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Navigating a Complicated System of Care: Foster Parent Satisfaction with Behavioral and Medical Health Services

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Abstract Children and youth in foster care often have increased medical and behavioral needs, as a result of maltreatment experiences. As primary caregivers, foster parents serve a critical role in ensuring their medical and behavioral health needs are met, yet there is little research depicting foster parents' experiences with such services. This study examined perspectives of 442 foster parents regarding their experiences with children's behavioral and medical health services, through closed and open-ended survey questions, to provide further insight into how to best meet the needs of children in the foster care system. Findings suggest that foster parents are generally satisfied with medical services. They were particularly pleased when they perceived caseworkers were efficient with paperwork and provided comprehensive information at intake. They appreciated providers who were able to make appointments on short notice and were patient with children with a variety of needs. Foster parents were less satisfied with behavioral health services. They cited concerns about the timeliness of acquiring behavioral health services, lack of individualized services, and how turnover impacted consistency and progress of services. Consistently, foster parents provided examples of their role in advocating for the needs of the children in their care and described the need to be heard, consulted, and included in assessment and treatment. This study offers important implications for service providers and policy makers to review implementation of current practice and policies, and demonstrates the commitment foster parents have to ensuring the health and behavioral health needs of our most vulnerable children are met.

Keywords Foster care · Services · Medical and behavioral health · Foster parents · Satisfaction

Introduction

According to the 2014 AFCARS Preliminary Report, more than half (53 %) of children in foster care nationally are placed with a licensed non-relative foster family (U.S. Department of Health and Human Services 2014). Foster parents serve a critical role in the child welfare system, caring for children and youth who experienced maltreatment, many of whom present with significant behavioral health and medical needs. Foster parents' ability to care for the emotional, medical, and dental needs of children in their care is dependent on the availability and delivery of quality services. However, previous studies indicate that foster parents report having little say in decision-making and services for the children in their care (Buehler et al. 2006; Hudson and Levasseur 2002). This is concerning as foster parents can provide unique insight into the behaviors, progress, and service needs as they interact with the children and service providers on a regular basis. There is a need to understand the perspectives of foster parents regarding their experiences with children's behavioral, dental, and medical health services, to promote positive examples of service provision as well as offer important considerations for improvement.

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Medical and Behavioral Health Needs of Children in Foster Care

Child welfare agencies are charged with providing the necessary medical, dental, and behavioral health care for children while in foster care. It has been well documented that children in the foster care system demonstrate a variety of medical and behavioral health conditions (e.g., Heflinger et al. 2000; Kortenkamp and Macomber 2002; McCrae 2009; McMillen et al. 2005; Mekonnen et al. 2009; Oswald et al. 2010; Pecora et al. 2009; Sawyer et al. 2007; Steele and Buchi 2008; Vandivere et al. 2003) and require a range of treatments, medications, and specialized care. Rubin et al. (2005) reported that an estimated one in every two children in foster care has a chronic medical problem, and an estimated 40–80 % of youth in foster care have a serious behavioral or mental health condition requiring treatment (Clausen et al. 1998; Garland et al. 2000; Glisson 1994; Halfon et al. 1995; Landsverk et al. 2002; Stahmer et al. 2005).

Children of all ages who experience maltreatment are susceptible to various developmental delays, behavioral problems, and health conditions (Clausen et al. 1998; Glisson 1994; Halfon et al. 1995; Heflinger et al. 2000; Landsverk et al. 2006; Urquiza et al. 1994). For example, a study of children entering foster care in Utah from 2001 to 2004 experienced high rates of obesity, oppositional defiance disorder and conduct disorder, reactive attachment, adjustment disorders, and mood disorders (Steele and Buchi 2008). Research on children placed in out-of-home care revealed that between 23 and 61 % of children under the age of five were significantly developmentally delayed upon screening compared with 10–12 % of the general population (Urquiza et al. 1994; Klee et al. 1997). Such delays can be attributed to prenatal exposure to alcohol/drugs or abuse or neglect in the home. In addition, studies have documented the increased prevalence of post-traumatic stress disorder (PTSD), alcohol abuse and dependence, various forms of depression, and social phobia among children and youth in foster care at higher rates than their peers who are not in care (Auslander et al. 2002; Clausen et al. 1998; Dos Reis et al. 2001; McMillen et al. 2004). Such conditions left untreated and unresolved can have negative long-term consequences into adulthood such as incarceration, relationship and financial problems. With an increased number of children entering foster care and the high levels of need among children and youth in foster care, experts are calling for improved access and treatment that is child and family-centered, community-based, and culturally competent (Pasztor et al. 2006, 2009; Stroul 2002; Stroul and Friedman 1996). However, concerns continue about inconsistencies in the availability and quality of services provided for children in care and how services are monitored and delivered (Buehler et al. 2003).

Medical and Behavioral Health Services and Placement Stability

Studies of foster parent perspectives have indicated problems regarding lack of adequate services and support, which impacts their overall satisfaction and retention in fostering (e.g. Buehler et al. 2003; Triseliotis et al. 2000). In addition, a recent survey of foster parents in a southwestern state identified concerns related to acquiring and maintaining services for children and youth placed in their care, as well as paying for services beyond what was covered by insurance or made available through the system of care (Geiger et al. 2013). Medical and behavioral needs of the child are also related to placement disruption and/or breakdown. For example, children with disabilities or complex medical needs were more likely to experience a disruption in placement (Leslie et al. 2005) and children who were more behaviorally adjusted were less likely to have a disruption in placement (Macdonald and Turner 2005).

Although studies indicate behavioral and medical needs as a concern for foster parents, there is a paucity of research regarding what specific services and experiences with service provision are concerning to foster parents. When considering the national average of time spent in foster care is nearly 2 years (U.S. Department of Health and Human Services 2014), it is imperative to understand the perspectives of foster parents as primary caregivers and often coordinators of services during this critical period (Pasztor et al. 2006).

Method

Study Design

A mixed methods concurrent triangulation design (Creswell 2003) was used to examine foster parent satisfaction with physical and behavioral health services for children in their care, as a follow-up to a larger study regarding foster parent satisfaction. The original study utilized mixed methods to investigate what impacted decisions to continue fostering of 649 foster parents in a southwestern state in 2012. Results from the original study indicated there were concerns about behavioral health services, including timeliness and availability of services, as well as having to pay for some expenses out of pocket (Geiger et al. 2013). Specific questions referencing these concerns were not included in the initial survey, and meetings with foster family community stakeholders prompted the need for further clarification of foster parent experiences specific to behavioral health and medical, dental, and vision services. In response to this feedback, a second anonymous online survey was created that elicited further data regarding health, dental, vision, and behavioral health services.

The follow-up cross-sectional survey was developed in conjunction with a foster parent advocate, insurance provider, and child welfare agency representatives to ensure the current study would offer enhanced understanding about the concerns previously expressed by foster parents. Twenty-three closed-ended questions were used to examine various aspects of services for children in foster care placements, including how satisfied respondents were with behavioral health and medical health services, where information about services was obtained, and what expenses were paid for beyond what was covered through state-provided insurance.

Demographic questions were asked of race/ethnicity, highest level of education, income (not including foster care payments), and household type. Groups of children fostered was determined based on categories provided by the state child welfare system: birth to 5 years, 6–12 years, 13 and older, birth to 18 years, medically fragile infants, therapeutic needs, and respite. Closed-ended questions regarding satisfaction with specific services were presented on a seven point Likert-type scale ranging from *very dissatisfied* to *very satisfied*. Other questions of where information was obtained and expenses were based on categories determined in consultation with community and professional providers.

Participants were also provided an option to offer additional information through five open-ended questions. Open-ended questions such as “What else would you like to tell us about your experiences with medical, dental, and vision services for the children who are or have been in your care?” sought to provide clarification to quantitative responses and to provide an opportunity for feedback that may not have been addressed in the quantitative elements of the survey. Thematic analysis was used to sort and review qualitative responses. Open coding was used by two researchers to identify all potential categories present in the open-ended responses. Closed-ended items were triangulated with open-ended responses, allowing for increased understanding regarding the meaning of these quantitative data.

After IRB approval was received through the authors’ institution, convenience sampling was used to recruit foster parents in a southwestern state to participate in the online survey. An email information letter and survey link were sent through a designee at the public child welfare agency and by staff at two agencies serving foster families, in the same way participants were recruited in the initial study. As the purpose of the current study was to provide additional information and clarification of concerns presented by participants in the original study, participants were only eligible to complete the follow-up survey if they were one of the 649 foster families who participated in the initial survey by email invitation. Informed consent was provided on the introductory page of the online survey, and clearly noted that proceeding into the survey would be considered their consent to participate. The online survey was managed through Qualtrics software and remained open for 6 weeks from December 2012 to January 2013.

Results

Description of Sample

A total of 442 foster parents completed the online survey, representing a 68 % response rate of the original survey respondents (Geiger et al. 2013). *T* tests of the sample demographics from the current and previous study demonstrated no significant between-group differences based on race/ethnicity, type of household, income, or time fostering. In the current study, 91 % of respondents were non-relative placements, and the majority (74 %) were two-parent households and making $40,000 or more in annual income. More than half (57 %) of parents were fostering children ages birth to five, 38 % were fostering children 6–12 years, and 17 % were fostering children 13 and older. Eighteen percent of foster parents were fostering children across all ages, from birth to 18. Twelve percent of respondents reported to be fostering medically fragile infants, 9 % children with therapeutic needs, and 31 % indicated they were providing respite care (Table 1).

Satisfaction and Knowledge of Services

Foster parents were asked if they had cared for children or youth in the past 5 years with medical, dental, or vision needs. They were also asked whether they have fostered children or youth with behavioral health needs. Ninety-three percent ($n = 397$) of respondents reported fostering children in the last 5 years with medical health needs and 80 % ($n = 353$) reported that they foster children or youth presenting with behavioral health needs. Of the parents reporting children with such needs, respondents were asked how satisfied they were that the children’s needs were being met. Fifty-four percent ($n = 217$) of foster parents were very satisfied that the medical, dental, and vision needs of the children in their care have been met; 29 % ($n = 114$) were satisfied, 9 % ($n = 35$) were somewhat

Table 1 Sample description

Variable	Current study (N = 442)			Previous study (N = 649)		
	M (SD)	Frequency	Percent	M (SD)	Frequency	Percent
Number of years fostering	4.77 (4.78)			4.42 (5.46)		
Relative placement (%)		40	9.05			
Race/ethnicity—parent 1						
African American		22	4.98		39	6.01
American Indian		5	1.13		3	0.46
Asian		2	0.45		2	0.31
White/Caucasian		360	81.45		517	79.66
Latino/a or Hispanic		38	8.60		59	9.09
Multiracial		9	2.04		18	2.77
Other		4	0.90		6	0.92
Missing		2	0.45		5	0.77
Race/ethnicity—parent 2						
African American		11	2.49		22	3.39
American Indian		3	0.68		7	1.08
Asian		5	1.13		6	0.92
White/Caucasian		245	55.43		373	57.47
Latino/a or Hispanic		49	11.09		45	6.93
Multiracial		11	2.49		14	2.16
Other		3	0.68		2	0.31
Missing		115	26.02		180	27.73
Income						
Below $10,000		7	1.58		13	2.00
$10,000–$19,999		12	2.71		27	4.16
$20,000–$29,999		31	7.01		43	6.63
$30,000–$39,999		55	12.44		79	12.17
$40,000–$49,999		49	11.09		76	11.71
$50,000–$59,999		54	12.22		83	12.79
$60,000–$69,999		51	11.54		54	8.32
$70,000–$79,999		38	8.60		55	8.47
$80,000–$89,999		35	7.92		54	8.32
$90,000 or more		101	22.85		146	22.50
Missing		9	2.04		19	2.93
Household						
Single parent		112	25.34		178	27.42
Male/female couple		313	70.81		450	69.34
Same sex couple		16	3.62		19	2.93
Missing		1	0.23		2	0.31

satisfied, 2 % ($n = 9$) were neutral, 4 % ($n = 14$) reported being somewhat dissatisfied, 1 % ($n = 5$) were dissatisfied, and <1 % ($n = 3$) reported being very dissatisfied. Alternatively, only 6 % ($n = 19$) of foster parents were very satisfied that their children's behavioral health needs were being met. Seventeen percent ($n = 58$) were satisfied, 20 % ($n = 69$) were somewhat satisfied, 7 % ($n = 24$) were neutral, 16 % ($n = 53$) were somewhat dissatisfied, 18 % ($n = 60$) were dissatisfied, and 16 % ($n = 54$) were very dissatisfied.

To explore where information regarding services was acquired, foster parents were asked who provided information about requesting and setting up services, from a list including child welfare worker, licensing worker, guardian at litem (GAL)/GAL's social worker, another attorney, court appointed special advocate, another foster parent, behavioral health provider, medical/primary care provider, or by looking it up themselves online or in a manual. Respondents were allowed to choose multiple responses as appropriate and were also allowed to enter an 'other' response. Most often, parents reported getting behavioral health information from child welfare caseworkers (64 %, $n = 216$), licensing workers (33 %, $n = 111$), and/or behavioral health providers (30 %, $n = 102$). Regarding medical, dental, and vision services, foster parents most often obtained information from child welfare caseworkers (46 %, $n = 185$), by looking it up themselves (45 %, $n = 182$), and/or from licensing workers (32 %, $n = 129$). 'Other' sources of information for behavioral health services included obtaining information from crisis response counselors, child and family teams, schools, Native American communities/advocates, or they themselves had knowledge from previous experiences with foster children or working as a child welfare/behavioral health employee. Foster parents reported getting medical service information from 'other' sources such as insurance provider, another doctor, school, or hospital.

Medical, Dental, and Vision Services

Ninety-two percent ($n = 366$) of foster parents reported being satisfied that the medical, dental, and vision needs of the children in their care were being met, as indicated with response of *somewhat satisfied*, *satisfied*, or *very satisfied*. Described another way, the average satisfaction for medical, dental, and vision services was 6.21 (SD = 1.18) on the seven point, Likert-type scale, indicating participants were primarily satisfied with such services. Two hundred seventy-five foster parents provided additional open-ended feedback about their experiences with medical health services, which was 69 % of the foster parents who expressed they had utilized such services in the past 5 years. Consistent with this level of satisfaction, one foster parent commented, "The coverage is excellent for basic needs, and the service providers I have found are excellent and responsive." Another parent reported, "The state takes very good care of the children's physical medical needs."

Foster parents provided positive examples of experiences with specific providers, including finding providers who were able to take appointments for foster children on short notice, and those who were flexible with the changing needs of foster families. One parent shared, "I have had no problems in scheduling or taking my foster child to any medical or dental appointment or scheduling short notice, same-day appointments. The care has been outstanding." Other parents provided examples of providers taking extra time with children who were nervous about services and communicating in a timely fashion. Illustrating this point, one parent explained, "All providers have provided quality service and made the experience as comfortable and convenient as possible for both the children and us." Although the level of satisfaction with medical health services was high, some foster parents also provided feedback regarding challenges they have encountered. Themes emerged from qualitative responses related to authorizations, dental and vision care, prescriptions, and with general medical service provision.

Authorizations

Foster parents described medical and physical health services as easy to obtain, however several felt that specialized services and surgeries took too long to get the appropriate authorizations. In these cases, parents described the importance of their role in advocating for the needs of the child. One parent stated, "I have to do all the advocating and research. I fight for every single service he gets and it takes *months* [italics included by participant] and many calls and documentation to get him medically necessary things or records." Advocacy was also needed if foster parents felt children in their care were being treated differently due to their status as a child placed in out-of-home care. One parent explained, "It has been my experience that a foster parent must seek out caring doctors and dentists in order to have the children treated as though they were your own."

Related to healthcare, foster parents also appreciated when basic information such as prior exams, immunization records, and family medical history, was passed along in a timely manner. Parents cited satisfaction with service providers and caseworkers who were efficient with paperwork, provided medical history records at intake, or tracked it down quickly from previous providers. Having such information at intake helps avoid repetition of appointments and minimizes the need for foster parents to pay out of pocket to ensure the child's physical health needs are met.

Dental and Vision

Findings regarding dental and vision services also indicated overall satisfaction with these services. Foster parents reported that regular dental and vision care was easy to acquire and experiences with providers who were often able to take short notice, same-day appointments was helpful. One parent shared an experience with a dentist's office taking extra care and attention with their foster children: "Most children in my care have had little contact with dentists or horrific experiences. [The dental staff] embrace these children and their fears and the children walk out loving the dentist. It is an amazing transformation."

Despite a general sense of satisfaction, some parents reported difficulty finding dentists that will accept the foster children's insurance, and the allowable dental work is limited. Some discussed having to go to more than one dentist based on insurance coverage, to meet the needs of their family, and foster parents in rural areas reported difficulty finding insurance-covered dental and vision providers. They indicated they often need to travel to urban areas for service.

Although most respondents indicated a high level of satisfaction with general dental services, several discussed the importance of orthodontia and reported this service was often denied because it did not meet the insurance-designated criteria for medical need even when problems impacted breathing, eating, and general self-esteem. One foster parent explained:

> We have had foster teens who needed braces but because it didn't impede their speech, [they] were denied services. These children already have so many strikes against them; giving them a nice smile is the least we could do. As foster parents we put braces on four of our kids and what a difference it made with their self esteem!

Parents also recommended additional vision coverage, as the minimum may not be appropriate for children in foster care. Children in foster care are often changing placements, in which glasses may be lost, stolen, or otherwise damaged, without being able to replace them. Other foster parents commented that children and youth involved in activities would benefit from coverage including contact lenses. One parent explained, "The most basic eyeglasses are provided; however, for athletes this is not adequate. Contacts are not much more expensive but are not considered in the plan, so this limits their participation in some sports."

Prescriptions

Some experiences with prescription coverage were described as positive, such as one parent commenting, "My local pharmacy has done an exceptional job in filling prescriptions and working out any kinks with insurance." Other foster parents discussed challenges when trying to fill a prescription for a child in their care. Delays in receiving/transferring insurance delayed coverage of current prescriptions and refills. For example, one parent said, "The biggest problem we have is getting refills on medications; calling regarding meds or refills [and] calls back have sometimes been non-existent."

Several foster parents also reported having to pay out-of-pocket for prescriptions already prescribed, as well as coverage of necessary over-the-counter medications. Seventy-eight percent of foster parents surveyed reported paying for over the counter medication at least once, and 33 % reported paying out of pocket for pharmaceutical medication that the child in their care required that was not covered by state-provided insurance. One parent stated, "We paid over $800 for lice removal out of our own pocket. We are currently paying for ringworm treatment out of our own pocket. Not covered under [insurance]." Many of the children coming into foster care have high individualized needs and health issues such as lice, which parents are not comfortable leaving untreated.

Behavioral Health Services

Only 43 % ($n = 146$) of foster parents who cared for children with behavioral health needs in the past 5 years were satisfied that the children's behavioral health needs were being met, with an average rating of 3.72 (SD = 1.91) on the seven point Likert-type scale. To further explore foster parents' satisfaction with behavioral health services, questions were asked about specific aspects of behavioral health care, ranging from information provided to acquiring and providing services and their involvement in decision-making. Table 2 provides more detail of the quantitative responses presented. Respondents were able to clarify their experiences with open-ended responses. One hundred eighty-eight foster parents (56 %) provided additional feedback, ranging from a few words to long paragraphs of information, demonstrating their commitment to improving the overall system to best meet the needs of the children in their care.

Foster parents detailed both general impressions as well as specific examples of experiences, representing a mixed appraisal of behavioral health services. Parents reported satisfaction with behavioral health services when providers were flexible in scheduling and maintained consistent communication. For example, one parent described the agency that served her foster children as "providing good quality services; keeping us informed and trying to make it as convenient as possible on the child and us." Another parent commented that the agency she took her foster children to "provided a multitude of services and supports. They did an excellent job… I can call them and set services back up or just schedule an appointment when needed." When service providers were responsive and flexible, foster parents cited great appreciation for these efforts. Additional themes regarding delays in acquiring services, the need for individualized services, systemic barriers, and communication were also addressed by participants.

Delays in Acquiring Services

Although some parents shared positive experiences with behavioral health services, nearly 60 % ($n = 195$) of parents reported dissatisfaction with the timeliness of acquiring behavioral health services. One parent shared, "A more timely start of therapy would have been much more beneficial to my child and myself. After 6 months without

Table 2 Satisfaction with aspects of behavioral health services

Variable	Frequency	Percent
Communication of information at intake		
Very satisfied	28	8.28
Satisfied	49	14.50
Somewhat satisfied	42	12.43
Neutral	46	13.61
Somewhat dissatisfied	46	13.61
Dissatisfied	48	14.20
Very dissatisfied	73	21.60
Missing	6	1.78
Services need were acquired		
Very satisfied	24	7.10
Satisfied	53	15.68
Somewhat satisfied	65	19.23
Neutral	31	9.17
Somewhat dissatisfied	50	14.79
Dissatisfied	62	18.34
Very dissatisfied	47	13.91
Missing	6	1.78
Timeliness of service implementation		
Very satisfied	19	5.62
Satisfied	31	9.17
Somewhat satisfied	53	15.68
Neutral	33	9.76
Somewhat dissatisfied	63	18.64
Dissatisfied	50	14.79
Very dissatisfied	82	24.26
Missing	7	2.07
Ability to navigate the system		
Very satisfied	18	5.33
Satisfied	45	13.31
Somewhat satisfied	47	13.91
Neutral	49	14.50
Somewhat dissatisfied	68	20.12
Dissatisfied	58	17.16
Very dissatisfied	46	13.61
Missing	7	2.07
Ability to coordinate appointments		
Very satisfied	41	12.13
Satisfied	74	21.89
Somewhat satisfied	68	20.12
Neutral	52	15.38
Somewhat dissatisfied	34	10.06
Dissatisfied	28	8.28
Very dissatisfied	36	10.65
Missing	5	1.48
Convenience/location of services		
Very satisfied	38	11.24
Satisfied	74	21.89
Somewhat satisfied	60	17.75
Neutral	55	16.27
Somewhat dissatisfied	41	12.13
Dissatisfied	29	8.58
Very dissatisfied	34	10.06
Missing	7	2.07
Input taken in taken into consideration		
Very satisfied	44	13.02
Satisfied	87	25.74
Somewhat satisfied	45	13.31
Neutral	41	12.13
Somewhat dissatisfied	41	12.13
Dissatisfied	35	10.36
Very dissatisfied	38	11.24
Missing	7	2.07
Consistency of services		
Very satisfied	32	9.47
Satisfied	63	18.64
Somewhat satisfied	43	12.72
Neutral	44	13.02
Somewhat dissatisfied	52	15.38
Dissatisfied	44	13.02
Very dissatisfied	53	15.68
Missing	7	2.07
Quality of services		
Very satisfied	34	10.06
Satisfied	53	15.68
Somewhat satisfied	76	22.49
Neutral	52	15.38
Somewhat dissatisfied	36	10.65
Dissatisfied	36	10.65
Very dissatisfied	44	13.02
Missing	7	2.07

help, I was ready to give up.” The same foster parent also reported:

> Once the therapy started, it was very consistent and helpful to both of us. The therapist interacted with me at every session. He was available to me through his office or personal cell phone day or night. She [the child] is finally making progress with her behaviors in a positive manner.

Other foster parents reported delays in acquiring services due to waiting to determine the agency assigned, no appointments available at the assigned agency in the near future, and delays in having services ordered or determined appropriate. Particularly in times of urgency, respondents indicated the delay in services resulted in disruptions and an increase of problematic behavior. Only 34 % ($n = 119$) of parents were satisfied with the communication of a child's behavioral health history and needs upon intake, as evidenced by responses to three data points of *somewhat satisfied, satisfied,* and *very satisfied*. Forty-nine percent ($n = 167$) were at least somewhat dissatisfied with such communication, by indicating they were either *somewhat dissatisfied, dissatisfied,* or *very dissatisfied*. In describing a situation where services were delayed, one parent shared:

> The child came to us with diagnoses and no plan of action for treatment conveyed to us. It seems he was diagnosed and left for us to deal with. His psych eval[uation] even gave a treatment plan but nobody helped us see it through. I only found it on the paperwork from his file that I even learned that there was a plan suggested by the psychologist or psychiatrist who diagnosed him… He has been with us for months and should have been receiving services all along.

Individualized Services to Meet the Needs of the Child

Foster parents were most satisfied when services were individualized to meet the needs of the child, including attention to historical events as well as the foster parents' perspective of current behaviors. For example, one parent reported, "They [crisis response] base their intake [assessment] within 24 h of placement. No one knows in 24 h what services are needed. If they came 2 weeks after placement we would have a lot more information about needed services." Once service need was assessed, only 42 % ($n = 142$) of parents were satisfied that behavioral health services that were needed for their children were acquired. One parent responded, "When I was doing therapeutic care, it was a challenge to get services to fit the severity of the child's needs. It was like a Band-Aid for a gushing wound." Many children involved in the foster care system experience a number of traumatic and adverse life events and require specialized services and counseling.

Many foster parents in the study described the need for consistency in services, with more follow-up and follow through. Although foster parents report positive experiences when services are in place, only 41 % ($n = 138$) of parents reported being satisfied with the consistency of services. As one parent describes:

> When we were able to get counseling for the children, it was satisfactory, but most of the time there is no follow up after the intake and it takes many phone calls and advocating on my part to get any services at all.

Parents also described concern about labeling and overmedicating. One parent shared, "[Providers were] too quick to put them [foster children] on medication and not really work at the root of the issues," which speaks to the need for more individualized treatment. Foster parents in the current study also reported having to pay out-of-pocket for specialized counseling for PTSD or anger management, animal therapy, and transportation to appointments, to ensure the children received needed services. Finally, several respondents cited the need for more therapists with specialized training and skills to work with children experiencing trauma, attachment issues, or autism.

Systemic Issues and Turnover

Foster parents in the study provided both positive and negative experiences related to systems level issues with behavioral health services, highlighting caseworkers and providers who are going above and beyond, as well as consequences of an overburdened system. One parent commented, "I have had the same therapist work with one of my kids for the 3 years off and on, that was needed. I think this is a rare situation, but it was very beneficial for all my kids to have the same person each time." Others reported turnover negatively affecting a child's progress and contributing to delays in services. One parent stated:

> There has been and continues to be a very high turnover with counseling personnel. There has not been consistent services for the children and they are constantly being introduced to new counselors, hindering the bond that is necessary for the children to open up to the counselor.

Some respondents also observed therapists under pressure to "close out" cases or "get it done" in a certain number of sessions, another illustration that the system is overtaxed. Another foster parent explained, "Our one foster son had a program at school for learning to socialize better, which was great, but then the federal funds were cut. It was a valuable small student-group counseling program."

In terms of scheduling, 54 % ($n = 183$) of foster parents report being satisfied with their ability to coordinate appointments that fit their schedule and 51 % ($n = 172$) were satisfied with the convenience and location of services. Open-ended feedback from foster parents indicated challenges with limited appointment availability and difficulty scheduling appointments outside of regular business hours when the child is not in school. Parents also cautioned against "over-scheduling" children with too many services, with one parent explaining, "Therapists try to get the kids signed up for so many [groups] in a week, in addition to their individual therapy. This sounds great, but getting the kids to and from all of these groups… eats up any family time."

Communication Between Providers, Caseworkers, and Foster Parents

A common theme throughout foster parents' comments in this study was the need to be heard, consulted, and included in the assessment and treatment of the children in their care. Fifty-two percent ($n = 176$) of foster parents reported being satisfied with their involvement in decision-making, and there were examples of positive encounters with caseworkers and service providers, such as "my caseworker is amazing and does everything quickly and in the best [interest] for the child," and "the doctors and therapist have been very receptive and understanding."

Other foster parents reported they felt they were not consistently included in goal setting, treatment planning, assessment, or follow-up. One parent explained, "The foster parent needs to be in contact with the therapist so we can relay behaviors or be able to understand how to help the child at home." Parents consistently reported they would appreciate being provided information or asked about the child's progress indicating a desire for increased communication between the child welfare caseworker, providers, and foster parents. Collaborative efforts include consideration of foster parent input and communication of treatment goals helps support the child and placement. As one parent stated, "Had our input been considered, I believe the placement would not have disrupted."

Foster parents also consistently reported advocating for the children in their care and feeling responsible for navigating services. Only 33 % ($n = 110$) of parents were satisfied with their ability to navigate the behavioral health system and services needed for the children in their care. Some foster parents indicated relying on previous experience for confidence in navigating services. For example, one parent said, "I did all of the leg work for mental health services and notified the case manager. I had previous experience navigating the system so I had no problems getting services for our foster children." Others indicated their resolve to learn about the system and to advocate for the services needed through "hours upon hours" of phone calls, emails, and letters.

One foster parent also commented that emotional and behavioral support for their foster children goes beyond formal services, when explaining:

> There is only so much counselors can do. Then it's up to us as [foster care] providers to learn to help them cope with their conditions. We as providers must also come to the realization that we cannot 'fix' them or make up for their losses. We can only hope to move them forward by letting them know we have high expectations for them and guide them in making good choices. Supporting them as best we can and model good citizenship to the best of our ability is our focus as parents.

This ongoing support for the behavioral health needs of foster children highlights the value of collaborative efforts.

Out of Pocket Expenses

Respondents indicated that many are choosing to meet the behavioral and medical health needs of foster children, even if it is sometimes beyond what is communicated or covered by insurance. A small percentage of survey respondents reported paying for behavioral or medical health expenses beyond what was covered by insurance, with 5–10 % paying for behavioral health services out of pocket, and 3–14 % paying for out of pocket for medical health expenses. When asked specifically about out of pocket expenses, foster parents provided detail about such expenses including who informed them they were responsible to pay for the services or items.

Medical Expenses

With regard to medical health expenses, more than three-quarters (77 %, $n = 302$) of foster parents surveyed reported paying for over-the-counter medication at least once with nearly half (45 %, $n = 177$) paying for such expenses each month. Thirty-three percent ($n = 128$) of foster parents reported paying out-of-pocket for pharmaceutical medications, and 19 % ($n = 73$) reported paying for medical supplies or equipment beyond what was covered by state-provided insurance. Parents provided more detail that they were paying for dental guards, knee braces, humidifiers, eye patches, infant recliners for gastroesophageal reflux, orthotics, walkers, tools for feeding therapy, and tubes for breathing machines. Parents also reported paying for 'other' expenses such as transportation, specialized treatments and equipment (e.g., sensory toys and tools), sports physicals, and books.

Nearly half (49 %, $n = 193$) of parents surveyed also reported paying for diapers at least once a month for the children in their care. Parents provided additional comments that the "monthly payment is not enough for the amount needed for each child" and many reported caring for children with bed-wetting issues who needed pull-up diapers still. One parent explained:

> We were told the child 'should have been potty trained' by then. Since it was not a medical need, diapers were not covered. Foster parents have *no control* when a child comes to them *not* potty trained [italics provided by respondent]. And a foster parent has to decide if potty training immediately is in the

> child and family's best interest… or if other needs take precedence (which they usually do).

Behavioral Health Expenses

Regarding behavioral health care expenses, 8 % ($n = 25$) of participants who responded to the question reported paying for psychotropic medications at least once, and 8 % reported paying for other behavioral health medications beyond what was covered. Ten percent ($n = 34$) of responding foster parents paid for equipment related to behavioral health, and 5 % ($n = 17$) reported paying for additional behavioral health services such as anger management, animal therapy, occupational therapy, and other specialized therapies or therapists not covered by the state provided behavioral health plan.

Discussion and Implications

This study examined the perspectives of 442 foster care providers in a southwestern state regarding their experiences with behavioral health and medical, dental, and vision health services. Responses on the closed and open-ended items offer important implications regarding the policies and services provided to foster children, and highlight the clear commitment to meeting the behavioral and medical health needs of children in their care.

Of the 80 % of foster parents who reported having children in their care with behavioral health needs, only 43 % were satisfied that the behavioral health needs of the children and youth placed in their care were being met. This finding is striking considering 92 % of foster parents were satisfied that medical, dental, and vision needs were being met. Participants in this study provided considerable feedback regarding what specific challenges they had faced. Consistent with previous research, foster parents were concerned about the availability and implementation of behavioral health services (Buehler et al. 2003; Geiger et al. 2013). Fifty-eight percent of parents in this study reported dissatisfaction with the timeliness in acquiring behavioral health services with many parents reporting frustration with services 'too little, too late.' Despite the investment of foster parents to support the emotional and behavioral health needs of the children in their care, lack of communication and coordination of services can hinder satisfaction with services and the ability to adequately meet the needs of children in foster care. Although policies in this state support the idea that foster parents are incorporated into the decision making regarding how best to meet the emotional and psychological needs of children, findings from this study suggest the implementation of this policy may be inconsistent. Evaluating how such policies are conducted in practice is a critical part of ensuring quality care.

Concerns about adequately meeting the needs of foster children included specific suggestions for counseling services to focus more on the history of trauma and to address the need for enhanced continuity in care. High turnover in case management as well as with therapists was concerning as children either have to continue to re-tell their traumatic experiences or more frequently, shut down emotionally from services which could be beneficial. Other parents described concerns about unrealistic expectations of resolving trauma in four to eight sessions. As children develop and continue to experience separation and triggers of trauma, they need to have ongoing support. Utilizing crisis services is often the only way to get services, when there are delays in setting up services or they have been discontinued. This presents an inefficient use of services. Findings suggest policies related to the timeliness, availability, and length of service should be reevaluated.

Navigating the system to acquire services is clearly difficult for many foster parents who report that they receive contradictory information leading them to resolve situations based on their own or from the experiences of other foster parents. Only 35 % of parents were confident in their ability to navigate the behavioral health system, reporting inconsistencies with service provision and communication. This was particularly concerning for parents who felt their voice was not considered when making treatment decisions. For example, one parent stated, "Service providers many times don't seem to take foster parents' opinions into consideration when providing services." Foster parents spend more time with foster children than other professionals lending support to the idea that they should have a voice in decision-making, something that is consistent with previous research (Pasztor et al. 2006). Procedures such as including foster parents in child team meetings that provide a multidisciplinary team approach to decision making is supported by these findings.

Respondents in this study reported that they primarily received information about obtaining services from CPS caseworkers, licensing workers, other foster parents, and looking it up themselves. Interestingly, 13 % of foster parents also reported receiving information from other sources such as crisis response counselors, child and family teams, community advocates, or schools, suggesting the importance of educating multiple providers about how best to support foster parents as they seek services for foster children and youth. Receiving information from varied sources can create confusion when the messages received are contradictory. It is important that professionals working across the system of care are trained in policies and procedures regarding behavioral health services in each state, to ensure clear and consistent information is provided to foster parents. Other methods of communication such as websites and regular newsletters can also provide an outlet for providing information foster parents need to ensure the mental health needs of the children in their care are met.

In general, foster parents were satisfied with medical health services, although they would like to see faster communication regarding authorizations and a reduction in expenses paid for out of pocket. Foster parents' general satisfaction with medical services may provide a model for areas of service, such as behavioral health, where foster parents are less satisfied. Timeliness of service implementation and addressing underlying and ongoing needs is important. As one parent explained, "Providing minimal services to these children is like stopping the bleeding but not fixing the problem." Addressing underlying behavioral health issues including problems related to trauma, emotional distress, and attachment is essential.

Although any child may experience trauma or loss, children involved in child welfare tend to be exposed to an accumulation of such experiences, often greater in comparison to their same age peers. There is a need to address how behavioral health services and supports are implemented with this population. Foster parents' satisfaction with medical health services in this study can serve as a model for transforming how behavioral health services are delivered. For example, the model of child and family teams is designed to be a wraparound service provided for children involved with behavioral health services, however, the inconsistency in communication reported by foster parents in this study and timeliness of implementation of specific services is concerning. There is clearly value in having multiple team members with oversight to services; however, systemic issues such as high caseloads and turnover are likely impacting the quality of services and effectiveness of the child and family team.

With medical health services, foster parents are recognized as the primary caretaker and guardian, allowing them the authority to manage basic medical appointments to meet the needs of the children in their care. In behavioral health services, foster parents are intended to be an active team member, however, foster parents in this study indicate feeling they have little say or ability to coordinate individualized services. Having a central person who is not directly involved in service provision may be helpful for coordination of services, as well as contributing to easing an overburdened system. Foster parents are clearly strong advocates for the children in their care, and feel confident in navigating medical health services in most cases. Incorporating the voice of foster parents to this same degree in behavioral health services may be useful.

The authors recognize that situations and services likely vary by placement. Other studies have demonstrated that children's medical needs differ significantly by length of stay and emotional needs for certain ages (Sullivan and Van Zyl 2008), and mental health needs varying by types of maltreatment (Burns et al. 2004). This study did not ask questions about the children and youth in foster care, but rather the foster parents' perceptions of services and recommendations for improvement. The purpose of this study was to provide more detail about specific aspects of services foster parents have experienced, from which to inform policies and programs to better serve our most vulnerable children. Service availabilities may differ based on budgets, needs, and agencies.

We also recognize that additional avenues of funding and support exist to pay for expenses some foster parents communicated as having to pay for out of pocket. Clearly there are a number of foster parents who were either unaware or confused about these options, something that seems worth addressing. Some foster parents have figured out how to navigate these situations on their own and some report relying on the experience of other foster parents to learn of additional sources of funding or avenues for authorizations for which they may not have previously been aware. Although this support is highly valued, having clear and updated information available to all foster parents through websites and newsletters remains essential to their capacity to care for the health and behavioral health needs of children placed in their care.

Conclusion

Foster parents provide care for children who typically have significant medical and behavioral health needs. This study highlights important aspects of foster parents' experience and level of satisfaction with system delivery, quality, and availability of health and behavioral health services. The large number of foster parents who responded to open-ended questions about other important considerations for behavioral and medical health services, speaks to the desire for their voices to be heard. Some of the comments from foster parents were nearly 400 words in length.

Recognizing that foster parents are obtaining information from multiple sources emphasizes the need for more comprehensive understanding of medical and behavioral health systems by social work practitioners in a variety of settings beyond the behavioral and medical health systems, such as those working in schools and community advocacy settings. Creating a central source of reliable and up-to-date information for families, providers, and case managers concerning coverage, services, and care providers remains critical. Oftentimes, services and products are available and included in coverage, but many foster care providers are not aware or information is inconsistent. Also, forming a list of "preferred providers" with experience in serving foster children and youth might be helpful to families. Such providers would be those who are able to demonstrate flexibility with scheduling and can offer understanding regarding unique needs of the children and families involved with the child welfare system.

Foster parents are committed to meeting the behavioral and medical health needs of their children, however the inconsistencies they are experiencing in acquiring and maintaining services is concerning. By better understanding these experiences, service providers can work towards improving practice and policies related to these systems and provide better support for foster parents and children in foster care. A common theme throughout foster parents' comments in the study was the need to be heard, consulted, and included in the assessment and treatment of the child in their care. Children in foster care spend the majority of their time outside of school with their foster families, but parents in the study asserted they were seldom included in goal setting, treatment planning, assessment, and follow up. Ongoing consultation is needed with foster parents to ensure providers have up-to-date information about how the child is functioning and to ensure consistency in support and treatment goals at home.

Foster parents in this study consistently communicated that they are committed to not only meeting the immediate physical and behavioral health needs of the children in their care, but to also ensuring the children are supported in an ongoing manner. Enhancing current services in behavioral health as well as medical, dental, and vision allows for the physical and emotional wounds of our most vulnerable children to be healed. Setting up our systems of care to address not only the immediate needs but also providing individualized ongoing services, can support positive development and outcomes.

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