Community Mental Health Journal, Vol. 35, No. 5, October 1999

Essential Case Management Services for Young Children in Foster Care

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ABSTRACT: A growing number of children in the United States are being placed into foster care. Past studies indicate that effective case manager interventions have helped foster families with a variety of different problems. This study enrolled a randomly selected sample of 130 children under age four who had been newly placed into foster care. The purpose of this study was to identify the services needed by foster care families and determine which services require the most case manager effort. Consistent with other research, many foster care children in this study exhibited developmental, medical and psychosocial concerns. Nevertheless, we found that it was services aimed at the foster care parents, rather than the foster care children, that required the most labor-intensive case management services.

INTRODUCTION

Between the late 1980s and early 1990s, "the average monthly number of children in foster care nationwide . . . increased from 280,000 to 429,000" (General Accounting Office, 1995). Foster care children and

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The authors wish to recognize the invaluable contributions of the clinical, research and support staff at the Center for the Vulnerable Child, Children's Hospital Oakland including Christy Begley, Rebekah Chew, Julia Cosgrove, Frances Knudtson, Peggy Pearson, Ellen Seligman, Eyisha Te'o, Karen Thomas, Elizabeth Walser and Marguerite Wright. This investigation was funded by the National Institute of Mental Health R01-MH48473 and the Department of Health and Human Services, Bureau of Primary Health Care CSH 901930-09.

their families exhibit a variety of physical, social and psychological problems (Cain & Barth, 1991; Combs-Orme, Chernoff & Kager, 1991; Halfon & Klee, 1991; Halfon, Mendonca & Berkowitz, 1995; Moffatt, Peddie, Stulginskas, Pless & Steinmetz, 1985; Schorr, 1982), and case management has been one service employed to address these problems (Berkowitz, Halfon & Klee, 1992; Division of Programs for Special Populations, 1992). Case management offers the flexibility to reconfigure services to meet the changing needs of clients. In an intensive case management model, case managers assess the family's needs; develop a plan to meet those needs; provide emotional and informational support; facilitate and coordinate linkages with social, health care and other services; and monitor progress over time. Unfortunately, in part due to the increasing number of children entering foster care, most child welfare agencies are unable to provide the breadth and intensity of these services (Jessup & Soman, 1994).

Not only do foster care children require assistance for multiple developmental, social, emotional and health care needs, but they also change foster care placements, moving from one foster family to another (General Accounting Office, 1995; Halfon & Klee, 1991; Klee, Soman & Halfon, 1992). This family transiency makes it difficult to piece together a complete health and psychological history (Urquiza, Wirtz, Peterson & Singer, 1994). When children change foster care placements, case managers need to: (1) establish contact with the new foster parents; (2) obtain histories of services received; (3) reformulate their plan of care; (4) if necessary, identify a new health care provider; and (5) renegotiate their strategy for intervention.

Because of their flexibility, many studies recommend case managers or multidisciplinary teams to ensure comprehensive care for foster care children (Halfon et al., 1995; Simms, 1989); however, there is little specificity on which services and interventions are most useful (Goerge, Wulczyn & Fanshel, 1994). The purpose of this paper is to determine the case management services employed for foster care children and their families, and identify those services that required the most case management effort for the foster care families having the most difficulties.

THE CENTER FOR THE VULNERABLE CHILD (CVC)

The Center for the Vulnerable Child at Children's Hospital Oakland, California (CVC) was established in 1986 to develop a comprehensive,

multi-disciplinary, "one-stop-shopping" approach to physical, psychological and developmental pediatric services. The CVC's unique model has been described in detail elsewhere (Berkowitz et al., 1992) and has been used to serve three populations of vulnerable children: (1) those living with foster parents; (2) those newly reunified with their biological parents; and (3) those residing in homeless shelters with their biological parents or at-risk for homelessness due to parental substance abuse. However, this study only involves foster care children.

The CVC model of intensive case management consists of an array of services that are family-centered and flexible. Interventions are tailored to meet the needs of each family. Services focus on the following major areas: (1) coordinating access to appropriate services; (2) providing information on the child's emotional health and developmental strengths to enhance parenting skills; (3) mental health consultation to caregivers and teachers for children exhibiting emotional or behavior problems; and (4) developing caregivers' personal and social supports.

METHODS

This study uses the cross-sectional data of a longitudinal study that was conducted to evaluate the effectiveness of mental health services for foster care children. A total of 130 children under four years old who were newly placed into the County's foster care system were randomly selected for study participation. The researchers elicited consent for study participation from the foster children's county social worker and their foster parents.

Data were collected using three instruments. The Participation Log is a structured checklist on which the case managers recorded their activities for each foster care child and their family bimonthly. The Social Services Record Abstraction is a standardized form used when reviewing the social service records for: events leading to foster care placement; the County's interventions; charges filed against the birth parents; and changes in foster care placement. The Intake Plan is completed by the case managers and contains demographic characteristics (such as child age, gender, ethnicity/race, number of other children in family, number of foster care placements), and the case manager's assessment of the foster care child and foster family's needs (i.e., developmental, medical, behavioral, transitional, social/emotional, and educational). The Intake Plan also lists five possible recommendations (i.e., respite child care, medical coordination, foster parent support groups, foster parent education groups, and counseling). Respite child care is an on-site therapeutic nursery where a foster care child has a safe place to play while their foster care parents receive a break from the of day-to-day child care. Medical coordination is recommended if the foster care child needs more medical care than is usually provided by a primary care physician. Foster parent support groups enable parents to share their difficulties and fears concerning their foster care children, and receive advice and peer support from other foster care parents. Foster parent education groups provide guidance on parenting issues such as discipline and age-appropriate activities. Case managers recommended counseling

(i.e., family sessions or one-to-one sessions with the foster care parent) on-site or in the home for children who exhibited emotional or behavioral problems, but were not receiving treatment.

DATA ANALYSIS

We analyzed data using SAS Release 6.03 (SAS Institute, 1991) and STATA Intercooled, Version 4.0 (STATA, 1994). Frequencies of categorical variables were compared using Chi-Square Tests of Independence and, for categorical variables with sparse cells, Fisher's Exact Test. Logistic regression with stepwise elimination was used for multivariable analyses with binary and polytomous outcomes. Odds ratios (OR) and 95% confidence intervals (CI) are presented. Significance was declared at the $p < 0.05$ level.

RESULTS

Approximately half the children were male and half were female (see Table 1). Most were two years or older, and the majority of children were African-American. Although multiple charges may be listed for foster care placement, the charge listed most often was neglect, often secondary to parental substance abuse.

We enrolled children into the study within three months of foster care placement. At that time, almost half the foster care children were in emergency foster care placements and the vast majority had been in one or two foster care placements although more than a fifth of foster care children had three or more placements.

Case managers made several service recommendations at intake. Table 2 shows that most services that were recommended at intake were provided during the follow-up period (which ranged from six months to four years, with a mean follow-up time of two years). These included respite child care, medical coordination, foster parent support groups and counseling.

With the many needs of young foster children, case managers are stretched to provide a vast array of services. Some services are short term and relatively easy to provide while others are not. Case managers noted the effort that they needed to provide recommended services. The effort was defined as high intensity if interventions were needed at least weekly, and low intensity if interventions were needed monthly or less often. Moderate intensity levels of case management were more than monthly, but less than weekly contact. We used polytomous logistic regression with stepwise selection to examine the services and family characteristics that required high versus moderate or

TABLE 1

Demographic and Placement Characteristics of Foster Care Children (n = 130)

Characteristics	*Percent*	*(n)*
Gender		
Female	49.2	(64)
Male	50.8	(66)
Age (years)		
≤ 1.00	8.5	(11)
1.01–2.00	29.2	(38)
2.01–3.00	30.0	(39)
3.01 or more	32.3	(42)
Ethnicity/Race[1]		
African-American	74.0	(94)
White	11.8	(15)
Mixed Race	11.0	(14)
Latino	3.1	(4)
Reason for Foster Care Placement (More than one may be cited)		
Neglect	93.8	(122)
Substance Abuse	88.5	(115)
Mental Illness, Developmental Disability	7.0	(9)
Abandonment	56.2	(73)
Incarceration	14.6	(19)
Sibling Abuse	51.5	(67)
Physical Abuse	5.4	(7)
Sexual Abuse	0.8	(1)
Emotional Abuse	0.8	(1)
Child Death	0.8	(1)
Current Foster Care Placement[2]		
Emergency	42.7	(53)
Relative	24.2	(30)
Long-Term	16.9	(21)
Other Foster Situations	16.0	(20)
Number of Placements		
One	45.4	(59)
Two	34.6	(45)
Three or More	20.1	(26)

Source: Social Services Record Abstraction
[1]Ethnicity/race is unknown for three children.
[2]Placement information is missing on six children.

TABLE 2

Services Recommended at Intake and Provided to Foster Care Children During Follow-up (n = 130)

	Recommended / Provided		*Recommended / NotProvided*	
Services	*Percent*	*(n)*	*Percent*	*(n)*
Child Respite Care	55.4	(36)	44.6	(29)**
Medical Coordination	77.2	(44)	22.8	(13)*
Foster Parent Support Group	52.9	(27)	47.1	(24)**
Parent Education Group	37.8	(17)	62.2	(28)
Counseling[1]	93.6	(29)	6.5	(2)*
On-Site	91.7	(11)	8.3	(1)*
In the Home	87.5	(21)	12.5	(3)*

Source: Participation Log
*$p < 0.05$
**$p < 0.01$
[1]Counseling was recommended to some families on-site and in the home.

low intensity case management. Independent variables used to predict high intensity case management included: demographic variables (age, gender, number of foster care placements, relative placement); child concerns (behavioral, transitional, developmental, educational, social/emotional, medical); and recommended foster parent/child needs (foster parent support groups, foster parent education groups, counseling, child follow-up, respite care).

We found that foster care families who were assessed as having the highest intensity level of case management were almost 15 times more likely to need counseling (OR = 14.49, CL = 3.88–54.08) and more than three times more likely to need foster parent education groups (OR = 3.48, Cl = 1.10–11.00) (see Table 3). Conversely, case managers were more likely to recommend parent support groups (OR = 2.60, Cl = 1.10–6.15) to foster care families receiving moderate versus low intensity case management. In summary, it appears that families who received the highest intensity level of case management services were those families who needed counseling and education, while families who received a moderate intensity level of case management were those who needed foster parent support.

TABLE 3

Odds Ratios (OR) and Confidence Intervals (CI) of Factors Associated with Case Management Intensity in Binary and Polytomous Outcome Logistic Regressions

	Binary Model		*Polytomous Model*			
	Highest CMI vs Low CMI		*Moderate CMI vs Low CMI*		*Highest CMI vs Low CMI*	
Recommendations	*OR*	*CI*	*OR*	*CI*	*OR*	*CI*
Home or Center Counseling	6.89	(2.60–18.23)***	3.24	(0.95–11.08)	14.49	(3.88–54.08)***
Parent Education Group	3.00	(1.10–8.22)*	1.26	(0.50–3.15)	3.48	(1.10–11.00)*
Parent Support Group	0.86	(0.31–2.40)	2.60	(1.10–6.15)*	1.57	(0.49–5.01)

*$p < 0.05$
***$p < 0.001$

DISCUSSION

The purpose of this investigation was to identify the services requiring the most case management effort. Consistent with other studies (Cain & Barth, 1991; Combs-Orme et al., 1991; Halfon et al., 1995), we found that many foster care children presented developmental, medical and psychosocial concerns; nevertheless, the most intensive case management services were assistance to foster care parents in the forms of counseling and parent education.

Foster care children, particularly those with social, emotional and behavioral problems need good physical and good social environments (Goerge et al., 1994). Counseling and parent education, which are direct and labor intensive services, are needed by both biological and foster families (Wright, Sklebar & Heiman, 1987).

Some children who have experienced multiple foster care placements have difficulty forming and maintaining relationships with their foster parents and others (Penzerro & Lein, 1995; Schorr, 1982). Attachment problems are an example of this problem and is manifested when children either accept any adult as a parent, or trust no one and become anxious, hostile and aggressive (Penzerro & Lein, 1995). Counseling and parenting education may help foster care parents have a better understanding of their foster care children (Cain & Barth, 1991; Carbino, 1991). Of course, many foster care children also need counseling, but unfortunately, they often do not receive it (Goerge et al., 1994; Klee & Halfon, 1987).

Families in the program who received moderate intensity levels of case management have been advised to attend foster parent support groups. The Foster Care Program offer support groups to enable foster care parents to share their concerns, learn from others and obtain peer-support. Foster families benefit by hearing and learning from others' successes and failures on how to better parent their foster care children. We found that when case managers recommended support groups, most foster parents attended them and enjoyed participating.

We were pleased to find that children and their foster care families who needed respite child care, medical coordination, foster parent support groups, or counseling, received these services. The only service for which this was not the case was foster parent education. Foster care parents were more likely to attend support groups than education groups, even though both were available. However, it is important to note that groups designated as "support" often have an educational component.

There are limitations in this study. First, this sample was restricted to foster care children under four years old. Also, foster care systems differ among states and counties; therefore, associations found in this sample may not occur in others. Finally, the case manager services described in this article were provided by the Center for the Vulnerable Child foster care program, and may not be available at other agencies.

CONCLUSION

With the continued evolution of the health care system, case managers, health administrators and policymakers recognize the need for and benefits of case management for vulnerable populations (Loomis, 1988). Foster care children may benefit from the consistency and continuity that case management services allow. Counseling and parent education are two important and labor-intensive services, but they are often unavailable to foster care families because of child welfare agencies' growing caseloads and worker turnover. Nevertheless, foster parents and children deserve the best possible support from the service system.

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