By Daniel Pollack

New Foster Parents Gain Experience with Incremental Challenges

After weeks—often months—the arduous licensing process is over. The home study is complete. The state central registry clearance and criminal background checks came back fine. There are no concerns regarding the applicant's health, mental health, character, motivation, financial resources, experience, discipline approach, background, and training—nor are there concerns regarding the home's physical or safety features. The new foster home is licensed.

And so, the new foster parents are ready for their first foster children. Seemingly, there should be no hesitation. But are these brand new foster parents really ready for any foster child? From a social work and legal perspective, would it be acceptable to put a young sibling group into a foster home if the parents have little or no parenting experience? There is a giant learning curve from licensed foster parent to successful foster parent and it is the obligation of the licensor and case managers to ensure that new foster parents are not overloaded beyond their capabilities.

Regular foster care homes are the mainstay of the foster care system. These are homes where children are integrated into family living situations. "Specialized," "Treatment," or "Therapeutic Foster Care" (TFC) homes are for children who have emotional or physical requirements that necessitate specialized settings. These homes are compensated according to the level of care the children required. Examples of children who might require TFC are newborns critically affected by their mother's drug abuse, children with physical impairments, children with developmental delays, and children who display severe behavioral outbursts (otherwise labeled emotionally disturbed).

As we all know, there is nothing regular about regular foster care. Even more so, the definition of therapeutic foster care (TFC) is woefully inexact. As the Child Welfare League of America acknowledges, "It is estimated that approximately 40,000 foster children across the country are receiving services under the TFC model. The current challenge within the law is that there is not a standard definition under Medicaid and as a result some interpretations and some applications across the 50 states can be different. The lack of a clear understanding of Medicaid policy can and has discouraged some state policymakers from implementing the important practice."[1] The result? Some foster children who should be in TFC settings wind up in regular foster settings—with inexperienced foster parents.

Many of us are familiar with the "July Effect," that infamous phenomenon in the medical world when new medical school graduates tiptoe into teaching hospitals as interns for the first time. The data[2] suggest that teaching hospital care in July, especially for a severely ill patient, can be notoriously worse than any other time. Why? Because the new interns are just getting their feet wet. Similarly,

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almost half of new car drivers get into an accident in their first year of driving, mostly with only minor fender benders. How do they improve? Practice.

The practice and legal implications for foster care are clear: New foster parents should begin fostering children who do not have an excessive array of overly complex issues. Like driving, being a really good foster parent improves with experience and accumulated knowledge.

Attorney Lily Eagle Dorman Colby, a foster youth advocate from California, and an ABA Commission on Youth at Risk member argues that, "Therapeutic foster care shouldn't be an on-off switch. Not only do we need more caregivers certified as therapeutic homes, but we need more therapeutic interventions available on a continuum of care. Families need to be able to not just be better trained and certified at the onset, but when children age, or new children enter a home, families need to be able to get the training, support, and coaching to meet the needs of the current children in their home. To further the analogy, not all cars are the same. Even if your brother owns a little Nissan and drives it well, he shouldn't necessarily be put behind the wheel of a stick-shift or a U-Haul without additional training, coaching, or support. The children in out-of-home care are unique, and we cannot train every caregiver to meet every unique need up front, but we do have an obligation to ensure that those needs are supported by quality caregivers who have supports to address those needs as they are identified."

All foster care is challenging. Every foster child is vulnerable. To provide a nurturing home for each one, while maintaining their dignity and privacy is not something that automatically comes with the paper license. It comes with time, understanding of trauma-informed care, knowledge of how trauma affects the development of a child, and a commitment on behalf of administrators to strengthen the screening, training, and coaching of every foster parent.

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Reference Notes

1. Sciamanna, J. Child Welfare League of America. *http://bit.ly/2GWjcMc*
2. Young, J. Q.; Ranji, S. R.; Wachter, R. M.; Lee, C. M.; Niehaus, B.; Auerbach, A. D., Annals of Internal Medicine (Sept. 6, 2011). *http://bit.ly/2Nq3xWx*

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medicine, Medicaid, casework, law, and epidemiology. This diversity is invaluable when unpacking and evolving the fundamental questions, as well as interpreting and applying what the data and analytics suggest.

3. Stay Flexible

Rather than relying on a long list of detailed requirements, the state has structured the work around guideposts and remained willing to pivot, based on what data-driven answers reveal. Sometimes those answers affirm a hypothesis. Other times, they point in an unexpected direction. No matter what, the multidisciplinary team has remained engaged in conversation with one another and the machines to determine the best next steps.

More specifically, the first guidepost was creating a descriptive view of moms at risk, which led to identification of three tangible markers of higher infant mortality risk. The second guidepost was understanding the home visiting providers who support new moms and their babies. The third was understanding the geography and social determinants of health at play in areas with higher infant mortality rates. Combined, these can empower the state to identify areas and groups where interventions may have higher impact.

4. Engage the Ecosystem

Beyond the core multidisciplinary team, the state has engaged a variety of stakeholders on the journey to reduce infant mortality. Having shared the initial findings with these collaborators, the team is embarking on co-creating a human-centered delivery model. The model leverages not only the clinical data the team has generated but also nonclinical and qualitative social data.

Together, we are crafting protocols that can be tailored based on specific community attributes and needs (for example, what's effective in urban areas may not work in rural counties). The beauty of a data-driven approach is that progress and performance can be tracked, with adjustments made as needed and then measured over time.

The delivery model and supporting protocols is where the human-machine collaboration truly takes shape. The state's caseworkers, health care providers, and other practitioners can increasingly access precise insights into how best to help and support families in caring for their newest and most vulnerable members.

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