Preventing Substance Abuse Among Youth in Foster Care

By Belinda Basca and Dustianne North

I went to live with my aunt and uncle when I was 6. The police had taken custody of me and my six siblings because…there were too many reports about my mom and stepdad being abusive and fighting. My aunt took me and one of my sisters.

…when I was 15, I started with weed, and then I tried speed and crack. At school when I was mad because I had been arguing with my aunt and uncle, I'd go to the bathroom to do drugs, which got my anger out and made me forget about everything…things were going so badly, I wished I could start my life over with my mom. I missed how she would spend time with me, which made me feel like she cared about me.

Finally my aunt told a social worker she couldn't control me anymore and put me in a group home. I was devastated. I felt like she was giving up on me. I was losing another person in my life, another mom. I didn't realize it at the time, but if it wasn't for her, I'd still be doing drugs and probably be involved in a gang.

By Joel M., 18 years old[1]

In 2007, California had approximately 80,000 children in its foster care system. This represents roughly 20% of the nation's total.

Source: Wonder, Inc.
http://www.wonderinc.org/program/foster_care_facts.html

Many youth who experience the foster care system struggle with substance use and abuse. When a child is removed from the home, multiple organizations and people become involved in caring for that child and addressing his or her needs. By understanding these complex needs and underscoring the context

in which services are provided, substance abuse prevention providers can adapt their service models to effectively address the needs of foster youth. This *Prevention Tactic* addresses how to tailor prevention-focused, substance abuse strategies to foster youth.

Youth in Foster Care: Why and Where

Most children become a part of the child welfare system because of confirmed child abuse or neglect, commonly referred to as maltreatment. Within that system, *foster care* refers to the care of minors who, for safety reasons, have been placed in an out-of-home living situation. Minors may be removed from their home due to severe maltreatment defined as neglect, physical abuse, sexual abuse, and emotional abuse. Child maltreatment can also include harm that a caregiver allows to happen or does not prevent from happening to a child.[2] Youth may also be placed out-of-home due to the parent's inability to address their child's delinquent and/or high risk behavior. Foster care is meant to be temporary with the goal of returning children to a rehabilitated and safe living environment. Nationwide, 86% of all children exiting foster care were discharged to a permanent home (reunification with family, adoption, or guardianship), with the other 14% being emancipated or having their cases transferred to another jurisdiction.[3]

prevention Tactics 9:4 (2009)

Tactics (Tak'tiks) n. 1. a plan for promoting a desired end. 2. the art of the possible.

- *73% of California's children in foster care are six years of age or older.*
- *60% of children remain in foster care for 18-24 months or more.*
- *69% of children placed in traditional foster homes or group homes are moved three or more times.*

Source: Wonder, Inc.
http://www.wonderinc.org/program/foster_care_facts.

Youth who initially enter the child welfare system may be placed in emergency care, a licensed shelter, transitional living program, juvenile detention (when a child has committed a crime), or a licensed Community Treatment Facility (when mental health and/or substance abuse treatment is necessary). If a juvenile dependency court determines it is not safe for a child to remain in or return to their home, minors are placed in foster care, which includes placement in a licensed foster home, with a relative ("kinship placement"), or in a group home. Nearly a quarter of youth in foster care are placed with kin (grandparents, other extended family, single individuals).[4]

Explaining Foster Youths' Increased Risk for Substance Abuse

Substance abuse is a factor in at least three quarters of all foster care placements. Foster youth exhibit higher rates of illegal drug use than youth who have never been in foster care (34% vs. 22%)[5], and recent studies indicate high rates of lifetime substance use and substance use disorders for youth in the foster care system.[6]

Implications of parental substance abuse

Often times, the alcohol and other drug (AOD) issues faced by foster youth can be traced to a family history of substance abuse and dependence. Parental addiction, both prenatally and during child rearing, is a significant factor in child abuse and neglect cases and can be a contributing factor in the removal of a child. These predisposing factors are multifaceted with research showing hereditary links, the influence of social norms, and the use of alcohol and other drugs as a learned coping mechanism. Studies suggest 40% to 80% of families in the child welfare system are affected by alcohol and drug dependence. [7]

- *The average length of time spent in out-of- home care for a child whose parent is not chemically dependent is 10 months.*
- *For a child whose parent is chemically dependent, the average is 26.8 months.*

Source: The Impact of Substance Abuse on Foster Care Connect for Kids.
http://www.connectforkids.org/node/57

Emotional harm and substance abuse

When maltreatment occurs in the home, even when substance abuse is not a contributing factor, it can still leave a child more vulnerable to substance abuse in adolescence. One of the most common coping strategies used by youth who are suffering emotionally is self medication through alcohol and other drugs, which can lead to further victimization, mental health problems, addiction, and lack of self-care. In the most extreme cases of child maltreatment, where exposure to abuse is repeated and/or severe, research shows there can be changes in brain physiology that, in practical terms, impact how children think, feel, and act.[8] Such changes can leave these children at higher risk for a variety of mental health problems and addictions. Nationally, 50% of children and youth in the child welfare system have mental health problems.[9]

Learned behavior and circumstances repeat:

Parents who themselves were once in foster care are nearly twice as likely to have their own children placed in foster care or become homeless than parents without this history.

Source: National Foster Care Youth Statistics. On the Move.
http://www.onthemovebayarea.org/node/561

A lack of permanence in multiple settings

Youth in foster care often experience multiple placements in homes and schools. Children experiencing numerous placement changes are affected emotionally, cognitively, and physically—contributing to both the internalizing and externalizing of negative behavior.[10] In addition, placement and school changes impact access to activities and programs, including student assistance programs (SAP) and substance abuse prevention services.

According to the California Foster Youth Education Task Force, for every change in school setting, foster youth fall three to six months further behind their classmates, creating a downward spiral. Consequences include alienation from teachers and peers who are doing well; a loss of self-efficacy (the feeling of success); detachment from school; and the acquisition of friends who are also alienated. As a result of poor attendance and low academic achievement, these youth may be transferred to continuation or community day schools. Survey data show that community school students are more likely to use drugs and alcohol with higher frequency and in higher amounts than their non-continuation school peers.[11] This reveals the need to imbed substance abuse prevention services into both mainstream and continuation schools.

When foster care ends

Typically, youth leave the foster care system when they reach the age of maturity, at age eighteen in California.[12] Some youth, however, emancipate early and live independently as young as age sixteen. According to the U.S. Census Bureau, of the approximately 500,000 children in the foster care system nationwide, an estimated 24,000 "age out" of care each year and live independently.[13]

These youth face challenges establishing a safe and secure living environment. One study reports a 50% homeless rate for youth who have been in foster care or probation.[14] There is also a small, but vulnerable population of youth who leave their placements before age eighteen. Many of these youth live in marginal or homeless conditions, which presents a risk for substance abuse. An analysis of three national surveys found that youth living on the streets had markedly higher rates of drug abuse and were involved in more serious drug use than either youth in shelters or living at home. [15]

Fortunately, there have been state and federal efforts to ensure the availability of support services and independent living programs (ILP) that continue until age 21. For these youth to receive services as "non-minor dependents," they have to be working on a plan for self sufficiency through school, GED, or vocational education. The important distinction is that "ILP services" until age 21 are different than "remaining in foster care" beyond age 18; foster care involves a much higher level of support than ILP services.

Substance Abuse Prevention: Selecting Service Models for Youth in Foster Care

While many substance abuse prevention programs are tailored for youth, most do not specifically address foster youth. More broadly focused foster youth prevention programs address mental and behavioral health, with some including substance use (see diagram). As AOD

prevention providers look to integrate their services into existing programs or look for programs that specifically address foster youth, they might consider evidence based programs,[16] such as:

- **Strengthening Families Program (SFP)** is a family skills training program designed to increase resilience and reduce risk factors for behavioral, emotional, academic, and social problems in children three to sixteen years of age. SFP comprises three life-skills courses delivered in weekly sessions and includes a parenting skills component.

- **Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students)** is designed to prevent and reduce substance use among students ages twelve to eighteen. The program was originally developed for students attending alternative high schools who are at high risk for substance use and abuse due to poor academic performance, truancy, discipline problems, negative attitudes toward school, and parental substance abuse.
- **Project ALERT** is a school-based AOD prevention program for middle/junior high school students and is based on the social influence model of prevention. It seeks to prevent adolescent nonusers from experimenting with drugs, and to prevent youth who are already experimenting from becoming more regular users or abusers.
- **The Comprehensive Student Assistance in Residential Settings Project** addresses foster youth who have been placed in group residential facilities and uses highly trained staff to provide culturally sensitive AOD prevention services.
- **Functional Family Therapy (FFT)** is a family-based prevention and intervention program that has been applied successfully in a variety of contexts to address a range of high-risk behaviors, including substance use.
- **Multidimensional Treatment Foster Care (MTFC)** is designed for foster youth who display chronic disruptive behavior, which may include problems associated with substance use. Its purpose is to avoid institutional placements by having youth live with families who are recruited, trained, and closely supervised to provide support services and intensive supervision at home, in school, and in the community.
- **One-to-One Mentoring Programs** match volunteers with youth, with some focusing on foster youth. The benefits of foster youth mentoring programs align with those of mentoring programs in general, and include decreased substance abuse.

- **Self-Motivation Group (SM Group)** is designed specifically for child welfare involved parents/caregivers of children through age twelve and consists of short-term orientation sessions that help parents recognize problems and build intervention skills.

Meeting the Special Needs of Foster Youth: Program Content and Service Delivery

Following are four suggested strategies for substance abuse prevention programs:

1. **Promote permanency:** Foster youth who endure multiple living situations and school placements may have fewer interactions with prevention programs, making it harder for them to gain the intended benefits. On the other hand, prevention programs that provide supportive and stable environments may help ameliorate some of these problems. Programs that continue to serve youth when their placements change are especially valuable and may be more effective.

"There's a perception that . . . these foster kids . . . if they're not with their mother or father, that means no one wants them, and no one wants them for a reason, so I think they're almost seen as a lost cause."

-Jelani, former foster youth.
Source-Foster Care: Voices from the Inside (2003)

Tips:

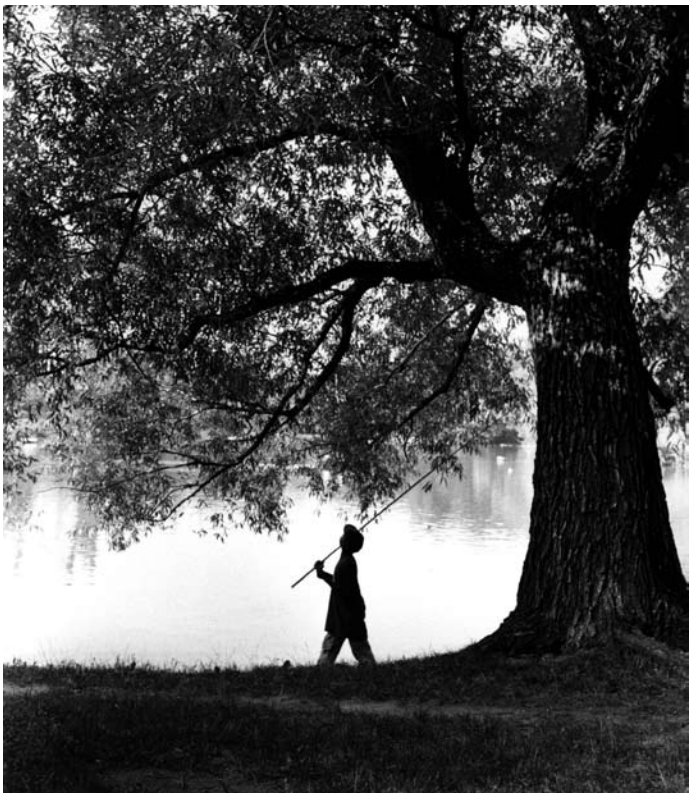
- Provide consistency, unconditional positive regard, and predictability in services.
- Encourage connections with caring adults in the community who will stay connected with youth regardless of their path through the system (mentors, volunteer therapists, ILP workers, and other professionals).
- Ensure that case workers and new placement families are aware of services.
- Offer services in multiple locations on the same schedule, so that mobile children can "enter" a new location without disruption. Or, integrate existing AOD prevention services into a broader program that has the potential to reach and sustain connections with foster youth.
- Plan to make confidential check-in call(s) when services end; in particular with foster youth.
- Connect older youth to available services within California County offices that provide emancipation and ILP services (including financial and other assistance).
- Coordinate and collaborate with the school district and county office of education, social and/or case worker(s), ILP coordinators, school administrators, guardians, and other service providers to ensure continuity of services.

2. Provide staff training and support: Reluctance to discuss feelings, to form secure attachments, to rely on others, or to let down their guard—these are some of the coping mechanisms foster youth employ. These strategies can hinder their ability to fully participate in prevention programming. To build up youths' inherent resiliency, staff and volunteers must be well trained, supervised, and supported to work with youth from a strength-based approach. Careful management, clinical supervision, or other support may be necessary for staff with personal experience of foster care issues. Finally, staff may need training and support to reach across organizations and systems and work collaboratively with other professionals.

Tips:

- Discover whether staff have faced similar issues as those faced by foster youth, and provide an opportunity to discuss, if needed.
- Determine protocols and appropriateness for sharing personal information with those served.
- Plan appropriate procedures and protocols for situations in which youth disclose personal information. Also make staff aware of mandated reporting rules regarding abuse and neglect.
- Train staff to work actively with other systems serving foster youth (departments of child welfare, juvenile justice, mental health, and substance abuse).

3. Understand shifting family dynamics: A typical youth in foster care undergoes stressful and emotionally taxing changes during their time in foster care. They often experience strong feelings of fear, shame, guilt, anger and confusion over their parent's circumstances. Many foster youth maintain a relationship and/or have supervised visits with their parent(s) of origin. Foster youth become part of a second family system, which may include foster



parents, siblings, and other foster relatives, as well as their own biological siblings or relatives. In group placements, there is a "household" of youth and staff who must co-exist. Prevention providers can understand and appreciate these unique relationship dynamics and anticipate that a range of feelings and accompanying behaviors may be expressed by youth.

Tips:

- Ensure that outreach and service activities are welcoming and respectful of the placement situation of the youth.
- Avoid using only stereotypical examples of living situations such as the stable nuclear family in printed materials and programming.
- Be careful not to make assumptions about parental involvement in the lives of youth.
- Consider the constraints and particularities of each placement and biological family.
- Remember that resources such as transportation and other supports may not be as easily available for youth in foster care.

4. Outreach to foster youth, but avoid stigmas and labeling: Foster youth often feel stigmatized for being part of the child welfare system and desperately seek to avoid being "found out." Special attention to service design is needed to strike a balance between assuring that the unique needs of foster care youth are addressed, without the identification of foster youth in a way that perpetuates stigma.

Tips:

- Review all printed materials and messaging to ensure that it is not stigmatizing.
- Ensure outreach strategies are neutral for the general popuation served.
- Avoid publicly identifying youth in your program as being in foster care or system-involved.

Conclusion

The California Health Kids Survey data reveals that many of our state's youth experiment with alcohol and other drugs. Foster youth do so at an even higher rate and with a broader range of more serious drugs, yet they feel less peer disapproval for this behavior. This emphasizes the importance of reaching out to foster youth and providing them with substance abuse prevention and early intervention strategies. When AOD prevention providers outreach to this population they must do so in a way that preserves an individual foster youth's anonymity. They must train staff to better understand the unique situations and pressures that can influence behavior choices and create more emotional pressure on foster youth. Meeting foster youths' unique needs also calls for special attention to service designs and referral procedures that take into consideration foster youths' altered living arrangements and adjustments to new schools, with an added focus on helping youth stay connected and grounded.

[1] http://www.layouth.com/modules.php?op=modload&name=Issue&action=IssueArticle&aid=1942&nid=68

[2] Abuse and Neglect Data Fact Sheet. American Humane Association. http://www.americanhumane.org/about-us/newsroom/fact-sheets/child-abuse-neglect.html

[3] U.S. Department of Health and Human Services. (2006). *Child welfare outcomes 2003*: Annual report. Washington, DC: U.S. Government Printing Office. Retrieved May 1, 2007, from www.acf.hhs.gov/programs/cb/pubs/cwo03/index.htm

[4] National Fact Sheet 2008. Child Welfare League of America (CWLA). http://www.cwla.org/advocacy/nationalfactsheet08.htm

[5] Substance Use and Need for Treatment among Youths Who Have Been in Foster Care. Feb. 18, 2005. National Survey on Drug Use and Health (NSDUH). http://www.oas.samhsa.gov/2k5/FosterCare/FosterCare.htm

[6] Vaughn, G., Ollie, M.T., McMillen, J.C., Scott, L. & Munson, M. (2007). Substance use and abuse among older youth in foster care. Addictive Behaviors, 32(9):1929-1935.

[7] National Fact Sheet 2008. Child Welfare League of America (CWLA). http://www.cwla.org/advocacy/nationalfactsheet08.htm

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[10] Newton, R.R., Litrownik, A.J., and Landsverk, J.A. (2000). Children and youth in foster care: disentangling the relationship between problem behaviors and number of placements. *Child Abuse and Neglect*, 24(10): 1363-1374.

[11] The California Healthy Kids Survey aggregate data for 2005-2007 shows, for example, that 85% of continuation and community day high school students report "Any AOD use," compared to 67% of 11th grade students across CA. www.wested.org/chks/pdf/CA_Agg_Upper_0507_tr.pdf

[12] In October 2005, SB 1633 was signed into law, which extends foster care benefits to youth who are seeking a high school equivalency certificate up until their 19th birthday. In addition, some counties are choosing to extend benefits. For example, Los Angeles County pays foster care benefits for youth to stay in care until age 21 if they are working towards a high school diploma or a non-traditional high school proficiency certificate such as the GED or CHSPE (http://www.bassc.net/html/pdfs/FINALAgingOutOfFosterCare.pdf).

[13] Youth Aging Out of Foster Care: Identifying Strategies and Best Practices. 2007-2008 Presidential Initiative. http://www.naco.org/Content/ContentGroups/Issue_Briefs/IB-YouthAgingoutofFoster-2008.pdf

[14] National Foster Care Youth Statistics. On the Move. http://www.onthemovebayarea.org/node/561

[15] National Institute on Drug Abuse, NIDA Notes: Children on the Brink, Youths at Risk of Drug Abuse. Volume 12, Number 3, May/June 1997. www.nida.nih.gov/NIDA_Notes/NNVol12N3/Runaway.html

[16] SAMHSA supports a searchable database of interventions for the prevention and treatment of mental and substance use disorders at www.nrepp.samhsa.gov/

[17] A comprehensive guide to structuring mentoring services for foster youth is available online at: http://www.emt.org/userfiles/FosterYouthSeries5.pdf

[18] Child Welfare Information Gateway, "How the Child Welfare System Works Factsheet, " 2008

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Santa Rosa, CA 95404

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prevention *Tactics*

Prevention Tactics are published periodically by CARS under its Community Prevention Initiative contract with the California Department of Alcohol and Drug Programs (ADP). The purpose of this publication is to help practitioners in the prevention field stay abreast of best practices emerging from current research and to provide practical tools and resources for implementing proven strategies.

The information or strategies highlighted in Prevention Tactics do not constitute an endorsement by ADP, nor are the ideas and opinions expressed herein those of ADP or its staff.

Edition 9:4
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