

Mental Health Needs of Youth in Foster Care: Challenges and Strategies

By Lissette Austin

When life becomes chaotic and feels like it is falling apart, it is easy to feel alone and depressed. And when you are an abused or neglected child who has been separated from family and shuttled from home to home, the feelings can become incredibly overwhelming and isolating—perhaps even spinning out of control. For many in foster care, the result of this kind of emotional trauma is the development of a mental health disorder. They find themselves in a system that is ill-equipped to provide the mental health services they need and that can further impede their progress towards emotional well-being.

According to the World Health Organization, nearly 20% of children and adolescents worldwide suffer from some type of emotional or behavioral problem. The U.S. Surgeon General reports that roughly 1 in 10 American children experience a mental illness severe enough to cause significant impairment. The prevalence of mental health problems of youth in foster care is even more staggering. “Anywhere from 40 to 85% of kids in foster care have mental health disorders, depending on which report you read,” says Stephen Hornberger, director of behavioral health for the Child Welfare League of America.

The reasons for these high numbers are understandable. Children in foster care are struggling to cope with the traumatic events that brought them into care, including parental abuse or neglect, homelessness and exposure to domestic violence and substance abuse. While they struggle to deal with the tremendous loss of their family, they also frequently blame themselves for being removed. Many children long to

I went to my first therapist at age 12. At the time, my life was filled with chaos, and I didn't know who to talk to or how to handle it. My dad was in jail, my mother and I weren't talking, and in a little more than a year, several family members had died. All the feelings I had began to build up inside, and I felt like I was drowning in my emotions. Sometimes I would cry like a baby. Other times I'd feel angry and confused.

*I didn't trust anyone, especially my family, and I thought people were saying negative things about me. I started to disrespect my elders, steal, stay out late, and fail in school. Things got so bad that I was sent to two different group homes. At the homes I pretended to feel better about myself, but being there made me feel like more of a failure and like I didn't deserve to live.**

return to their families, regardless of the history of mistreatment. At a time when they desperately need a sense of consistency and stability, they are living in the uncertain world that is foster care: multiple placements, unpredictable contact with family and the inability to control their own lives. These conditions can be a hotbed for serious emotional disturbances.

Although it is clear that a large number of children and youth in foster care are in need of mental health care, studies show that less than one-third receive mental health services. One of the reasons is the lack of experienced mental health professionals available to this population. “There is a shortage of well trained providers who can deal specifically with loss issues,” says Dr. Toni Heineman, clinical psychologist and executive director of A Home Within, a nonprofit organization dedicated to helping meet the mental health needs of

children in foster care. Heineman adds that a recent, informal survey revealed that only 3% of mental health providers work with children in foster care. Those that do are often inexperienced trainees unfamiliar with navigating the child welfare system and only available for one year. “Being abused, neglected and removed from their family are extraordinarily painful experiences for these kids,” she says. “Put them with people who aren't well trained and it can be an overwhelming experience for both parties.”

**This excerpt was written by Norm Brandt and reprinted from I'm Not Crazy: A Teen Guide to Getting Mental Health Help. For more information on this and other Youth Communication publications, visit youthcomm.org or see the sidebar on page 7.*

Another major challenge is the lack of mental health training for both child welfare staff and foster families. Minimal legislative and media attention to issues of child safety mean that less attention is placed by the system on the emotional needs of children in foster care. Although there is some variance from state to state, the general trend is that caseworkers have limited training in mental health issues. Lack of resources, high turnover rates and overburdened staff also contribute to unmet mental health needs.

Lack of training for foster parents adds to the problem. Former foster parent Shawn Hosford experienced this firsthand when she wasn't told that her 7-year-old foster-to-adopt son had Reactive Attachment Disorder, a fairly common diagnosis among foster children (see sidebar, pg. 13). Unaware and unprepared, her family struggled through an increasingly difficult period that ultimately ended with his removal. This devastating experience led her to quit her job and start a nonprofit organization dedicated to providing support and education for foster parents and anyone involved in the child welfare system. "Anyone who works with these children should be informed about the different mental health disorders these kids are dealing with," she says. "Education is critical."

Without training, those involved with foster children frequently have difficulty recognizing serious disorders. Many mental health problems go undiagnosed because symptoms are overshadowed by other disruptive behaviors such as substance abuse, anger and opposition. "Anxiety and depression are very common, and both are often masked by drug use," says Anita Marshall, senior child welfare advisor for the American Institutes for Research in Washington, DC.

Mental Health Resources by Youth

Youth Communication helps teenagers develop their skills in reading, writing, thinking and reflection so they can acquire the information they need to make thoughtful choices about their lives. Youth Communication trains teens in journalism and related skills; publishes magazines, books and other materials written and illustrated by young people; and encourages teens and the adults who work with them to use their publications to stimulate reading, writing, discussion and reflection. Below are three resources developed by Youth Communication that address the topic of mental health issues faced by teens.

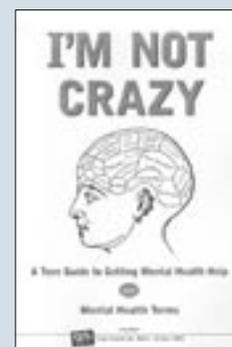
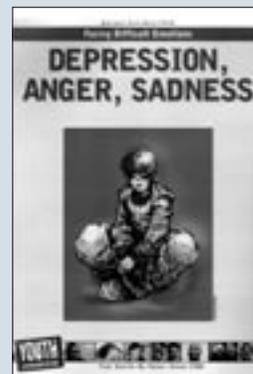
Fighting the Monster contains 39 true, credible and realistic stories by teens about getting help for depression, cutting, sexual abuse, domestic violence, substance abuse, eating disorders, bereavement, promiscuity, uncontrolled anger and many other topics. Teens describe what worked for them, including self-help, therapy and medication. This easy-to-read resource also contains "Think About It" questions with each story.

The teens in *Depression, Anger, and Sadness* candidly describe facing diffi-

cult emotional problems and what they did to try and help themselves. Because these writers not only describe their problems and fears but also the various ways they have tried to help themselves, their stories will help teens to face and better understand their own emotions.

An informative, reassuring and affirming guide for teens about how to get help from the mental health system, *I'm Not Crazy* is designed to tell teens the "real deal" about getting help, in language they can understand. This resource explains mental health services in a way that helps the teen reader get the services they need to get the most out of their lives.

All proceeds from sales go to furthering Youth Communication's nonprofit training and publishing programs for teens. Visit youthcomm.org to order these publications.





Web Resources

- National Institute of Mental Health
nimh.nih.gov/healthinformation/childmenu.cfm
- Child Welfare League of America
cwla.org
(In May 2005, CWLA hosts the “Addressing the Mental Health Needs of Children, Youth and Families” conference in New Orleans, LA.)
- A Home Within
ahomewithin.org
- American Academy of Child and Adolescent Psychiatry (AACAP)
aacap.org
- American Academy of Pediatrics
aap.org
- Comprehensive Mental Health Services Program for Children and their Families
mentalhealth.samhsa.gov/cmhs/childrenscampaign/ccmhs.asp
- National Child Welfare Resource Center for Family Centered Practice
cwresource.org
- The Carter Center Mental Health Program
cartercenter.org/healthprograms/program6.htm
- Screening for Mental Health, Inc.
mentalhealthscreening.org

“They are often self-medicating.”

Hornberger of CWLA agrees, adding that some disorders are overlooked because of the belief that parental neglect is less detrimental than abuse. “Research shows that neglect can actually have more long-term effects compared to the abuse cases,” he says. “Just because kids are quiet doesn’t mean that they are well.”

Additional system challenges include lack of collaboration between providers and parents (both foster and biological), lack of

continuity of care due to multiple placements, budget cuts that further limit access to trained providers, lack of routine mental health assessments and unmet mental health needs in family members. “I would say that the system has certainly had difficulty addressing the complexity and severity of mental health needs of these kids,” says Hornberger. “We are failing them in all jurisdictions.”

Pockets of Hope

With these circumstances, it is understandable that many who are involved in child welfare can end up feeling frustrated and helpless. But there are pockets of hope—people and organizations that are brainstorming and implementing solutions that could ultimately serve as guideposts for communities across the country.

One organization that is trying to make a difference is A Home Within. Their mission is to support and enhance the emotional well-being of children in foster care by addressing the low numbers of available mental health providers. Their innovative Children’s Psychotherapy Project (CPP) offers long-term individual psychotherapy with experienced clinicians to foster children and adolescents. With 10 chapters nationwide and one in Australia, directors are actively recruiting experienced therapists who are willing to volunteer their time. Therapists are asked to take one foster child into weekly psychotherapy for as long as that child needs treatment.

Another newer approach is therapeutic foster care, also called treatment foster care. An evidenced-based practice that was originally started to help children and youth in the juvenile justice system, it has now grown to include those in foster care and is being

introduced in a number of communities nationwide. This model actively includes foster parents in mental health treatment by having them provide the primary intervention in their homes. In order to do so, they receive mental health training, consultation and regular clinical support. Therapeutic foster care usually lasts six to twelve months and is often used as an alternative to residential treatment. “Many kids need to be in foster care that is actively supported by mental health providers,” says Marshall from the American Institutes for Research. “We need a lot more of this model out there.”

Solutions are also being developed and examined at a national level. In 1992, Congress passed legislation creating the Comprehensive Mental Health Services Program for Children and Their Families. This program in turn funded 85 state and local communities to build a “system of care” approach. This philosophy aims to help children and adolescents access individually-tailored mental health services near their homes through the close collaboration of local organizations and providers. Preliminary studies show this approach is more effective than traditional, uncoordinated mental health services.

Because children in foster care find themselves involved with several systems at once (families, foster care, mental health, school), this collaborative approach is ideal. In 1999, the *Surgeon General’s Report on Mental Health* outlined three evidence-based interventions that reflect effective system of care principles for foster youth: therapeutic foster care, intensive case management and wrap-around services, and Multisystemic Therapy (MST), a home and community-based intervention that addresses conduct-related mental health needs by intervening in all systems that impact youth. Studies

(continued on page 12)

Systems Challenges

Children and youth can find themselves involved with several social systems: foster care, mental health and their own families. All three systems share the same ultimate goals: to enable children to live safely with their families, attend and make progress in local schools, participate in the social and cultural life of their communities and develop the skills to live independently as young adults and contribute to society.

Foster care sees these goals through the mandates of child safety, permanence and well-being. Mental health's vision is characterized by the fulfillment of age-appropriate developmental-intellectual, emotional and social milestones in the child's family, schools and community. Families want their children to be successful and to belong. Families want to be asked what they know, what they think will or will not work and what support or resources they may need for their child and family to reach goals. Yet in spite of the connections among these goals, foster care, mental health and families face numerous systemic challenges that require an uncommon level of collaboration to resolve.

Challenges in the Foster Care System

- Staff turnover hinders the ability to meet the special needs of children and youth who have serious emotional disturbances. New staff often receive inappropriate training or insufficient supervision to support the child, the foster parent and the biological parent. When a child is oppositional or aggressive, both the foster parent and child need adequate support; otherwise, a disrupted placement and another rejection for the child result.

- The growing needs of seriously emotionally disturbed children and youth and the inconsistent availability of foster parent training and support result in high foster parent turnover. The result: placement disruption, inconsistent treatment and increased trauma for the child.
- Foster parents need to be considered partners in the treatment of children in their care.
- The legislatively mandated focus and media attention on the safety needs of children increase child welfare professionals' anxiety and take time away from attending to the emotional and trauma needs of the children for whom they are responsible.
- Increased mental health challenges of children require training to ensure earlier recognition and intervention. Younger children who display aggressive or sexually inappropriate behaviors are an increasing challenge for staff and foster parents who have limited training and support.
- Access to mental health services for referred children and youth is limited.

Challenges in the Mental Health System

- Fewer child and adolescent mental health professionals, especially psychiatrists, are available to work with children in foster care. This shortage is complicated by systemic budget cuts and low insurance rates of reimbursement.
- Mental health professionals working with foster care staff may not understand the child welfare system's mandates; the roles of individual workers; judicial time frames; the variance of roles across differing services components (such as guardianship, family reunification and permanency planning) and the rights retained by parents with children in foster care.
- Opportunities to identify children who are showing early signs of serious emotional disturbances are limited. Children entering foster care are not routinely screened for mental health needs but are referred only after they display problematic behavior.

- Coordinating and integrating care with multiple systems is difficult due in part to different mandates and values.
- Mental health providers often receive referrals with insufficient information to appropriately assess for treatment.
- Multiple and disrupted placements, missed appointments, lack of communication with mental health providers and discontinuation of treatment after the child is reunified with the family contribute to the lack of continuity of mental health care.
- Many mental health providers need more training to work with an increasing population of preschool sexually abused and/or sexually aggressive youngsters.
- Many mental health professionals need more training in effective and evidence-based interventions.

Challenges in Families

- Although 70% of children in foster care return to their families, these families are seldom seen as team members in their children's treatment while in care.
- Families are not routinely included in information gathering, such as their child's previous behaviors and demonstrated needs; previous treatments, both effective and ineffective; family history; and treatment preferences, including issues about medication.
- Within both the foster care and mental health cultures, families are not usually seen as partners and therapeutic allies.
- Youth in care are seldom involved in decisions about their care, such as treatment options, medications and education about psychotropic drugs and alternatives prior to discharge from foster care.
- Often family members have unmet mental health needs.

Source: Best Practice Next Practice Family-Centered Child Welfare, a publication of the National Child Welfare Resource Center for Family-Centered Practice, a service of the Children's Bureau.

The national evaluator of the Comprehensive Mental Health Services Program for Children and Their Families, ORC Macro, identified the five most prevalent diagnoses of children referred by foster care:

- Mood Disorders and Depression
- Oppositional Defiance Disorder
- Post-Traumatic Stress Disorder
- Adjustment Disorder
- Conduct Disorders

Source: *Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition (DSM-IV)*

While diagnosing children's mental health problems is the job of professionals and not CASA volunteers, the following information may be helpful background in advocating for assessments and treatments.

Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence

Depressive Disorders

Depressive disorders, which include major depressive disorder, dysthymic disorder and bipolar disorder, adversely affect mood, energy, interest, sleep, appetite and overall functioning. In contrast to the normal emotional experiences of sadness, feelings of loss or passing mood states, symptoms of depressive disorders are extreme and persistent and can interfere significantly with a young

person's ability to function at home, at school and with peers.

Major depressive disorder (major depression) is characterized by five or more of the following symptoms: persistent sad or irritable mood, loss of interest in activities once enjoyed, significant change in appetite or body weight, difficulty sleeping or oversleeping, psychomotor agitation or slowing, loss of energy, feelings of worthlessness or inappropriate guilt, difficulty concentrating and recurrent thoughts of death or suicide.

Dysthymic disorder, a typically less severe but more chronic form of depression, is diagnosed when depressed mood persists for at least one year in children and is accompanied by at least two other symptoms of depression (without meeting the criteria for major depression). Youth with dysthymic disorder are at risk for developing major depression.

Although *bipolar disorder* (manic-depressive illness) typically emerges in late adolescence or early adulthood, there is increasing evidence that this illness also can begin in childhood. Bipolar disorder beginning in childhood or early adolescence may be a different, possibly more severe form of the illness than older adolescent and adult-onset bipolar disorder. Research has revealed that when the illness begins before or soon after puberty, it is often characterized by a continuous, rapid-cycling, irritable and mixed manic and depressive symptom state that may co-occur with disruptive behavior disorders (particularly attention-deficit hyperactiv-

ity disorder or conduct disorder) or may have features of these disorders as initial symptoms. Diagnosis and treatment of depressive disorders in children and adolescents are critical for enabling young people with these illnesses to live up to their full potential.

Anxiety Disorders

Anxiety disorders, as a group, are the most common mental illnesses that occur in children and adolescents regardless of foster care status. Researchers estimate that the prevalence of any anxiety disorder among children and adolescents in the US is 13% in a six-month period.

Generalized anxiety disorder is characterized by persistent, exaggerated worry and tension over everyday events.

Obsessive-compulsive disorder (OCD) is characterized by intrusive, unwanted, repetitive thoughts and behaviors performed out of a feeling of urgent need.

Panic disorder is characterized by feelings of extreme fear and dread that strike unexpectedly and repeatedly for no apparent reason, often accompanied by intense physical symptoms, such as chest pain, pounding heart, shortness of breath, dizziness or abdominal distress.

Post-traumatic stress disorder (PTSD) is a condition that can occur after exposure to a terrifying event, most often characterized by the repeated re-experience of the ordeal in the form of frightening, intrusive memories; brings on hyper-vigilance and deadening of normal emotions.

Phobias: social phobia is the extreme fear of embarrassment or being scrutinized by others; specific phobia is the excessive

fear of an object or situation, such as dogs, heights, loud sounds, flying, costumed characters and enclosed spaces.

Other disorders: separation anxiety is excessive anxiety concerning separation from the home or from those to whom the person is most attached; selective mutism is the persistent failure to speak in specific social situations.

ADHD

Attention deficit hyperactivity disorder (ADHD) affects an estimated 4% of children and adolescents in the US in a six-month period. Its core symptoms include developmentally inappropriate levels of attention, concentration, activity, distractibility and impulsivity. Children with ADHD usually have impaired functioning in peer relationships and multiple settings including home and school. Untreated ADHD also has been found to have long-term adverse effects on academic performance, vocational success and social-emotional development.

Eating Disorders

Eating disorders involve serious disturbances in eating behavior, such as extreme and unhealthy reduction of food intake or severe overeating, as well as feelings of distress or extreme concern about body shape or weight. In the US, eating disorders are most common among adolescent girls and young adult women; only an estimated 5-15% of people with *anorexia nervosa* or *bulimia nervosa* and an estimated 35% of those with binge eating disorder are male. Eating disorders often co-occur with other illnesses such as depression, substance abuse

and anxiety disorders. In addition, eating disorders are associated with a wide range of other health complications, including serious heart conditions and kidney failure, which may lead to death.

Eating disorders are not due to a failure of will or behavior; rather, they are real, treatable medical illnesses in which certain maladaptive patterns of eating take on a life of their own.

Autism and Other Pervasive Developmental Disorders

Autism and other pervasive developmental disorders (PDDs), including *Asperger's disorder*, *Rett's disorder*, *childhood disintegrative disorder* and *pervasive developmental disorder—Not otherwise specified (PDD-NOS)*, are brain disorders that occur in an estimated 2 to 6 per 1,000 American children. They typically affect the ability to communicate, to form relationships with others and to respond appropriately to the outside world. The signs of PDDs usually develop by 3 years of age. The symptoms and deficits associated with each PDD may vary among children. For example, while some individuals with autism function at a relatively high level, with speech and intelligence intact, others are developmentally delayed, do not speak or have serious language difficulty. Research has made it possible to identify earlier those children who show signs of developing a PDD and thus to initiate early intervention. While there is no single best treatment program for all children with PDDs, both psychosocial

and pharmacological interventions can help improve their behavioral and cognitive functioning.

Schizophrenia

Schizophrenia is a chronic, severe and disabling brain disorder that affects about 1% of the population during their lifetime. Symptoms include hallucinations, false beliefs, disordered thinking and social withdrawal. Schizophrenia appears to be extremely rare in children; more typically, the illness emerges in late adolescence or early adulthood. However, research studies are revealing that various cognitive and social impairments may be evident early in children who later develop schizophrenia. These and other findings may lead to the development of preventive interventions for children. Only in this decade have researchers begun to make significant headway in understanding the origins of schizophrenia. In the emerging picture, genetic factors which confer susceptibility to schizophrenia appear to combine with other factors early in life to interfere with normal brain development. These developmental disturbances eventually appear as symptoms of schizophrenia many years later, typically during adolescence or young adulthood.

Adapted from the National Institute of Mental Health Brief Notes on the Mental Health of Children and Adolescents, available at nimh.nih.gov.

Additional Advocate Strategies & Tips

- Work as a team with family, foster parents, teachers, mental health providers and caseworkers to find ways to support and improve the child's self-esteem.
- Get foster parents access to resources if possible; encourage them to find ways to get support.
- Get support for yourself; find a therapist or mental health attorney willing to provide occasional consultations.
- Find out if mental health trainings are available in your area.
- Seek out community and online mental health resources.
- Advocate for mental health assessments whenever possible.
- Research the child's medication history—get second opinions if necessary.
- Watch for signs of major depression or other mental health issues (see sidebar at right).

(continued from page 8)

of these interventions show improved outcomes among foster youth including fewer placement changes, decreased aggression, reduction in arrests and hospitalizations and improved general functioning.

These outcomes illustrate the importance of an integrated community approach in addressing foster child and adolescent mental health needs. In response, the Child Welfare League of America and the American Academy of Child and Adolescent Psychiatry, together with more than 50 other consumer, professional and family-run organizations, have launched a national

initiative to improve the design, delivery and outcomes of mental health services provided to children in the foster care system. This strategic plan incorporates the values of the system of care philosophy and includes service coordination, early identification and family participation in all aspects of service planning and evaluation. Most of all, it stresses system collaboration. "No one system has the mandates, the resources or the reach to help each person," says Hornberger. "It needs to be a community effort."

The Role of a CASA Volunteer

As part of that community, what can CASA volunteers do to help the situation? How can they contribute to the improvement of the emotional well-being of the children they work with? Although the issues are complicated and solutions require many systems working together, there are steps CASA volunteers can take to help strengthen their role as mental health advocates—small steps that could potentially make a big difference.

The first is to pay attention. "CASA volunteers can be good eyes and ears," says Hornberger. "Stay close to the child and the family situation where they are residing. If things don't seem right, raise concerns immediately," he says. Harriet Zaretsky, a CASA volunteer for seven years, agrees. "Really pay attention to what is happening," she says. "A lot of times people make things look like everything is going well. You can write anything in a report, but it doesn't mean it's true."

Part of being able to recognize a red flag is getting more education about mental health issues. Although CASA training does include some components on mental health, there is always room for more learning.

"CASA volunteers should become educated about the different mental health disorders that kids are dealing with," says former foster parent Hosford. "These are complex issues," she says, "and it can be easy to look at them through our own filters, opinions and biases. Education can help you move beyond your own viewpoint." CASA volunteer Zaretsky also feels that being informed is key. "It is important to have a sensitivity to what the issues are—even if we aren't the professionals."

Signs of Depression in Children & Adolescents

- Persistent sad or irritable mood
- Loss of interest in favorite activities
- Poor performance in school; frequent absences
- Unprovoked anger or aggression
- Frequent, unexplained physical complaints such as head or stomach aches
- Tearfulness
- Loss of energy
- Difficulties with relationships
- Alcohol or substance abuse
- Reckless behavior
- Social isolation, poor communication
- Difficulty concentrating
- Extreme sensitivity to rejection or failure
- Recurring thoughts about death, self-injury or suicide

Note: None of the above symptoms alone is enough to indicate major depressive disorder. The National Institutes of Mental Health says that five or more symptoms must persist for at least two weeks before a diagnosis of major depression is indicated.



Reactive Attachment Disorder (RAD)

Reactive attachment disorder is a disturbance of social interaction caused by neglect of a child's basic physical and emotional needs, particularly during infancy. Babies placed in orphanages at birth and raised by multiple caretakers without primary parent-figures can also develop this disorder, even if physical care was adequate. A complete history, physical examination and psychiatric evaluation can help diagnose this disorder.

Reactive attachment disorder is caused by neglect of an infant's needs for physical safety, food, touching and emotional bonds with a primary or secondary caretaker. The risk of neglect to the infant or child is increased with parental isolation, lack of parenting skills, teen parents or a caregiver who is developmentally delayed. A frequent change in caregivers (for example, those occurring in orphanages or foster care) is another cause of reactive attachment disorder.

To Learn More:

nlm.nih.gov

National Institutes of Health information on RAD, its symptoms, causes and risk factors.

radkids.org

RAD information, pointers on getting help and a list of related resources.

Although mental health trainings may not be readily available, there are online resources that can help point volunteers in the right direction (see sidebar pg.8). A mental health attorney can also be a good resource, suggests Zaretsky. It also can be helpful to try to locate support and education opportunities for foster parents, who in their genuine desire to help may not realize that they might have unrealistic emotional expectations of their foster child. The more they can understand about the tremendous impact of loss and emotional upheaval the child is experiencing, the better.

Obtaining mental health assessments is also important. "When any child is taken away from their family and put in a situation that is strange to them, there may be a need for some kind of mental health assessment," says Marshall. Hornberger adds that it is important that the assessment is tailored to the child and isn't one-size-fits-all (for example, finding culturally sensitive assessments). "The battle isn't just to get more treatment services," he says, "but also to find services that work and make sense."

Trying to advocate for a foster child in the area of mental health can often become overwhelming and confusing. CASA volunteers need to recognize this and look for ways to get support. Being able to talk to a therapist or mental health attorney can help bring new insights and strategies. Heineman

feels that it could be helpful for volunteers to touch base with a therapist on a regular basis—and not just for the volunteers. "We need cross-fertilization here," she says. "We need to learn what CASA volunteers can do to be helpful to kids, and we need to let them know how we can be helpful." A Home Within is an organization that is available as a supportive resource.

Lastly, it is important to continue to mobilize the community so a child can receive the most comprehensive intervention possible. In this way, advocates can implement their own small system of care for the child. "Circles of communication are so important," says Hosford. Heineman agrees. "We see over and over again the fragmentation in the foster care system," she says. "It's so easy to point fingers, but what is most important here is working together. CASA volunteers can really help by getting everyone on the same page."

Clearly, even with these various strategies, navigating the mental health needs of children in foster care will not be simple. The barriers inherent in the foster care system will inevitably continue to challenge and frustrate those who want to help. Perhaps the most important message is to keep trying. "It's a very difficult area, working with mental health issues, but you can't give up," says Zaretsky. "These kids are going to have to work through what happened to them somehow—and if they have someone in their corner, that might make a difference. They really do need an advocate in the end."

Lisette Austin is a freelance writer and public speaker on the mixed race experience. She also works as a research coordinator for the University of Washington and lives in Seattle with her husband and two-year old son.