d) HIPAA

2. IDEA ensures access to what type of education?

   a) Free appropriate public education b) Private schooling c) Home schooling d) None

3. Which is a protective factor for families of children with disabilities?

   a) Social isolation b) Access to supportive networks c) Lack of respite care d) Frequent moves

4. True or False: Respite care provides temporary relief for caregivers.

5. The _____model focuses on removing barriers and promoting inclusion.

6. Under the ADA, disability is defined as an impairment that limits _____activities.

7. List two strategies for communicating effectively with children who have disabilities.

8. Name two resources or programs that support families of children with disabilities.

9. Why is transition planning important for youth with disabilities approaching adulthood?

10. Describe one benefit of early intervention services for children with developmental delays.

Name: _____ **Date:** _____

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Religious Rights of Youth in Out-of-Home Care

To find statute information for a particular State or Territory, go to the State Statutes Search.

Although little research exists on the religion and spirituality of youth in foster care, some studies suggest that religion may affect the experiences of these youth. For some, it may be a protective factor. The ability to engage in religious activities of youth's choice can give rise to social support and coping mechanisms and may improve their well-being. Maintaining a youth's connections to their own religion while in foster care can help them stay connected with their community and benefit from the strengths of their religion.[1]

For this publication, Child Welfare Information Gateway reviewed State, Territory, and Tribal laws and policies that protect the religious rights of youth who are in out-of-home care. The publication also discusses the responsibility of child-placing agencies to find placements that either match the youth's religious affiliation or have foster caregivers, including foster parents or staff in group care facilities, who are willing and able to support the youth's connection to their faith community.

WHAT'S INSIDE

[1] For more information, see the report from the U.S. Government Accountability Office, *Foster Care: Further Assistance From HHS Would Be Helpful in Supporting Youth's LGBTQ+ Identities and Religious Beliefs*.

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YOUTH'S RELIGIOUS RIGHTS

All States, the District of Columbia, and the U.S. Virgin Islands provide some protections from discrimination based on religion for youth placed in out-of-home care. These measures vary across the States. For example, approximately 20 States[2] have laws confirming that a youth may not be discriminated against based on their religion. In approximately 35 States[3] youth have the right to have their religious choice respected. Laws in 35 States[4] and the District of Columbia require that a youth in out-of-home care be allowed to observe the religious practices of their family or their own choosing. Ten States[5] allow youth to refrain from any faith-related activity. In six States,[6] American Indian/Alaska Native (AI/AN) children have the right to participate in the ceremonies and religious practices of their Tribes.

Preserving Tribal Connections of Native Youth

Some Tribal codes include measures to preserve the connections between Native children in out-of-home care and their Tribal communities. For example, the Aleut Community of St. Paul Island declares that each child has the right to learn the available culture, traditions, and history of the Tribe. The Tribal code of the Mashpee Wampanoag Nation has provisions dedicated to helping each child learn their Mashpee heritage, culture, traditions, and history so that they know who they are, where they come from, and what it means to be a member of the Mashpee Wampanoag Tribe.

The code of the Pascua Yaqui Nation imposes the following conditions when a Yaqui child is placed with a non-Yaqui family:

- The Yaqui child must have reasonable access (e.g., visits, phone calls, correspondence) to Yaqui family members.
- If the Yaqui child wishes to observe or participate in the Tribe's cultural and religious ceremonies, the Tribe's Social Services Department must be notified so that appropriate arrangements can be made.

[2] The word "approximately" is used to stress the fact that States frequently amend their laws and applies to all data in this publication. The information in this publication is current only through January 2024. The States that protect youth from discrimination based on religion include Arkansas, Florida, Georgia, Hawaii, Idaho, Maine, Maryland, Massachusetts, Minnesota, Mississippi, New Jersey, New Mexico, New York, North Dakota, Pennsylvania, Rhode Island, Utah, Vermont, Wisconsin, and Wyoming.

[3] Alaska, Arizona, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Utah, Washington, West Virginia, Wisconsin, and Wyoming

[4] Alaska, Arizona, California, Colorado, Connecticut, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Utah, Washington, West Virginia, Wisconsin, and Wyoming

[5] Hawaii, Louisiana, Michigan, Nevada, New Mexico, North Carolina, Ohio, Oklahoma, Pennsylvania, and Washington

[6] California, Idaho, Massachusetts, Montana, New Mexico, and South Dakota

California State law also provides the following rights to AI/AN children and youth in foster care:

- To be free from discrimination based on affiliation with a Tribe or Alaska Native village
- To live in a home that upholds the prevailing social and cultural standards of their Tribal community
- To have contact with Tribal members and members of their Tribal community consistent with their Tribe's prevailing social and cultural conditions and way of life
- To attend religious services, activities, and ceremonies of the child's choice, including traditional Native American religious practices

AGENCY RESPONSIBILITIES

In nine States,[7] the child-placing agency must consider the religious affiliation of the children and their parents when children are placed in foster care. In 22 States[8] and the Virgin Islands, the agency, to the extent possible, must place the child with a family or facility that meets the parents' religious preference.

Laws in 19 States[9] and the District of Columbia require the child-placing agency to provide foster caregivers with information on the importance of recognizing the religious beliefs of a child's family and respecting the religious preference expressed by the child's parents. In 32 States[10] and the District of Columbia, caregivers must respect the religious preference of the child. In 35 States,[11] the District of Columbia, and the Virgin Islands, caregivers must provide opportunities for a child in foster care to participate in their preferred religious and cultural activities.

Foster caregivers may invite a child to their place of worship if the child and the parents do not object (in six States[12]), but they cannot require the child to attend (in six States[13]). In 17 States[14] and the District of Columbia, caregivers cannot force children to participate in any religious activities or cultural events against their will. A youth in care cannot be pressured to change their religious affiliation (in 10 States[15]) or participate in significant religious rituals, such baptism or communion (in eight States[16]) without the express written authorization of their parents or the child-placing agency.

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[7] Alabama, Colorado, Georgia, Kansas, Kentucky, Maine, Mississippi, Pennsylvania, and Utah
[8] Arkansas, California, Georgia, Idaho, Illinois, Louisiana, Maine, Maryland, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New York, Oklahoma, Oregon, Tennessee, Virginia, West Virginia, and Wyoming
[9] Alaska, Arkansas, Hawaii, Idaho, Iowa, Kansas, Maine, Minnesota, Missouri, Montana, North Carolina, North Dakota, Oklahoma, Rhode Island, South Carolina, Tennessee, West Virginia, Wisconsin, and Wyoming
[10] Alaska, Arizona, Arkansas, Connecticut, Florida, Idaho, Indiana, Iowa, Kansas, Kentucky, Maine, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, New Hampshire, New York, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, South Dakota, Tennessee, Texas, Utah, Vermont, West Virginia, Wisconsin, and Wyoming
[11] Alaska, Arizona, Arkansas, Connecticut, Georgia, Hawaii, Idaho, Indiana, Iowa, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming
[12] Alabama, Alaska, New Jersey, South Dakota, Tennessee, and Texas
[13] Alaska, Arizona, Louisiana, New Jersey, North Carolina, and Rhode Island
[14] Arizona, Arkansas, California, Connecticut, Iowa, Maine, Michigan, New Jersey, North Carolina, Ohio, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, Washington, and West Virginia
[15] Indiana, Missouri, Nevada, New Hampshire, New York, North Carolina, Ohio, Rhode Island, South Carolina, and Wyoming
[16] Georgia, Indiana, Massachusetts, Nevada, New York, Ohio, South Carolina, and South Dakota

Residential facilities must respect the religious preference of the child and their parents (in eight States[17]) and ensure that each child is afforded opportunities to attend religious services or activities in their faith of choice (in 11 States[18]). In 11 States,[19] if the facility has a particular religious or denominational affiliation, it must provide a written description of its religious programming to the child and their parents prior to the child's admission. In 10 States,[20] the facility cannot require children to participate in religious services or activities.

GRIEVANCE PROCESS

Title IV-E of the Social Security Act[21] requires States to include in the case plan for any youth in foster care who is aged 14 or older a document that describes the youth's rights while in out-of-home care. The document must inform the youth of their rights to stay safe and avoid exploitation, receive appropriate education and health-care services, have regular visits with family members, and participate in relevant court proceedings.

Laws and policies in 44 States[22] and the District of Columbia give youth in out-of-home care the right to seek assistance if their religious or other rights are not being respected. In 26 States[23] and the District of Columbia, the placing agency must provide the youth with a statement of their right to seek redress and explain the process the agency has established for addressing grievances.

A youth may commence the grievance process by filing a complaint with one of the following:

- Their caseworker (in 12 States[24])
- Their caseworker's supervisor (in 7 States[25])
- Their legal representative, including their attorney (in 10 States[26]) or guardian ad litem (in 8 States[27])
- The social services department or placing agency (in 17 States[28] and the District of Columbia)
- The State ombudsman (in 10 States[29]) or the social services departments' office of the ombudsman (in Arizona and Indiana)

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[17] Delaware, Louisiana, Maine, New Hampshire, New York, North Carolina, Ohio, and South Carolina
[18] Delaware, Iowa, Louisiana, Maine, Michigan, New York, North Carolina, Ohio, Rhode Island, South Carolina, and Vermont
[19] Delaware, Iowa, Louisiana, Maine, Minnesota, New Hampshire, Missouri, Rhode Island, Vermont, Virginia, and Wyoming
[20] Delaware, Maine, Michigan, New Hampshire, North Carolina, Ohio, Rhode Island, South Carolina, Virginia, and Wyoming
[21] 42 U.S. Code § 675a(b)(1)
[22] Arizona, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming
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[29] Arizona, California, Colorado, Florida, Maine, Minnesota, Ohio, Utah, Washington, and West Virginia

- Office of the Child Advocate (in 6 States[30])
- The entity providing health or other services to the youth (in Louisiana and Nevada)
- The State Chafee Program Manager (in Montana and North Dakota)
- The hotline set up to receive complaints (in Oregon and Wyoming)
- The Tribal authority that approved a home (in California)

In 10 States,[31] youth also may petition the court that handles their case when they feel that their complaint has not been adequately addressed by the grievance process.

Laws and policies in 21 States[32] and the District of Columbia provide assurance that youth who have complaints will be protected from retaliation or threats of retaliation. Examples of retaliation include, but are not limited to, threats, punishments, or denial of privileges.

SUGGESTED CITATION:

Child Welfare Information Gateway. (2024). *Religious rights of youth in out-of-home care.* U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. https://www.childwelfare.gov/resources/religious-rights-youth-out-home-care

This publication is a product of the State Statutes Series prepared by Child Welfare Information Gateway. While every attempt has been made to be as complete as possible, additional information on these topics may be in other sections of a State's code as well as agency regulations, case law, and informal practices and procedures.

[30] Connecticut, Illinois, Michigan, New Hampshire, New Mexico, and Oklahoma
[31] Arizona, Delaware, Hawaii, Indiana, Kansas, Nevada, New York, Oklahoma, Rhode Island, and South Dakota
[32] California, Colorado, Connecticut, Delaware, Florida, Georgia, Illinois, Kansas, Louisiana, Maryland, Nevada, New Hampshire, New Mexico, New York, Ohio, Oklahoma, Oregon, Vermont, Virginia, Washington, and West Virginia

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

ACF

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Religious Rights of Youth in Out-of-Home Care – Quiz (2 hours)

Name: _____ Date: _____

1. True or False: All States provide some protections against discrimination based on religion for youth in out-of-home care.

2. Approximately how many States have laws confirming that a youth may not be discriminated against based on their religion?

a) 10 b) 20 c) 35 d) 50

3. Which of the following rights do youth in out-of-home care have in about 35 States?

a) The right to refrain from any faith-related activity

b) The right to have their religious choice respected

c) The right to change their religion

d) None of the above

4. Fill in the blank: Ten States allow youth to _____ from any faith-related activity.

5. Which group of children has specific rights to participate in ceremonies and religious practices of their Tribes?

a) All foster youth

b) American Indian/Alaska Native youth

c) Youth in residential facilities only

d) None of the above

6. True or False: Child-placing agencies in all States must place children with families that match the parents' religious preference.

7. Name two responsibilities of child-placing agencies regarding youth's religious rights.

8. Which law requires States to include in the case plan for youth aged 14 or older a document describing their rights while in out-of-home care?

a) Title IV-E of the Social Security Act

b) IDEA

c) HIPAA

d) Adoption and Safe Families Act

9. List two ways a youth can start the grievance process if their religious rights are not respected.

10. True or False: Youth who file complaints about their rights are protected from retaliation in all States.

Adapted from Child Welfare Information Gateway (2024).

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Partnering With Birth Parents to Promote Reunification

The most successful foster caregivers understand their role goes beyond supporting the children in their care to supporting the children's families as a whole. Many factors may influence how you interact with a birth family, including your agency's approach and the supports and training you receive as a caregiver.

Children, youth, and families benefit when foster and birth parents are supported by an agency culture that encourages a meaningful partnership and that provides quality support.

Child Welfare Information Gateway conducted a series of interviews with birth and foster parents—many of whom are partnership advocates with either the Birth Parent National Network (BPNN) or the Birth and Foster Parent Partnership (BFPP)—to help dispel some of the myths each may hold about the other. This factsheet shares their advice and highlights the many opportunities to help children, youth, and families in need.

What follows are common themes and tips that emerged in our conversations with birth and foster parents on how attitudes, expectations, and child- and family-centered actions can affect outcomes for children and families.

WHAT'S INSIDE

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BUILDING CONNECTIONS FROM THE START

Making connections with birth parents as soon as possible and keeping communication open and honest from the start can help build a strong and ongoing partnership. Below, birth and foster parents discussed important points to consider along the way.

COMMUNICATE EARLY AND OFTEN. MORE IS BETTER. KEEP IT REAL.

When safe and if case plans allow, foster parents should meet birth parents as early as the initial day of placement to exchange essential information about the child and to help ease any worries about foster care. Try putting yourself in the birth parent's shoes and think about what you would want to know about the people caring for your child. Regular check-ins through emails, phone calls, texts, photo sharing, etc., can help birth parents feel closer to their children, build trust with you, and encourage reunification.

A birth parent who had been involved with child welfare and who is now a birth parent advocate talked about facilitating CHAT (Communicating History and Transition) meetings as a way to encourage communication. "It's a time for both parties to ask whatever questions they want. It's a safe environment. Some foster parents don't want to do it, because they already have a picture of how this (birth) parent is. I have pushed hard for [foster parents] to be able to have these CHATs so they can understand [the process] is all about reunification, and if they want adoption, they're in the wrong place. I love holding these meetings and making sure [birth] parent voices are heard. I ask what the [foster] parent needs from the birth parent and what the birth parent needs from the [foster] parent to have a successful transition to reunification."

"There should be an initial meeting to introduce the foster and the birth parents so they can ask the little questions. What is your child like? What are their sleeping hours? What are their dislikes? This can be a great opportunity for [birth parents] to see that the foster caregiver is really concerned about their child and doesn't want to replace them. It lets them know right off the bat that you are on their side." —Keely, foster parent, BFPP

"Before she even came to our home, I had the opportunity to speak with her mother on the phone to start building a relationship. She was able to ask me questions about my family. Looking back on it, I think that was pivotal to her feeling comfortable with the placement." —Beth, foster parent, BFPP

"I wish my extended family had been more involved when I was in care, and I wish there had been more conversations with caseworkers about my [noncustodial father]. I would have been so much more grounded and connected if I had been allowed to maintain these relationships." —Jeri, a young adult who experienced several foster placements

LEANING ON YOUR CASEWORKER AND AGENCY

Your caseworker can help you go beyond simply "checking the boxes" of a case plan to actively partnering toward reunification by promoting a positive relationship with the birth family. Caseworkers can help make sure birth parents get to know their foster caregivers. A recipe for success includes caseworkers, caregivers, and families who prioritize partnership.

"We tell the [birth] parents, 'We're going to follow the rules, but we don't make them,' and we encourage them to do the things they need to do to move to unsupervised visits. As we build trust with birth parents, we can advocate for unsupervised visits." —Ellen, foster parent, BFPP

"When I had a supervisor or social worker where partnership was the goal, the case went really well. We were able to really connect and be together and the children were obviously much better. The chances of going home happened more often. Whoever is responsible for that relationship from the very first minute can make a difference with reunification." —Roberta, foster parent, BFPP

"My visit supervisor was amazing. One day she was like, 'This is ridiculous—you have never met the people caring for your child!' I said, 'No, never. I think they hate me.' She thought we should meet. [When we met] that foster parent could look at me and see that I was a loving mother. [This] allowed me to know [my child] was okay so I could work on what I needed to work on. I couldn't focus on anything until that happened." —Julie, birth parent, BPNN

KEEPING AN OPEN MIND AND AN OPEN HEART

How child welfare professionals and foster care providers interact with the families they serve can have an impact on child and family well-being and chances for reunification. The points below reflect the importance of resisting the urge to judge.

CHILDREN IN THE CHILD WELFARE SYSTEM ALREADY HAVE FAMILY MEMBERS WHO LOVE THEM.

The children in your care are not with you because their parents don't love them. They are with you because their parents or primary caregivers are struggling with a specific problem or need. Neglect may have occurred because the primary caregiver has challenges that, in most cases, can be overcome with the right support, treatment, and encouragement.

"The most dangerous thing I see is that black and white thinking of foster and adoptive parents 'saving' kids. These children are not orphans. They have families." —Amy, foster parent, BFPP

"One of my huge pet peeves is the language they use to recruit foster parents: 'These children just need some love.' These children *already* have love. They *already* have parents." — Roberta, foster parent, BFPP

"Know that [birth parents] want the best. They love their kids just like you love yours." —Sandra, birth parent, BPNN

A MOMENT IN TIME DOES NOT DEFINE A FAMILY.

Sometimes one heated moment can change lives, break up families, and have serious consequences for children or youth. Understanding that individuals are more than the sum of their mistakes or behaviors is important for moving forward.

"The incident between his mother and me was not only isolated but inflated with alcohol and drugs. That was not the [norm] for us."—Robert, birth parent, BPNN

"There was nothing wrong with my household and what we were doing as a family. We did have that 1-minute incident. You would come out of [family court] thinking, 'I must be an awful person.' I would carry this card that said, 'You will not be diminished by a 1-minute incident. You are a great mom.'" —Sandra, birth parent, BPNN

YOU DON'T KNOW WHAT YOU DON'T KNOW. KNOWLEDGE IS POWER.

There is a story behind the circumstances and actions that lead to child welfare involvement, and remember, there are two sides to every story. What you see may not represent that child's truth or the full extent of the child's family history.

"I don't know who [the foster mother] thought I was. Obviously, she didn't think very highly of me because of the way that she was relating to me. Who was telling her who I was? Who we are as a family? Who my kid was? Who his brother was? Not only had my son never been away from me, he had never been away from his brother."—Sandra, birth parent, BPNN

"When I came to the [BFPP] conference and heard [birth parents] say what they thought of foster parents, I wanted to stand on the table and say, 'No! I'm not standing in judgment of you. I'm definitely not trying to turn your child against you!'" —Keely, foster parent, BFPP

HELP, TRUST, AND EMPATHY MAKE ALL THE DIFFERENCE.

Birth parents don't choose to be involved with child welfare. Their involvement may be a result of their circumstances or, in many cases, of their own history. Temporarily losing custody of a child can result in an emotional roller coaster of grief, anger, and guilt. Putting yourself in the birth parents' shoes and asking yourself how you might feel in the same situation can give you an idea of what they might be going through and, more importantly, what they might need to be successful. You are most likely to build trust with birth parents when they believe you are trying to support them and understand how they feel—an essential part of any successful relationship.

"[Birth parents] are already so ashamed of themselves. They already feel like the most awful parent in the world. Just by saying 'You've done a great job' or 'Your kids have a really great bond with you' is really groundbreaking! Be the bigger person and take the first step. Be a part of family healing, and reach out in a very human way." —Julie, birth parent, BFPP

"It would have been helpful if someone at the hospital had asked me if there was anything I needed, because I was desperate for change. Instead, there was no engagement and instead punitive words. It was the darkest time of my life. I needed someone to believe in me." —Nancy, birth parent, BPNN

"[Birth parents] are scared and upset because you have their child. It takes a real strong person to say [to a birth parent], 'I'm so sorry you're angry. How can I help?'" —Linda, foster parent, BFPP

"I think empathy and compassion are key. If a [birth] parent read their bio to the foster parent, I think they would immediately have compassion." —Julie, birth parent, BFPP

MAINTAINING CONTACT AFTER REUNIFICATION OR OTHER PERMANENCY

Strong partnerships between birth and foster families can continue long after families have been reunified or after an adoption or other permanency option has been achieved. This ongoing relationship can help increase important social connections for children, youth, and families as well as their sense of stability and belonging. It can also provide families with extended support (e.g., someone to call when a parent needs a word of encouragement, or a babysitter) that can help prevent further child welfare involvement.

"We see a lot of kids that have lived with us at different times and their families. [With one] child we had at one point, his grandmother still calls us, and we do all the babysitting whenever she needs help. We have another young adult who went back to her family, and she calls us almost every weekend. She had a baby, and we're the godparents." —Ellen, foster parent, BFPP

"One of the outcomes [of a birth-foster parent partnership] where maybe a baby is not going to go home is that it allows that child to keep everybody important in its life. On the flip side, where the babies have gone home, the birth mom can still call upon the foster caregivers for occasional help. They're actually working together to raise these children." —Julie, birth parent, BFPP

"Just last week a birth mom we had worked with reached out to me and asked if we could talk. She was very honest with me about some stress she was experiencing and just needed to talk to somebody before she found a support group. I was deeply honored that she trusted me enough to be that person she called in that moment." —Beth, foster parent, BFPP

PARTNERSHIP RESOURCES

Everyone benefits when there are trusted professionals, neighbors, family members, and friends to call on for help with meals, tutoring, child care, and life's inevitable ups and downs. When families have this type of extended moral support, they are less likely to require any additional involvement with child welfare or other agencies. Your caseworker can help you build a community of support for yourself and the children in your care and their families.

Active partnerships that support the reunification process can take time to develop. Fortunately, there are resources to help. Below is a list of organizations, publications, and websites or webpages to support your work.

ORGANIZATIONS

The **Birth and Foster Parent Partnership (BFPP)** (https://ctfalliance.org/partnering-with-parents/bpnn/resources/#bfpp) supports birth families working together with foster and kinship care providers to strengthen families and promote reunification. BFPP is a partnership of the National Alliance of Children's Trust and Prevention Funds, the Youth Law Center's Quality Parenting Initiative, and Casey Family Programs.

The **Birth Parent National Network (BPNN)** (https://ctfalliance.org/partnering-with-parents/bpnn/) promotes and champions birth parents as leaders and strategic partners in prevention and child welfare system reform.

Circle of Parents (http://circleofparents.org) provides a supportive environment to discuss the challenges of raising children.

Parents Anonymous (http://www.parentsanonymous.org) uses mutual support and shared leadership to empower, inspire, and create long-term positive change.

The **Quality Parenting Initiative (QPI)** (http://www.qpi4kids.org/) is an approach as well as a network of sites dedicated to strengthening foster care with a focus on quality parenting. QPI seeks to define and raise expectations for foster care parenting, recruit and retain quality foster caregivers, and give caregivers a voice. QPI is an initiative of the Youth Law Center.

PUBLICATIONS

Birth Parents With Trauma Histories and the Child Welfare System: A Guide for Resource Parents provides tips that foster parents can use to understand how trauma may affect the way birth parents parent. (https://www.nctsn.org/resources/birth-parents-trauma-histories-and-child-welfare-system-guide-resource-parents)

Reunification: Bringing Your Children Home From Foster Care provides a general overview of the reunification process for families with children removed from their care. (https://www.childwelfare.gov/pubs/reunification/)

Supporting Successful Reunifications explores strategies for achieving reunification and preventing reentry. (https://www.childwelfare.gov/pubs/supporting-successful-reunifications/)

WEB RESOURCES

The **Birth Parent/Foster Parent Relationships to Support Family Reunification** section of the Information Gateway website provides a list of useful resources. (https://www.childwelfare.gov/topics/permanency/reunification/parents/reunification/)

CFSA Family Link provides resources that promote foster parent-birth parent partnerships and is a project of the District of Columbia's Child and Family Services Agency (CFSA) and Foster and Adoptive Parent Advocacy Center. (https://cfsa.dc.gov/page/cfsa-family-link)

The **Foster and Adoptive Parent Advocacy Center** provides trainings on shared parenting to address the concerns of foster, adoptive, and kinship parents in the District of Columbia. (http://dcfapac.org/trainings.html)

Resources for Parents With Children and Youth in Out-of-Home Care provides a list of organizations and publications to help caregivers navigate foster care and the reunification process. (https://www.childwelfare.gov/topics/outofhome/casework/parentcasework/parentresources/)

The **Reunifying Families** section of the Information Gateway website provides a list of resources to support family reunification. (https://www.childwelfare.gov/topics/permanency/reunification)

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

Name: *Date:* *2 training hours*

Partnering with Birth Parents to Promote Reunification

1. How would a foster parent build a strong and ongoing partnership with birth parents?

2. Name three types of communication which allow the birth parent to feel closer to their children while in placement?

   a.

   b.

   c.

3. What is CHAT and why might it be beneficial for birth parent and foster parent?

4. Who can assist the birth parent and the foster parent by promoting a positive relationship?

5. Keep an open _____ and open _____, in order

   to resist the urge to _____.

6. Why does building trust and having empathy with/for the birth parents make all the difference?

7. Recall one comment from a birth parent in the article that informs you as a resource parent and/or will make you a better resource parent when interacting with birth parents.

8. Why would maintaining an ongoing relationship with the birth parent post-reunification or -adoption be beneficial?

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