Published in final edited form as:
Arch Psychiatr Nurs. 2013 December ; 27(6): . doi:10.1016/j.apnu.2013.09.003.

Pioneering the Psychiatric Nurse Role in Foster Care (*)

Julie E. Bertram, MSN [Instructor],
Saint Louis University School of Nursing, 3525 Caroline Street Office 411 St. Louis MO 63126, 314-977-8998 hummerj@slu.edu

Sarah Carter Narendorf, PhD [**] **[Assistant Professor]**, and
University of Houston, Graduate School of Social Work, 110HA Social Work Building Room 313 Houston, TX 77204-4013, 713-743-8672 sanarendorf@uh.edu

J. Curtis McMillen, PhD [***] **[Professor]**
University of Chicago, School of Social Service Administration, 969 E. 60th Street BW-16 Chicago, IL 60637, 773-702-1155 cmcmillen@uchicago.edu

Abstract

Older youth served in the foster care system have elevated rates of mental health disorders and are high users of mental health services, yet concerns have been raised about the quality of this care. This paper describes the details of a psychiatric nurse's work within a multidisciplinary team to address gaps in care for older youth with psychiatric disorders. We describe the process, outcomes, and lessons learned in developing and piloting a psychiatric nurse intervention for older youth in the foster care system as part of a multidimensional treatment foster care program. Our experiences support further work to develop a role for nursing to improve the quality of mental health treatment in foster care.

Keywords

Foster Care; Psychiatric Nurses; Quality of Care; Nursing Role

There are over 400,000 children in foster care in the United States and approximately 20,000 youth leave, that is, 'age out,' of foster care each year (Administration on Children, Youth and Families, 2012). Young people served in the foster care system are a high need group that is characterized by extensive histories of trauma and high rates of mental health and behavioral problems (Burns et al., 2004). These problems typically last into adulthood and cause ongoing quality of life issues (Felitti, 2009). Of paramount concern are the bleak outcomes of youth who have aged out of the foster care system. One study of these youth found that 37% were homeless at some point after exiting care, 15 % reported fair to poor health, 50% were unemployed, and approximately 42% of young men had been arrested (Courtney, Dworsky, Lee, and Raap, 2009). The years prior to the exit of these youth from

[*]National Institute of Mental Health funded study NIMH R34 MH 081359

[**]NIMH Pre-doctoral Fellow; NIMH T32-MH-19960 2007-2010

[***]NIMH Principal Investigator; NIMH R34 MH 081359 08/15/2007-05/31/2010

Parts of this paper were presented at the ISPN 15th Annual Conference, April 18, 2013

the foster care system provide a critical window of opportunity for targeted intervention to support improved mental health and functioning.

Unfortunately, there are significant concerns about the quality of mental health treatment that young people receive while in the foster care system. Studies have found that older foster youth use mental health services at very high rates while they are in the foster care system (McMillen et al., 2005; Courtney et al., 2005); however, these high rates of service use have not resulted in strong functional outcomes in young adulthood (Courtney et al., 2009). In fact, high rates of psychotropic medication use (McMillen et al., 2004; Rubin et al., 2012), polypharmacy (Zito et al., 2008; dosReis et al., 2011), and problems in continuity of care (McMillen et al., 2005) have raised alarms about whether youth in the foster care system may be receiving inappropriate treatments for the symptoms they present. The disproportionately high rate of psychotropic medication use among foster care youth, up to five times the rate of young people who are not in foster care, has been empirically documented in the literature (Rubin et al., 2012; Zito et al., 2008). This strikingly high rate of medication use may be just the tip of the iceberg when it comes to concerns about quality of care within the Child Welfare system.

Understanding the roots of these problems in quality is complex. In a qualitative investigation of the interface between the child welfare and mental health systems, McMillen and colleagues identified multiple drivers of the quality problems including macro level causes such as a shortage of child psychiatrists, child welfare stakeholder motivations such as a desire to save placements, and service realities such as very short appointment times and hospital stays that contributed to a toxic diagnostic and prescribing context where decisions about psychiatric treatment were often made under pressure with limited clinical information (McMillen et al., 2005; McMillen et al., 2007). In addition, others have described the quality of care and continuity of services for foster youth as inconsistent and poor (Bass and Behrman, 2004; Sanchez, Gomez and Davis, 2010).

These problems in quality of care are particularly pertinent for older youth, who often are aging out of the system after many years in care. The placement into foster care is meant to be a temporary arrangement. The goal for all young people in the foster care system is to obtain permanency in their living environment with consistent caregivers who love them and help them grow. However, the longer a young person stays in foster care, the less likely the chances of achieving permanency. Young people, notably older youth who may have been in care for many years, often have histories of many placements (Havlicek, McMillen, Fedoravicius, McNelly and Robinson, 2012), resulting in a lack of continuity in mental health treatment. In some cases, this has led to an accumulation of sometimes conflicting diagnoses and medications over time (Narendorf, Bertram and McMillen, 2011), without any individual having the time to sort through and decide the most appropriate course of treatment. The notion of getting ‘lost’ in the system has to do with individual young people’s life histories and circumstantial experiences being forgotten, not known or not passed along as the young person moves from foster home to foster home. Getting ‘lost’ in the foster care system may be the result of many causal factors: a lack of traditional parental advocates, lack of Child Welfare agency resources, lack of adequate oversight mechanisms, and a culture of oppression (Bruskas, 2008). The complex trauma histories of these youth (Oswald, Heil and Goldbeck, 2010), behavior management issues, and a lack of knowledge of psychosocial treatment options among the adults who have been entrusted with their care, may indeed result in over-reliance on psychotropic medications as the preferred treatment option for these vulnerable youth.

Despite policy recommendations about screening, treatment and psychotropic medication management for foster youth (Administration on Children, Youth and Families, 2012;

American Academy of Child and Adolescent Psychiatry, 2001; American Academy of Child and Adolescent Psychiatry and Child Welfare League of America, 2002; American Academy of Child and Adolescent Psychiatry, 2008), inconsistent and poor quality of care continue to be problematic (Camp, 2011). Specifically, Rubin and colleagues (2012) documented geographic variation among five states in the areas of polypharmacy and the use of antipsychotic medication use among foster youth, and found higher rates of polypharmacy and antipsychotic drug use among foster youth in comparison with same age youth who were not in foster care. The use of multiple psychotropic medications has not been empirically supported in young people, although treating symptoms with more than one medication at a time is being seen with more frequency in the pediatric population (Pearson, 2013). The use of powerful antipsychotic medications in youth is disturbing because of the risk of serious side effects associated with their use (United States Government Accountability Office, 2012); furthermore, there is little longitudinal data to know what will happen to youth over time, with exposure to these medications. It is acknowledged that the problem of over-reliance on psychotropic medications within the Child Welfare system has reached alarming proportions, and is now considered a national health priority. Legislation and audits, currently underway, are formalized recognition that a problem exists and that action is necessary to bring about much needed change (Mackie et al., 2011).

The recognized problems in the prescribing environment for foster youth such as short appointment times and quick prescription decision-making are particularly problematic for foster youth who often have histories of extensive trauma. More than 95% of youth entering the custody of Child Welfare have experienced at least one traumatic event in their lifetime, and up to 75% have experienced events that are classified as moderate or severe (Griffin et al., 2011). When young people experience trauma they may respond with symptoms that often mimic the symptoms of mental disorders, presenting challenges for differential diagnosis (Griffin et al., 2011). It is possible that if a person's trauma responses are dealt with properly, a formal mental health diagnosis may either not be made or it may be made with a more precise diagnostic label. While the identification of problematic behaviors often leads case managers and foster parents to seek mental health treatment for youth in their care, it may not be trauma-informed care. Trauma-informed care recognizes that underneath the behavior patterns of foster youth, manifested in problematic emotional expression, the youth have most likely experienced trauma. Consistency in providers who take the time to get to know the youth is an important element in creating an atmosphere of safety and recovery. In short, careful and detailed assessments that examine the impacts of trauma are particularly needed among foster youth in order to provide quality care, yet the constraints of the system mean that they are often receiving short evaluations and a lack of consistency in providers over time. Our pilot study supported a clear role for a psychiatric nurse to work with older foster youth as an important bridge to quality which could potentially be expanded to integrate nursing into the management of mental health treatment across the whole foster care system.

Introducing a Psychiatric Nurse

In response to the aforementioned challenges, we developed a role for a psychiatric nurse to provide detailed assessments and promote greater continuity within a broader treatment foster care intervention study. Literature has supported the use of psychiatric nurses to: (1)serve as knowledge brokers for health information, (2) provide case manager support, (3) provide medication management and/or oversight, (4) conduct health screening, and (5) provide education and advocacy training for youth, foster parents and caseworkers in order to increase the quality of care, satisfaction with services, and confidence in self-advocacy among service users (Bruskas, 2003; Galehouse, Herrick and Raphel, 2010; Gramkowski, et

al., 2009; Hart, 2010; Kools, 1997; Kools & Kennedy, 2003; Pearson, 2013; Schneiderman, 2003; Schneiderman, 2004; Schneiderman, 2008; van der Voort et al., 2011). Psychiatric nurses are involved in relationship-building, education, and case consultation (American Psychiatric Nurses Association and International Society of Psychiatric and Mental Health Nurses, 2007). Nurse practitioners have diagnostic and prescriptive privileges, and some clinical nurse specialists have these privileges as well, depending on state rules.

Our aim in this paper is to describe the details of the psychiatric nurse's work in a multidisciplinary team to address gaps in care that had previously been identified surrounding mental health treatment (McMillen et al., 2005). We describe the process, outcomes, and lessons learned in developing and piloting a psychiatric nurse intervention for youth in the foster care system as part of a multidimensional treatment foster care program.

Intervention Development

The psychiatric nurse role was a component of a treatment foster care intervention study. The role of the psychiatric nurse was developed to help clarify the young person's mental health issues, organize the medication profile of each youth, and facilitate continuity of care through the formulation of a mental health summary. The role was created through a process of consulting with academic nurse experts, conducting a literature review and interviewing key stakeholders. Stakeholder meetings were held in which youth, foster parents, case managers and supervisors provided feedback about the manuals. The stakeholders were positive and receptive about the proposed intervention.

The creation of a manualized process allowed for standardization of the intended assessments, interventions, and outcomes, and created a reference point for the nurse as she worked. The diagnostic review procedure was developed by interviewing academic experts in the field of advanced practice nursing and reviewing the literature around polypharmacy, medication management, and healthcare transitions. A pre-pilot intervention with two youth who would not be part of the study was completed prior to starting the actual program. These two pilot cases were used as practice to test out the manual and the diagnostic review procedure prior to the intervention being started in January 2009. Training meetings were held on several occasions to acclimate the nurse to her role.

Piloting the Intervention

The nurse intervention was a component of a broader intervention, Treatment Foster Care for Older Youth with Mental Health Needs Study which was developed to facilitate transition to a naturalistic living situation using a team approach to address needs for support, education and treatment for foster youth with psychiatric diagnoses. These youth lived in residential (group) care and were approaching the years of transition-the years between the ages of 16 and 18. The aims of the study were multifaceted and included: obtaining baseline screenings and thorough diagnostic and medication reviews prior to youth exiting out of residential care in order to inform planning of care, supporting youth with necessary relationships, opportunities, education, and treatments to successfully manage their lives outside of residential care environments, assisting youth to develop goals for the present and future in multiple areas of living and documenting the perspectives of the youth and treatment team members as the intervention was being implemented and at its conclusion.

Eight youth received the psychiatric nurse intervention as part of the broader study. Youth were referred from an agency contracted to handle difficult child welfare cases. All youth resided in residential treatment settings at the time the intervention began, were currently on psychiatric medications, and had a history of psychiatric hospitalization. The mean age of

the sample was 17.4 years; two were male and six were female. One was Caucasian, one was biracial and six were African American. Each youth had undergone a mean of thirteen placement changes, had an average of eight past mental health diagnoses assigned to them, and were on a mean of eight medications, all of which has been published elsewhere (Narendorf, Bertram, and McMillen, 2011). Youth exited the residential settings at different times during the course of the study, and entered into foster homes in which the foster parents had received specific training for a multi-component treatment foster care intervention. As part of the intervention development study, young people and caseworkers participated in qualitative interviews about their experiences with the program, including the nurse intervention. These interviews were conducted by a trained interviewer using a semi-structured interview guide. Interviews were recorded and professionally transcribed and then coded for themes. All study procedures were approved by the University Institutional Review Board.

The Nurse Intervention Components

The nurse approached each foster youth as a unique person. The building of rapport was accomplished through conveying interest in each one as a person of dignity and inherent worth. One of the underlying priorities of the evaluation was getting a sense of who the young person was and what that person's story was. The nurse's approach reflected an awareness that many diagnoses had often been given to the young person, and mindfulness that bringing up conversations about past events and diagnoses could be triggers or activating situations for the young person becoming distraught. The nurse approach therefore stressed the importance of conveying friendliness and concern, and attempted to communicate that while there were questions to be answered as part of the data collection, that the youth's story and personhood were equally important. These principles are consistent with the person-centered nursing framework described by McCormack and McNance (2006), a process model that includes the professional attributes of the nurse, the contextual factors in the care environment and the processes of interaction.

Besides the careful approach, the nurse role was comprised of several discrete functions that we describe below. The nurse completed a comprehensive assessment with each young person as soon as he or she entered the treatment foster care program. This assessment resulted in a summary document that presented a review of diagnostic history and current presentation as well as a comprehensive summary of the young person's medication history. The process of completing this assessment provided a strong base for further nurse involvement as a consultant in future encounters and was also used to provide psychoeducation.

Comprehensive Assessment

The first contact between the nurse and each young person was through a thorough assessment. The program coordinator contacted the nurse as soon as a young person was identified as being enrolled in the study. At this point, the nurse was given simple demographic information, such as the name and age of the participant, and the agency contact and caseworker's name. She began the assessment process with electronic, paper, and historical chart review from several sources. As she compiled data about placements, medications, diagnoses, and symptoms the nurse became the expert in the young person's story. The time spent investigating the young person's background proved a worthy investment, as often links were established between family history, behavior patterns, placement disruptions, and medication changes.

Next the nurse interviewed multiple informants, including the case manager, the young person, the case manager at residential placement, the foster parent, the psychiatrist, and

anyone else the youth identified as important to provide information. The interviews were conducted using a semi-structured approach, in which the goals were to gather impressions of diagnoses, impressions of what has helped and what hasn't helped in terms of treatment. A psychiatric nurse manual guided the review process with suggested categories and subcategories of topical areas, sample questions, and a data collection checklist to gather impressions from informants. The in-depth assessment process is one that many psychiatrists and caseworkers wish they had time to conduct because an appropriate plan of care starts with an accurate and thorough assessment. The nurse was able to put the time in to gather this much needed, rich history of the youth, which ultimately resulted in better understanding and appreciation for the person's psychiatric, developmental, social, academic and medical needs.

Diagnostic Review

The diagnostic review was conducted in the following manner. For each diagnosis that was discovered either in case files or interviews, the date, provider or informant, and symptoms were recorded. The diagnoses were then cross-checked against the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) criteria. If additional information was needed to clarify or inform the diagnosis, academic literature was searched and compared to the young person's presentation of symptoms. The perspectives of multiple informants helped the nurse to distinguish which diagnoses were accurate or useful in the present and which could be eliminated as no longer valid. The diagnostic review was consolidated into summary form in a diagnostic and medication summary document.

Medication Review

The medication review was similarly conducted. For each medication that was discovered, contextual information was recorded. Details about medication use included the date prescribed, who prescribed it, medication name, dosage, treatment goal, side effects, and the selfreported/other-reported patient response. If the medication had caused a problem, that information was recorded as well. The information about medication use was gathered from charts and interviews. Again, the use of multiple informants to gather perspectives assisted the nurse in distinguishing a rich medication use history.

Consolidated Summary

The diagnostic and medication information was assembled into a consolidated summary which documented the young person's background, history of placements, history of symptoms, and history of medication use. This became in essence, the young person's experience of mental health treatment in the welfare system. The summary was finalized by providing a working five axes diagnosis, discussion of medication and medication issues and recommendations for health promotion. The summary was presented at a foster care team meeting within a month of the referral of the young person to the nurse. At this time any member of the foster care support team could ask questions or make statements about the summary. The summary served as a basis for in-depth knowledge of the young person who was being followed by a treatment team. The summary was also the launching point for the creation of individualized psychoeducation sessions.

Nurse Consultation

There were three distinct areas in which the nurse provided consultation services. One was identified as ad-hoc consultation, one as treatment team member, and one as crisis intervention specialist. As issues arose with symptoms or medications, the nurse was the identified expert who shared counsel with the team about the most appropriate course of action. For example, one youth complained of frequent urination and urinary tract

infections; weight gain was a problem for another; a third had a coagulation disorder, and a fourth had poor management of diabetes. These were all situations in which the nurse could help the team formulate appropriate questions to ask and suggest ways of managing these medical concerns. Thus, as consultant, she provided her expertise on a short term basis to assist the team in problem solving.

Second, as the study evolved, the nurse's attendance at weekly team meetings was increasingly valued because she was able to serve as the historical expert of the young person's story, by virtue of having conducted thorough chart reviews, interviews, and summaries on each person. During the team meetings, she could offer information about past history, side effects, mental and physical health concerns that were presented and she was thus able to link past with current holistic health information regarding each youth as his or her care was discussed.

Third, the role of the crisis intervention specialist via consultation was of particular importance. The need for this specialist presented itself when one of the youth had made some vague, possibly suicidal statements at her foster home. The young person had made some remarks about wishing she would go to sleep and not wake up, which was interpreted initially as a possible suicidal comment that needed an immediate follow-up to determine if there was a plan, intent, means, or other risk factors which would require hospitalization. The nurse was able to help the team resolve this issue by using the nursing process of assessment, problem identification, outcome identification, intervention development and planning, and evaluation of expected outcomes. The youth was personally interviewed by the nurse, and analysis of contextual factors resulted in the youth's being able to stay in the home with additional support. She in fact was not suicidal but was having adjustment issues in a new placement. This intervention and added support prevented an unnecessary hospitalization while at the same time providing the care that was actually needed at that moment in time.

Psychoeducation with Youth and Foster Parents

In this particular study, the education of youth and families took a strength-based and recovery perspective. The nurse role was designed to view psychoeducation as a method of teaching young people and foster parents about health conditions, providing support, generating hope, and providing resources and solutions to problem behavior. The diagnostic review process was a springboard for the beginning of dialogues with youth and foster parents about the young person's mental health. These conversations were framed within a process that involved developing awareness and appreciation for the young person's strengths and hardships, an understanding of values, hopes, and dreams, and education about feelings, symptoms, medications, and coping resources. Education toward achieving life goals and developing a more secure sense of self were useful targets for psychoeducation. Having an ability to advocate for oneself in young person-provider interactions was another useful target. When psychoeducation was framed positively, youth tended to look at their situation with more control, and were empowered to ask questions and take on more responsibility toward their own wellness.

All youth received individual psychoeducation but each was unique in terms of needs and developmental maturity, so the curriculum for psychoeducation had some built-in flexibility. Generally, it started with warm-up activities designed to build trust and rapport. An overview of the sessions was provided. The nurse found out how the young person was doing, set up an agenda, and gave two worksheets for the young person to fill out and bring back to the next session. One was a narrative asking the young person to describe what he or she is like when she is at her best. The other asked the young person to list five people he or she would like to call on when having difficulties.

At each point in the psychoeducation process it was important to foster collaboration. Use of values clarification exercises and discussion of hopes and dreams exercises engaged the youth, made them feel like their ideas mattered, and served as a foundation for change and learning. The therapeutic use of reflection and making sure to allow for discussion of questions, concerns, and how to present information was included in each session. Having a list of symptoms from the diagnostic review was helpful, but in the spirit of collaboration, it was important to get the young person's input on how he or she would express symptoms. The nurse used the diagnostic summary to create a list of top three symptoms and then engaged the young person to create examples for each symptom. She used the young person's expressed concerns to teach about what these symptoms might mean.

Each youth had medication changes while in care. The nurse created a current medication list to carry in the wallet, or purse, and emphasized that medication is not a cure, but one among several tools in managing one's health. She also discussed practical issues, which varied depending on the young person's situation and level of independence. Working along with them in a side by side fashion seemed to work better than simply telling them what to do.

The mental health summary was a consolidated version of what was discussed in the psychoeducation sessions. The young person practiced taking ownership by presenting the summary to the case manager. Topics included in the summary paralleled the table of contents used in the psychoeducation binder. The binder of materials was given to the young person as tangible evidence of what was discussed and could then be used for reference. Some of the foster youth were encouraged to present their psychoeducation information to their case managers or other identified support persons. Some young people chose to do an informal presentation to share the information they learned during psychoeducation with other important people in their lives.

Psychoeducation also occurred with foster parents in a group format. This training was provided to foster parents in response to questions and concerns that arose during the intervention. The nurse was identified as an expert who could most adeptly answer their questions about both symptoms and medications. A survey of needs with 23 items was given to foster parents to determine what issues were most important to them. A table of contents and written educational materials were available for review, including how diagnoses were made and limitations of diagnoses, common themes that occur in foster youth, information about specific diagnoses, information about how to create structure in the home, the importance of modeling, and planning for the holidays. Weblinks were provided for relaxation, Borderline Personality disorder, NAMI Family to Family Program, and Facts for Families. A flexible, conversational format promoted foster families' ability to ask questions and discuss concerns in a multi-family meeting.

Outcomes

The nurse diagnostic and medication reviews uncovered complicated accounts of young peoples' lives (Narendorf et al., 2011). Hardships that these youth endured included loss of parental support at a young age, severe neglect, physical and emotional abuse, illicit drug exposure, and sexual victimization. Emotion regulation issues and difficulties with relationships led to numerous placement changes, school failures, delinquency and incarceration. The multiple psychiatric diagnoses that were found in case files appeared to reflect inadequate continuity of care. The nurse synthesized the unique stories of each young person but struggled to adequately and correctly capture the young peoples' conditions through the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). As noted in prior work on the relationship between trauma and mental disorders (i.e. Griffin et al.,

2011), the nurse identified symptoms that crossed diagnostic boundaries and clinical presentations that were not adequately accounted for by the DSM-IV criteria. However, the nurse was able to purge old, outdated or inaccurate diagnoses across cases which resulted in reductions in most cases so that youth were assigned an average of two diagnoses. The nurse reviewed the medication profiles, and recommended a reconsideration of two youth's medication schedules based on one person's side effects, one youth being on greater than maximum recommended doses of medications, and polypharmacy without clear benefits.

As part of the evaluation of the intervention, semi-structured qualitative interviews were conducted with three caseworkers and all of the young people in the study. The advantages of the nurse's work are illustrated in the comments from participants in the study. The themes below, reflected in italicized print, highlight the challenges youth and case managers experienced as they navigated the mental health system and the affordances of having a psychiatric nurse's expertise to help manage those challenges. First, the caseworkers were grateful for the nurse taking the time to sort through all the information, and making sense of it. The following quotes illustrate the themes of both *anxiety* and *gratitude* from case workers as they tried to manage complex medical information.

> "So trying to sort through all of her medical stuff was ridiculously difficult, and that was something that I really struggled with when she'd go to the hospital, they'd say, "Can she be on this or that?" And I'd say, 'Honestly, I don't know, you're the psychiatrist, I just, I don't know.' You know, her medical information was so jumbled." [caseworker #1]

> "… my client has had so many diagnoses and had been in so many mental health facilities, been in so many psychiatric hospitals and every time with a different diagnosis and different medication or whatever. So, that piece was really helpful for somebody to just take the time to get all of that information and get down specifically …diagnosed with bipolar ten times…by these ten different doctors… and for my client from the twenty diagnoses that she had, we got down to a personality disorder and a mood disorder. That was helpful." [caseworker #2]

The following quote from a caseworker reflected a *limited understanding* of medications and the side effects of medication, leaving her in a *position of helplessness* in trying to advocate for the young person:

> "So I knew things, you know, from the time that I started working with her like she can't take Risperdal because she was getting breast milk or she, you know, she had a brain scan and she had…I forgot what you call it, not a tumor, but something on her pituitary gland that was, you know, causing that. She had some thyroid problems. So I knew those things about her medically that happened while I was working with her, but trying to sift through anything else was ridiculous in that file, and to have [the nurse] go through all the past medications, all the medications she's on now, what could've contributed to, you know, different side effects that she had, what she shouldn't take, all that stuff that was so helpful…" [caseworker #2]

The next quote illustrates how having a summary of medication use and its effects seemed to be important for *continuity of care*:

> "… and I would take that to the hospital when she'd have hospitalizations, I kept that with me, so you know I would beg them to read it, at least the parts about the side effects and stuff she'd been on. Actually one time when she got hospitalized… and she had a medical problem and been admitted to the psych unit after that was cleared, and they just right away said, okay, well we're going to take her off this one and put her on that one. It was kind of one that could be interchanged, and just

> right away I was like she can't be on that. It was one of the things [the nurse] put on there she couldn't be on it; she had some really bad side effects from it. But they were just going to do it because it was an easier medication to get approval for." [caseworker #2]

From the youth perspective, three important themes were generated: *sense of continuity, confusion about diagnostic labeling, and self-advocacy*. The young people who received individualized psychoeducation with the nurse described how having an understanding of their conditions, and what to do if in need of treatment was helpful. For example, one young person discussed that just having the material located in one place was valuable, while a second young person was able to make sense of her behaviors and what they might mean in dialogue with the nurse:

> "So like, now I have this medicine book at home, which has all my medicines I've taken over the years, doctors I go to, diagnosis like, what is my diagnosis…? Like, if I look for ADHD there's a paper in that book that shows what ADHD is, and describes it, and… if I meet a doctor for something, I can just go to the book and find it." [case #1]

The *confusion* in making sense of diagnostic labeling was apparent in another youth's words:

> "So, some people told me I was schizophrenic, and I hear I was ADHD. She just told me that half those things that I was diagnosed with, they didn't fit me because I couldn't be ADHD because I was never hyper, and I was always focused in school. I've made good grades in school. And then, schizophrenic I never heard anything, or I never was paranoid, or see anything so that didn't make sense. But, she said I might not even have bipolar. She said I might have conduct disorder."[case #2]

A third youth had a medical diagnosis of Diabetes and other health problems related to obesity. She claimed *self-advocacy* after having psychoeducation with the nurse:

> "Yeah, because instead of me being on all this different medicine for stuff that I didn't need to be on, she clarified that this medicine was for this, and she told what the medicine was for, and how they reacted with my body and stuff …I know when I go to like psychiatrist's appointments, at first I didn't care what they used to give me. Now I ask questions about my medication to make sure that it won't affect my diabetes…." [case #3]

Lessons Learned

After piloting the nurse intervention with eight cases, several valuable lessons emerged that can guide future work. The lessons learned in the study are grouped around the categories value added, emotional dysregulation, and challenges. The nurse's value as a unique individual with a specialized skill set is highlighted first, followed by a discussion around the young people's emotional needs, and last the challenges within the system are discussed.

Value Added

The nurse diagnostic and medication review process was time intensive, requiring approximately thirty hours for complicated youth, which included multiple chart reviews and interviews in addition to report-writing, however many people (case managers, treatment team, foster parents and psychiatrists) valued the consultation. Foster parents in particular were hungry for more information about how to be of best help for the young people who were in their home. They told the treatment team that they needed more information about the complex needs that the youth presented (Havlicek et al., 2012). Later as the nurse provided medication management training to families, the foster parents voiced

their appreciation of specialized training: “I thought the Med Management Class was terrific – the instructor was very knowledgeable and presented her material extremely well. Please pass that along!”(Foster care supervisor, personal communication, November 20, 2012).

Emotion Regulation Issues

Early in the study, the treatment team noticed severe emotion regulation issues with the very first youth enrolled in the study, and subsequently discovered that emotional regulation was an enormous challenge for all the youth (Narendorf, Fedoravicius, McMillen, McNelly and Robinson, 2012). The nurse shared her impressions of what the emotional regulation issues might mean, namely many of the young people in the study were adjusting to the types of invalidating environmental histories typically seen in Borderline Personality Disorder (Linehan, 1993). While it would be premature to diagnose the youth with this serious mental health disorder, research pointed toward evidence-based treatment strategies such as dialectical behavior therapy for addressing the difficulties that the youth were having. The team studied the dialectical behavior therapy literature and obtained training in DBT. While not adopting the whole package, the team led youth in skills training on mindfulness, assertiveness, and selfsoothing skills in a planned day of psychoeducation.

Challenges in the Foster Care System

Challenges to working in the foster care system were identified around three issues: communication flow within the system, process issues surrounding data management, and communication with psychiatrists. First, the nurse did not know who all the relevant people were that were involved in each young person’s life, and she had to navigate this task independently, while being mindful of the private and confidential nature of each young person’s situation. Even though the agency was educated about the nurse’s role, she often needed to remind the staff what information she needed and what she was going to do with the information. Over time, trust was built among the nurse and the agency, but in the beginning, the caseworkers were not particularly forthcoming about where all the data was, which slowed down the nurse’s data collection process. Because the nurse called multiple informants to schedule times to have conversations or to do chart reviews, and some informants were not quick to return calls, the data collection process was not efficient. That could have perhaps been streamlined with the use of e-messaging to ask for the same information across parties.

Second, there were documentation issues that were problematic. For example, electronic information was stored in multiple locations, and paper copies were stored separately at multiple locations. There were electronic mechanisms in place to record medication changes and diagnoses, but they often were not kept up to date. This highlights the importance of front-line workers using the electronic medical records system as intended and according to guidelines to ensure continuity of care.

Third, there were communication barriers with psychiatrists. Some would not return calls or letters asking for correspondence even with consent and assent procedures in place. However, one psychiatrist seemed to value the nurse’s writing progress notes on the young person who was getting medication consultation from him. There may be a perceived benefit to psychiatrists who get such progress notes regularly in order to better inform care. Nurses may also need to create and individualize their approaches to find which communication techniques or formats facilitate communication with each provider. This is an area for further exploration in order to better include psychiatrists as involved members of treatment teams.

Summary

The treatment team discovered a broader role for psychiatric nursing in foster care for older youth. In this study the nurse's role was discrete, as originally envisioned, but she was used in several capacities beyond what was originally anticipated. The nurse brought a medical and holistic perspective to the treatment team, could navigate medical and co-occurring illnesses, and was able to support providers in the system because of her knowledge. The needs for the knowledge, skills, and understanding of a psychiatric nurse were substantial.

The psychiatric nurse did not replace the role of social workers or case managers, but rather complimented the treatment team by contributing knowledge of psychiatric nursing. While some of the skill set overlaps with social work, the psychiatric nurse role filled several needed gaps, in that she was able to provide a keen eye for processes and patterns related to psychiatric diagnosing and prescribing, help bolster the confidence of case managers, youth and foster parents to advocate for the youth's mental health care, and provide an integrated perspective on physical and mental health for a population with complex co-morbidities. There is a need for better mental health communication across the foster care system, and our experiences suggest that a nurse could be the facilitator of system change.

Future Directions

These findings suggest that one way to improve the fragmentation in care within the foster care system is to employ psychiatric and mental health nurses. We have attempted to provide rich detail about the processes of developing the role and the perceived benefits of having a psychiatric nurse located within the foster care system in this paper. We would be remiss if we did not also include our hypotheses of why the intervention was successful. We will briefly discuss this and offer suggestions for future role development below.

Psychiatric nurses are trained to use the self as a therapeutic instrument of intervention. This is actually not unlike other healthcare disciplines who are also concerned with relationship building and advocacy efforts. What makes the nurse's perspective and contribution unique, we believe, is a particular profession with its own values, ethics, discipline, and science. It is psychiatric nursing. There is also an intangible but effectual quality of being able to get in between the spaces of the power differential that exists between child psychiatrists and case managers. Nurses may sense these tensions and experience similar feelings of intimidation in communications with physicians, but because of their role training, may be able to negotiate the nuances of these tensions in ways that are helpful to both foster youth and the caregivers who assist them. Nurses may be able to ease these tensions and work in ways that foster collaboration and mutual respect for the benefit of the youth. Nurses are generally viewed as non-threatening and trustworthy, but do have a knowledge of medicines and the physiological dimension of the person that allow them to both teach and advocate for foster youth. Furthermore, the work of building relationships proved to be a pivotal force in this particular nurse intervention's success.Building relationships with foster youth, case managers and foster parents required a deliberate effort to get to know and understand each subgroup as having particular needs and goals. The nurse was keenly aware that building these relationships was part of the intervention work, and was perhaps more important than collecting data or creating case summaries.

In the future we envision a psychiatric nurse will be employed within the child welfare system to provide the particular assessments and interventions described in this paper. This study also pointed to needs for better healthcare communication and needs for advocacy training. Training in shared decision making (SDM) to improve confidence and satisfaction of foster youth, foster parents, case managers and psychiatrists could be a next step in nurse intervention development. The use of SDM in foster care will improve stakeholder

confidence in ability to handle youth mental health problems, improve youth engagement with treatment, improve satisfaction in treatment from the point of view of foster youth, foster parents and case managers, increase psychiatrist satisfaction with the information provided or with treatment approaches, and potentially improve psychiatrist confidence in treatment.

References

Administration on Children, Youth and Families, Administration for Children and Families, U.S. Department of Health and Human Services (ACYF). Information memorandum: Promoting the safe, appropriate, and effective use of psychotropic medication for children in foster care (ACYF-CB-IM-12-03). Washington, DC: Author; 2012. Retrieved http://www.acf.hhs.gov/sites/default/files/cb/im1204.pdf

American Academy of Child and Adolescent Psychiatry and Child Welfare League of America. AACAP/CWLA policy statement on mental health and substance use screening and assessment of children in foster care. 2002. Retrieved http://www.aacap.org/cs/root/policy_statements/aacap/cwla_policy_statement_on_mental_health_and_use_of_alcohol_and_other_drugs_screening_and_assessment_of_children_in_foster_care

American Academy of Child and Adolescent Psychiatry. Psychiatric care of children in the foster care system. 2001. Retrieved http://www.aacap.org/cs/root/policy_statements/psychiatric_care_of_children_in_the_foster_care_system

American Academy of Child and Adolescent Psychiatry. AACAP position statement on oversight of psychotropic medication use for children in state custody: A best principles guideline. 2008. Retrieved http://www.aacap.org/galleries/PracticeInformation/FosterCare_BestPrinciples_FINAL.pdf

American Psychiatric Nurses Association and International Society of Psychiatric and Mental Health Nursing. Psychiatric mental health nursing scope & standards. Silver Spring, Md: American Nurses Association; 2007.

Bass S, Behrman RE. Children, families, and foster care: Analysis and recommendations. Future of Children. 2004; 14(1):5.

Bruskas D. Children in foster care: A vulnerable population at risk. Journal of Child and Adolescent Psychiatric Nursing. 2008; 21:70–77. [PubMed: 18429837]

Burns B, Phillips S, Wagner HR, Barth R, Kolko D, Campbell Y, Landsverk J. Mental health need and access to mental health services by youths involved with child welfare: A national survey. Journal of the American Academy of Child and Adolescent Psychiatry. 2004; 43(8):960–977. [PubMed: 15266190]

Camp, AR. A mistreated epidemic: State and federal failure to adequately regulate psychotropic medications prescribed to children in foster care. Temple Law Review. 2011. Retrieved http://ssrn.com/abstract=1567682

Felitti VJ. Adverse childhood experiences and adult health. Academic Pediatrics. 2009; 9(3):131–132. [PubMed: 19450768]

Galehouse P, Herrick C, Raphel S. on Foster Care. International Society of Psychiatric-Mental Health Nurses. Journal of Child and Adolescent Psychiatric Nursing. 2010; 23(1):36–39. [PubMed: 20122087]

Gramkowski B, Kools S, Paul S, Boyer CB, Monasterio E, Robbins N. Health risk behavior of youth in foster care. Journal of Child and Adolescent Psychiatric Nursing. 2009; 22(2):77–85. [PubMed: 19490278]

Griffin G, McClelland G, Holzberg M, Stolbach B, Maj N, Kisiel C. Addressing the impact of trauma before diagnosing mental illness in child welfare. Child Welfare. 2011; 90(6):69–89. [PubMed: 22533043]

Havlicek J, McMillen JC, Fedoravicius N, McNelly D, Robinson D. Conceptualizing the step-down for foster youth approaching adulthood: Perceptions of service providers, caseworkers, and foster parents. Child and Youth Services Review. 2012; 34(12):2327.

Kools S. Adolescent identity development in foster care. Family Relations. 1997; 46(3):263–271.

Kools S, Kennedy C. Foster youth health and development: Implications for primary care. Pediatric Nursing. 2003; 29(1):39–45. [PubMed: 12630505]

Linehan, M. Skills training manual for treating borderline personality disorder. The Guilford Press; 1993.

Mackie TI, Hyde J, Rodday AM, Dawson E, Lakshmikanthan R, Bellonci C, Shoonover DR, Leslie LK. Psychotropic medication oversight for youth in foster care: A national perspective on state child welfare policy and practice guidelines. Children and Youth Services Review. 2011; 33(11): 2213–2220.

McCormack B, McCance TV. Development of a framework for person-centred nursing. Journal of Advanced Nursing. 2006; 56:472–479. [PubMed: 17078823]

McMillen, JC.; Fedoravicius, N.; Rowe, J. The intersection of mental health and Child Welfare services. St. Louis MO: The Center for Mental Health Services Research; 2005.

McMillen JC, Fedoravicius N, Rowe J, Zima B, Ware NC. A Crisis of credibility: Professionals' concerns about the psychiatric care provided to clients of the child welfare system. Administration and Policy in Mental Health and Mental Health Services Research. 2007; 34:203–212. [PubMed: 17066331]

McMillen JC, Scott LD, Zima BT, Ollie MT, Munson MR, Spitznagel E. Use of mental health services among older youths in foster care. Psychiatric Services. 2004; 55:811–817. [PubMed: 15232022]

McMillen JC, Zima BT, Scott LD, Auslander WF, Munson MR, Ollie MT, Spitznagel EL. The prevalence of psychiatric disorders among older youths in the foster care system. Journal of the American Academy of Child and Adolescent Psychiatry. 2005; 44:88–95. [PubMed: 15608548]

Narendorf SC, Fedoravicius N, McMillen JC, McNelly D, Robinson DR. Stepping down and stepping in: Youth's perspectives on making the transition from residential treatment to treatment foster care. Child and youth services review. 2012; 34(1):43–49.

Narendorf SC, Bertram J, McMillen JC. Diagnosis and medication overload? A nurse review of the psychiatric histories of older youth in treatment foster care. Child Welfare. 2011; 90(3):27–43. [PubMed: 22403899]

Oswald SH, Heil K, Goldbeck L. History of maltreatment and mental health problems in foster children: A review of the literature. Journal of Pediatric Psychology. 2010; 35(5):462–472. [PubMed: 20007747]

Pearson GS. Use of polypharmacy with children and adolescents. Journal of Child and Adolescent Psychiatric Nursing. 2013; 26:158–159. [PubMed: 23607828]

Raghavan R, Zima BT, Andersen RM, Leibowitz AA, Schuster MA, Landsverk J. Psychotropic medication use in a national probability sample of children in the child welfare system. Journal of Child and Adolescent Psychopharmacology. 2005; 15(1):97–106. [PubMed: 15741791]

Sanchez K, Gomez R, Davis K. Fostering connections and medical homes: Addressing health disparities among children in substitute care. Children and Youth Services Review. 2010; 32(2): 286–291.

Schneiderman JU. Health issues of children in foster care. Contemporary Nurse. 2003; 14(2):123–128. [PubMed: 12785602]

Schneiderman JU. The health of children in foster care. The Journal of School Nursing. 2004; 20:343–351. [PubMed: 15560732]

Schneiderman JU. Qualitative study on the role of nurses as health case managers of children in foster care in California. Journal of Pediatric Nursing. 2008; 23(4):241–249. [PubMed: 18638668]

United States Government Accountability Office. Children's Mental Health: Concerns Remain about Appropriate Services for Children in Medicaid and Foster Care. 2012. Retrieved http://www.gao.gov/assets/660/650716.pdf

van der Voort, Trijntje YG, van Meijel B, Goossens PJJ, Renes J, Beekman ATF, Kupka RW. Collaborative care for patients with bipolar disorder: A randomised controlled trial. BMC Psychiatry. 2011; 11(1):133–133. [PubMed: 21849078]

Zito JM, Safer DJ, Sai D, Gardner JF, Thomas D, Coombes P, et al. Psychotropic medication patterns among youth in foster care. Pediatrics. 2008; 121(1):157–163. [PubMed: 18166570]