Barriers to Accessing Health Care in Hawaii's Foster Youth

By

Sara Johnson

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Department of Anthropology

University of Pennsylvania

Thesis Advisor(s): Dr. Morgan Hoke & Dr. Katherine Moore

Abstract

Foster youth (FY) face multiple barriers to accessing basic medical care and many are not given access to adequate mental health treatment after enduring the trauma of separation from their families. This thesis elevates FY's voices, using their own narratives to examine the issues they face in receiving adequate medical care and mental health resources. The study includes semi-structured interviews to query the local understanding of FY's health disparities. Deductive coding was used to search and highlight the sections of the interviews that touched on reoccurring themes. Several themes centered on the significant need for improved FY access to resources. The most common theme was that mental health was never addressed and that FY were not listened to or checked in on. Additionally, there was a repeated sentiment of bitter feelings and judgments. Further, many FY expressed a desire not to allow stigma or shame to shape their identities. The FY all expressed the desire to be heard, which related to their accounts of negligence from their caseworkers. There is an immense need for trauma-informed care and essential phycological services for every child and parent. This training should be extended to state workers, foster parents, therapists, and doctors in order to reduce mental health disparities faced by FY. Further, there is a need for access to high-quality health care and mental health services with trauma-based care available to every child who enters state care.

Keywords: Hawaii, foster youth, medical disparities, trauma informed care, Child Welfare Services, mental health, neglect, passive and active maltreatment

INTRODUCTION

According to recent federal data, there are approximately 400,000 children in foster care in the United States (The Administration for Children and Families, 2019). The nature of a foster care placement is always a traumatic event for a child (Deans et al., 2015). Therefore, these children are at "increased risk for unmet medical, developmental and behavioral conditions"(Deans et al., 2015, p.146). For example, 80% of foster youth suffer from behavioral or mental health problems (Halfon, 1995). Further, in comparison to veterans, former foster youth are twice as likely to suffer from post-traumatic stress disorder (The Administration for Children and Families, 2020). Additionally, eight out of every ten foster youth enter the system with notable mental health needs (The Administration for Children and Families 2020). However, the medical inequities faced by foster youth are not limited to mental health but extend to all around health and wellbeing. For example, around half of foster children experiencing chronic illnesses and physical disabilities, with 28% having three or more conditions (Halfon, 1995).

Unfortunately, care for both mental and physical health is significantly lacking for foster youth. While there are standards set for assessing mental health risks in foster youth, these standards do not translate into providing mental health resources to foster youth. The traumatic experiences that this group of vulnerable children experience in custody are neither random nor senseless, but rather represent a systematic failure of the structures in place that are intended to support some of the most vulnerable among us. The government is aware that the system is underfunded and understaffed yet chooses not to prioritize allocating the necessary funds to ensure its wards' survival and success.

American social worker and political scientist Schoenburg states that:

> One would think that agencies would make sure that they grasp the one area in which the problems are concrete and diagnosable, in which resources for help have clearly become more available over the years, and in which the results are demonstrable- foster children's many physical problems. (Hochstadt, Jaudes, Zimo, & Schachter, 1987)

The current federal measures and procedures have led to the continuous neglect of foster youth in America despite various efforts to improve the system. The redistribution of responsibilities between numerous federal and state agencies ultimately results in a lack of accountability in providing healthcare access for foster children. This lack of accountability can leave the door open for children to slip through without receiving medical attention. Additionally, the quality of care provided to foster youth is limited and not regularly assessed leading to inaccurate assessment of the children's treatments (Deans et al., 2015). This limitation can create an environment that allows foster youths to have severe medical and mental needs to arise as a coping mechanism and can cause behavioral issues later in life. Compared to their peers, male former foster youth are 4 times as likely to commit a crime, and females are 10 times more likely to do so (The Administration for Children and Families, 2020). Nationally, 50% of the homeless population spent time in foster care (Shalita, 2020).

It is further apparent that access to medical care, especially mental health resources, is influenced by race. One study indicates that Latino youth have the least access to medical care, African Americans are in the middle accessibility, and white foster youth have the highest rates of health care access (Villagrana, 2016). However, in this study, even the highest rates of access to medical care still meant less than half of white foster youth received mental healthcare during their time in foster care and after aging out (Villagrana, 2016). Additionally, 54% of aged out adults ended mental health treatment after exiting foster care (Villagrana, 2016). The provision of mental health resources depends largely on the type of maltreatment that leads to a child being placed in foster care. For example, where sexual trauma, violence, and other "active" forms of

trauma are experienced, children are more likely to receive treatment. However, children who face "passive" types of maltreatment, such as neglect, are not likely to receive treatment (Garland, Landsverk, Hough, & Ellis-Macleod, 1996). This lack of access to mental health care, even in cases where there are only “passive” forms of maltreatment, is problematic because any rupture and removal from a family environment may represent a major traumatic event and thus should make all foster youth eligible for mental health services.

This thesis aims to better understand the issues facing foster youth today in receiving effective medical care. Additionally, I hope to compare what previous researchers have identified as the sources for the issues faced by foster children with the narratives provided by foster youth themselves. Rather than providing the historical context or focusing on the statistics that highlight this issue's severity, this thesis documents and examines individual stories to point to the broader issues using ethnographic methods. The narratives of the youths are not intended to provide a detailed answer to the large-scale and expansive problems of medical disparities. Instead, the purpose of this thesis is to highlight some of the common themes represented throughout the lives of aged-out foster youths through the use of their own narratives. This action is a powerful tool, as bringing these voices to the foreground allows us to understand some of the plight felt and how they believe they could have been best supported medically. Their voices are relevant and fundamental in these discussions, yet seldom incorporated or heard. This thesis will begin with a background section that will explore the foster care system in Hawaii and health inequalities among foster youth in Hawaii and beyond. This section will be followed by a description of the methods used in the course of the research. Results will then be presented as foster youth narratives largely focused on sharing the experiences of foster youth in their own

words. The subsequent discussion section will highlight the key themes that emerged in the analysis of the narratives and their potential implications.

BACKGROUND

The Foster Care System in Hawaii

In Hawaii in 2020, there were 2,766 children in foster care, and only 1,978 licensed foster homes (Casey Foundation, 2021). The average time spent in foster care was 1.6 years, and the average foster care placement was 2.6 homes (Casey Foundation, 2021). In the past four years, Hawaii has seen a 21% increase in the number of children placed in foster care (State of Hawaii Department of Human Services Social Services Division, 2019). 24% of foster youth entered the system due to abuse claims, and 76% were admitted to state care due to neglect (State of Hawaii Department of Human Services Social Services Division, 2019). Native Hawaiian or part Native Hawaiian children account for approximately 45% of the foster youth despite only making up 10% of the total population (State of Hawaii Department of Human Services Social Services Division, 2019). Because many foster youth run away from their foster homes and are unprotected, they are often the victims of sexual exploitation. Shockingly there were 131 alleged victims of human sex trafficking and forced to perform sex work while in state care in the past two years, with 34% being Native Hawaiians.

There are two state forms of foster care in Hawaii: regular state care run by the Department of Human Services and therapeutic foster homes by the Department of Health and Child Welfare Services. These are public forms of foster care run entirely by the state and which rely solely on public funding. These agencies obtain their funding sources from various government sources, with 70% coming from Title IV-E, or Foster Care Program, and 21% from

social services block grants (Casey Foundation, 2022). This statistic translates to $47,886,572.22 in federal funding received by Hawaii (Casey Foundation, 2022). There are also 869 adult foster care homes licensed by the state, although further discussion of the adult foster care system is outside of the scope of this thesis (Mollica et al., 2009).

In Hawaii, the foster care system has been largely privatized. The privatization of foster care occurs when states farm the work out to private groups who are able to make a profit from foster care provision. However, there is an important difference between privatized for-profit foster care organizations and private non-profit foster care organizations. This system of privatization varies state by state and for the purposes of this thesis, this discussion is limited within the context of the Big Island of Hawaii. Private forms of foster care are funded by private organizations, have their own screening processes, and do not have to rely on state funding to provide the resources. There are both benefits and potential consequences of private foster care organizations, some of which will be discussed later in this thesis. On the Big Island of Hawaii, there are two central private foster care agencies, Catholic Charities and The Salvation Army Family Intervention Services. These private foster care agencies are non-profit religious-based agencies with larger funding bases who also receive additional funding from religious organizations. They must obtain approval and licensing from the Department of Human Services and typically focus on therapeutic foster care placements where the state feels the child needs extra attention, therapeutically trained care, and temporary or emergency placements (Catholic Charities Hawaii, 2020). Catholic charities served 56 foster youth on the big island, only about 2% of the total youth in custody (Catholic Charities Hawaii, 2020).

There is no universal system that tracks and monitors all foster youth in America. States set their own policies regarding the tracking and monitoring of their wards usually this involved

the maintenance of case files. Stubbs states, "while still no formal, tangible, national foster care "system" exists, local states and counties have developed similar methods to administer and monitor child welfare services to families, youth, and program providers" (2018, p.13). Every child placed in care receives a Child Information Folder or CIF. This folder contains "all health/medical, psychological, social and educational documents that are available to DHS at the time of the child's placement" (State of Hawaii Department of Human Services, 2016, p.1). This folder serves as the primary source of information regarding each child and is transferred and updated each time the child moves homes, whether in private or public care. The case file determines how each child is understood in new schools, foster homes, judges, and therapists. However, it can be highly unreliable and create false understandings of each child. Stubbs states:

> This so- called 'case file' is often never actually one individual physical file, but rather a series of binders, folders, or boxes that collectively comprise the case record. Materially, any given case record may also exist in multiple locations, in various forms of media, accessible to a variety of social actors. And, unlike other organizational systems that use administrative technologies like recordkeeping and filing, in foster care systems nationwide, the case file remains for the most part, materialized on hard copies of paper, despite our present digital era. Over its bureaucratic life course, this case-related storage device will contain a multitude of smaller graphic artifacts like consent forms, treatment plans, educational and medical records, as well as the occasional photo or identification document like a birth certificate or Social Security Card. And, this child welfare case record cannot exist without a partnering legal case record or file, from the local dependency court system. (2018, p.3)

According to an interview with an anonymous manager who has worked at Child Welfare Services for 25 years, both private and public foster care agencies use an online security program that tracks each child as their mechanism of accountability. This program automatically tracks each child's placements, mandatory state check-ins, court dates, and state worker notes. The programing notifies the child's caseworker when the child needs visitation, and if ignored longer than 30 days, it is reported to the managers of Child Welfare Services. However, according to this manager, there is typically no enforced penalty for allowing a child to fall behind in care.

Managers typically override the program due to the understanding of high caseloads.

Hawaii has implemented very liberal policies regarding financing for aged-out foster youth and financial payments for foster parents. Foster youths are eligible for Imua Kakou payments of 771 dollars a month as supplementary income if they attend university or volunteer or work full time. They also provide financial, investing, and life training as youth age out. Further, foster parents receive between 576 and 676 dollars monthly per child based on age (State of Hawaii Department of Human Services Social Services Division, 2019). Yet these improvements have not been effective in reducing the inequalities experienced by foster youth.

Health Inequalities Among Foster Youth in Hawaii and Beyond

When examining the barriers to accessing healthcare faced by foster youth it is important to discuss the converging inequalities that foster youth endure in Hawaii and America, and the ways these inequalities become biologically embodied. Foster youth are at increased risk for many aspects of inequality from housing insecurity to gender inequalities, special attention must be placed on the consequences that inadequate government, social and healthcare support have on the well-being of foster youth and their families. The persisting legacy of neoliberalism is apparent in the expectation of individual caseworkers to successfully manage the well-being of foster youth without significant institutional support. Caseworkers are meant to serve as primary advocates for foster youth in navigating the foster care system. Many feel enormous, personal responsibility for managing foster youths' complex educational, mental and physical health needs (Jolles et al., 2019). Caseworkers take on the role of pseudo-parents through duties like monitoring their charges' educational progress, taking them to the doctor when they fall ill, or advocating for their mental health needs.

However, with little institutional support or compensation for these individual activities, emotional detachment increases over time, as caseworkers with fewer years of experience are far more likely to feel personal responsibility for the mental and behavioral well-being of their charges (Jolles et al., 2019). Additionally, high workloads and inadequate institutional support give way to significant oversights, to the detriment of their assigned foster youth. In Hawaii, a 21% increase in children placed in the foster care system in the past four years has resulted in a 44:1 ratio of cases per worker every month (State of Hawaii Department of Human Services Social Services Division, 2019). As a result, as few as 77% of foster youth receive their monthly visits, compared to the national standard of 95% (State of Hawaii Department of Human Services Social Services Division, 2019). The blame for any failures thus comes to rest on caseworkers with little attention given to the lack of support provided by government agencies, as is consistent with many neoliberal governing policies (Brown & Baker, 2012).

As independent choices also define the viability and worthiness of biological vs. foster system caregivers, the foster care system often prioritizes permanent adoption placements over family reunification. Foster care policies largely focus on facilitating the permanent adoption of foster youth, supposedly in the name of ensuring family stability and supporting children's development (Harden, 2004). This goal implies that foster children's biological parents are permanently unfit and will never be viable caregiver options after their children are placed in the system. This goal is contrast to the rhetoric on their website which stresses reunification. There is a disjuncture between their practice and their stated goals, as only 60% of youth are reunited with their biological parents (State of Hawaii Department of Human Services Social Services Division, 2019). Further, in Hawaii, 10% of foster youth reunited with their biological parents often return to foster care within 12 months (State of Hawaii Department of Human Services

Social Services Division, 2019). Mainstream, moralized narratives about individual responsible conduct and discipline with substance use disorders often converge to support this attitude, as parental substance use is extremely prevalent among foster youth and their biological families (Deutsch & Fortin, 2015). Often, economic, social, and physical environmental influences on substance use initiation are dismissed, thanks to reductive "Just Say No!" campaigns that cast drug use as a simple choice between right and wrong (Spooner & Hall, 2002). As a result, many parents with substance use disorders, are villainized for "choosing" drugs over their children. Second, maintaining sobriety is incorrectly cast as a matter of self-discipline. Relapses are moralized as failing to resist the "high," when in truth, relapses are often driven by the desire to avoid withdrawal symptoms and regain a "normal" functioning (Koob & Volkow, 2010). As a result, individuals who fail to remain compliant patients are precluded from participating as equal citizens of society (Brown & Baker, 2012). Supporting biological families in improving their home lives to allow them to be reunited with their children is therefore dismissed in favor of finding caregivers who have made so called correct, responsible, and moral choices and are thus more deserving of having children.

The extreme, unaddressed psychosocial stressors placed on foster youth highlights the major role adequate mental healthcare plays in facilitating individual participation in "normal," society. Though the nature of a foster care placement is always a traumatic event for a child, only 15% of foster youth automatically receive clinical treatment (Burns et al., 2004) and children who face "passive" types of maltreatment, or children who cope "well" with their traumas are unlikely to receive treatment or support (Garland et al., 1996). Given the extreme lack of mental health support for foster youth, it is no surprise that they are often behind in educational attainment and struggle to accumulate the social and material capital that allows them to

integrate fully in society. Only 51% of all foster youth graduate high school and only 4% of former foster youth successfully obtain a bachelor's degree by the age of 26 (The Administration for Children and Families, 2020). Even so, educational achievement does not ensure stability: nearly half of the foster youth aging out of the system face immediate homelessness (Gypen et al., 2017; Dworsky et al., 2013). Additionally, statistics imply that "less educated" foster youth are more inclined to rely on or engage in criminal activity out of necessity or environmental influence (Gypen et al., 2017). This increase in criminal activity creates extended engagement with police and the justice system, which increases inequalities and can lessen the future overall quality of life.

Lastly, the unaddressed psychosocial stressors and mental health needs also play a major role in the physical well-being of foster youth, exacerbated by systematic care discontinuity for foster youth and the limited availability of healthy stress coping mechanisms. For instance, discontinuous preventive and primary care for foster youth often leads to gaps in immunization regimens (Deutsch & Fortin, 2015). Foster children's susceptibility to severe infections is additionally compounded by the immunosuppressant activity of elevated cortisol, the stress hormone released in reaction to psychosocial stress. This immunosuppression can often interact with other biological systems in early development, some of which children in foster care may be particularly vulnerable to. For example, malnourishment as an infant, can weaken infants' immune system (McDade, 2005). Substance use is also highly prevalent among foster youth as a coping mechanism. As such, foster youth are at elevated risk for a variety of physical disorders, such as bloodborne diseases or chronic organ damage (Deutsch & Fortin, 2015). The Affordable Care Act mandated Medicaid coverage for foster youth to the age of 26 in all 50 states, but improvements in access to medical care for this population have been modest (Bullinger &

Meinhofer, 2021). While this policy change moves in the right direction, applying for Medicaid coverage every year requires familiarity with administrative jargon and documentation to prove an individual's need. The application is complex and proves challenging for even highly educated individuals, highlighting the persistent inaccessibility of accessing health insurance for foster youth, despite Medicaid's supposed "universal" coverage for them. Therefore, though one would expect agencies to better address more tangible health problems, foster children's many physical health needs remain unmet (Hochstadt et al., 1987).

Examining the ways inequalities are embodied illuminates new pathways through which various inequalities layer, reinforce, and reproduce one another in the context of the foster care system and the health of foster youth. These intersecting inequalities highlight how the seemingly neutral ideologies of neoliberalism and individualism villainize and penalize agents at different points in the foster care system for circumstances beyond their control. We must further think through bottom-up approaches for helping address these inequalities and think deeply about what individual actions can effectively support change for foster youth. This thesis helps meet this goal by highlighting areas of need that have clear and concise modification steps.

METHODS

Study Design and Sample

This ethnographic study consists of semi-structured interviews intended to assess the local understanding of foster youth's health disparities in Hawaii. The research took place in Kailua Kona, Hawaii. Kailua Kona is a very small town with a population of 15,000 people but it is located on the Big Island of Hawaii. There are 2,766 children in foster care in the state of Hawaii. The Big Island houses 31% of the foster youth in the state (State of Hawaii Department of Human Services Social Services Division, 2019). The state report did not publish the rates of

youth in Kailua Kona compared to Hilo, as the same agency runs the entire island. According to one state worker, about two years ago they shut down the Hilo office due to funding, and now there is only one office for the entire island. Once IRB approval was obtained the recruitment period began, Participants were recruited using word of mouth and snowball sampling. I reached out to state workers for whom I had contact information; they then passed my information out to any aged-out foster youth for whom they still had contact information. Any youth who were interested responded through email and was given more information on the study and to set up a time for an interview. A total of five foster care youth participated in interviews. These youth ranged in age from 19 to 33. Three of the participants were Native Hawaiian, one was African American, and one was White. All the participants spent at least three years in state custody in Kailua Kona, HI. An additional five interviews were conducted with state workers and were intended to elicit information on policies regarding state check-ins, managing foster youths medical and mental health needs, and barriers to providing care. To maintain participant privacy, all of the names that appear in this thesis are pseudonyms.

Interview Methods

There were two types of interviews. The first was designed for aged-out foster youth and the second set of interview questions was intended for state workers. For foster youth interviews, there were around 40 sample questions asked. For the state worker interviews, approximately 20 sample questions were asked. (*See Table 1.*) A semi-structured interview method was deployed in order to ensure that participants were able to lead the discussion in ways that felt most productive to them and allowed them to express their feelings and concerns. Questions were used to prompt participants as needed but they were also permitted to narrativize freely. Interviews

with foster youth lasted on average 45 minutes and ranged from 25 minutes to 1 hour and 33 minutes in duration while those with foster care workers tended to last around 30 minutes.

Table 1:

Aged Out Foster Youth:	State Workers:
- Do you feel that the placement you had was traumatic? - How do you view mental health and the stigma attached to it? How was it discussed growing up? - Who took you to your annual checkups, dentist appointments, therapy appointments, etc.? (If they occurred) - Have you experienced any illnesses under state care? - Was this illness a mental illness or a physical illness? - Did your medical staff, social workers, or foster parents explain to you the effects or causes of your condition? - Do you feel like your race/sex affected your care? - Do you think the state has a working system for treating its clients' medical and mental health needs? - What recommendations would you make to a policy member addressing medical disparities within state custody?	- What organization do you work for, and what is your role within the organization? - Who within your agency is in charge of your checking in on the children, and what is the required frequency of these check-ins? - Do you know if the children receive these check-ins? - Is there someone who monitors this? - What would you say is the biggest challenge in getting foster youth to receive regular checkups and medical treatment? Mental health treatment? - Do you think that the medical needs of foster children are being met to the level they should? - And if not, what effects would you think this has on the children in state custody? - How can we get foster youth more comfortable addressing their mental health? - What changes to the state policies do you think are necessary to ensure foster youth's success in terms of medical needs?

Qualitative Analysis

All interviews were audio recorded using Zoom and then transcribed using otter.ai software. All software-based transcriptions were checked for accuracy against recordings. Following transcription, the recordings were deleted. Deductive coding was used to search and highlight the sections of the interviews that touched on common themes. The themes selected for coding were mental health, medical treatment, therapy, desires, feelings of loneliness, state workers, support, resentment, trauma, stigma, and pieces relating to expressing oneself. Two interviews, one from a former foster youth and one from a state worker, were removed from analysis after the participants reached out and asked to be withdrawn from the study for personal

reasons.

RESULTS

As stated in the introduction to this thesis, one of the primary goals of this work is to center the voices of foster youth themselves. While there is considerable research on foster youth, rarely are the voices and perspectives of those youth present, rather they are often obscured by statistics and generalized descriptions of the foster youth system. In order to fulfill the objective of highlighting the voices of foster youth, this thesis uses a blend of narrative writing interspersed with passages transcribed from interviews with each individual. Following in the tradition of ethnographic work which centers the voices of its interlocuters, this research presents long excerpts from interviews with foster youth which has the effect of centering their voices and stories. What follows in this section are four narratives of individual foster youth which are used to depict the obstacles these youth face in accessing health care. The major themes of the research are then linked to these narratives in the following discussion section.

Kealoha

Kealoha was two years old when she was first taken into state custody. The state placed her temporarily in their care, until they moved her in with a relative that they licensed to be a foster parent. 48% of foster youth are placed with a relative foster parent (Casey Foundation, 2022), to help the transition on the child. Unfortunately, that relative quickly turned abusive though she remained in their care for another three years. She returned to state custody at age 13, where she remained until she aged out at 18. During that period, she lived in approximately 20 different homes. When asked about her placements, she stated that "I was changing homes and social workers almost as much as I changed my underwear, and I changed my underwear a lot, okay." When asked about her childhood, she referred to herself as just a troubled kid, recalling

how some of her own actions, themselves a cry for help, resulted in the perpetuation of the violence of the foster care system:

> Like, I was doing sexual things, you know, to my foster sisters, at only like, six years old, you know? So you can tell there's something seriously wrong with this kid *(herself)* sitting in front of you. You know, this kid just needs to talk to somebody but my foster parents just booted me and I got placed into another home. I was in fights in school. And I was just like I said, a troubled kid. And then I ended out in a home that had no kids, because they were like, you know, this kid can't be with nobody. I just had to be really alone. So I ended up with this family. I was just, I was just miserable. I cried every night, you know, wanting my mom or just any people to be around. It was hard, you know, being the only kid around.

Kealoha's cries for help were ignored, and as she was not receiving any clinical treatment her behavior went unaddressed. This maltreatment and subsequent punishment for mental health crises not only reflects her lack of care, but further highlights how other foster youth were further exposed to the violence of state care. Kealoha, due to lack of mental health support to overcome her trauma, became someone who perpetuated further trauma for her foster siblings.

Kealoha was characterized as what some people involved in the foster care system call "a runner" or someone who would continuously run away from homes at the first sight of conflict. She reported running away from numerous homes for many different reasons, for drugs, for parties, to avoid conflict, to avoid stigmatization, and so on. Despite her constant running away and acts of violence, Kealoha fervently wanted someone to be there and listen to her.

> But that's like, all we ever wanted was to be heard. We didn't want a response. We didn't want an opinion. We didn't want, you know, someone to say what was wrong with the scenario or what can we do to better it? We didn't want that. We just wanted someone to sit there and listen to what we have to say and just, you know? Okay, maybe you would just sit there and you nod your head like you understand. You know?

Kealoha statements here are consistent with the narratives of many foster youth; they needed to be heard. Foster youth reported needing to have someone to process with, who made them feel like what they were feeling is valid. While the state has mandated check-ins for foster

youth, she does not remember receiving these check-ins often, and if they occurred, the workers predominantly addressed the foster parents rather than actually sit down with the Kealoha herself.

> I've never had a stable worker that was assigned to my case that was like, hey, we're gonna get this through the long run. It was within maybe three or four months, and then oh, this is your new social worker. And then a few months later, they retire or they, you know, they want to do something else. I never have stability. I've never had a solid social worker case. Of course, we used to have those ones that would come to like my foster family's house, they would come over, and we would perform and put on this huge show for them. When I turned like 19, or 20, I ran into one of the workers again, and I said, you really see, right? You've seen what was going on there, didn't you? Because he wouldn't come just for me, it was for all of us, 13 kids. They had to do it. And that's why I'm like, why didn't you do nothing? We were putting on performances, doing breakdances and hula, serving papaya, and putting together literal performances like theater. Yeah. Like, that's kind of psychotic. I'm not gonna lie.

She felt that they were putting on a show for their workers, where she felt emotionally neglected and forced to pretend that she was okay. The story described above also has the added element of Kealoha being a native Hawaiian descendant, which entails another aspect of performance. Native Hawaiian wards in this home were forced to perform native dances, serve native food, and entertain predominantly white state workers. These performances reinforced ideas about how Native Hawaiians are supposed to present themselves in order to be considered acceptable in the eyes of the state.

Not only did Kealoha desire to be heard, but she also had many things that needed medical treatment and therapy. Kealoha does not recall ever being vaccinated or seeing a dentist, and remembers that she had trouble getting access to sports physicals to participate in high school athletics. Additionally, from a young age, Kealoha was forced to deal with trauma, mental health crises, abusive homes, rejection, isolation, and many other factors that impede childhood development and physical and emotional growth. She started using methamphetamine at the age of 12 when she was introduced to the drug by a boy on her soccer team. Additionally, she stayed

in one problematic home where she was neglected physically and emotionally for much of her adolescence.

> Like I would wake up at three in the morning and just run. I used to wet my bed every day. I didn't stop peeing my bed till I was 16. And it was bad because, being in the home for seven years, when I lived with Stephanie guys[1], they never changed my mattress. I had a sinkhole with springs stabbing me and peeing my bed every night. So I will try to leave as early as possible. Like I would try to hide. You know, I just don't want to get in trouble or get hit. And there was no one to talk about it with. I would try to use the bathroom at night. They would put an alarm on my door. Some nights they would lock the door. I got up and would pound on the door like, hey, I got to use the bathroom! They'd open it. Then lock the door again. Because they apparently said I was stealing food. I'm like, fucking, excuse my language. But damn, like, I didn't even know you could steal food. Or like you could steal it from the store, but stealing it from a cabinet in the home that you live in. I've tried committing suicide as a kid in that home. And it was just ignored. You know, they took all the hangers, though. Anything high off the ground, like the fans, were removed. They took them down, boarded up the windows, took out light bulbs. I used to hide knives in my room. Okay, sorry. I was a psychotic kid, but I'm not now. I swear I'm okay. So you know, instead of talking to someone, you know, like, sharing it with a psychiatrist, I guess, it was like, oh, let's just shut her out. Let's hide her. You know? Keep me home from school. Even to the first day I ever got my "girls thing," right, I fainted and it was ignored. Like it was heavy, you know, I fainted like three times that day and I was still sent to school. I didn't even know what to do.

It is significant to note that Kealoha received no education or support about her period or reproductive health. This is something basic that all foster children should have guaranteed access to. Further, not only was Kealoha dealing with mental health problems due to the separation from her biological family, but she was also being punished for experiencing mental health issues. She described vivid nightmares where she would wake up screaming for her mother, and during this time, she was not provided individual therapy; instead, a group therapist talked with all 13 of the youth in the home at once.

This isolation weighed heavy on Kealoha, as she was completely separated from everyone and everything she knew, typically without warning or explanation.

[1] The speaker is using the language Hawaiian Pidgin. The term “Stephanie guys” references living with Stephanie and her family.

> Yeah, just a separation from something you've always known, you know? My mom was using drugs. And, of course, I didn't know that then. But, you know, after I figured it out later. But I lost something I've always known, you know? That is your mom, your baby, you know? And my father was never in the picture he left when I was like, two. So, you know, it was a lot of pain. Especially later, when my brother came into the picture, and to be separated from him was even more painful than it was being taken from my mom, you know? Because I'm the oldest, I have to watch over him, and now he's gone, you know, so it sucked entirely. It's just traumatic. And then to be placed in a foster home only down the road. Of course, I would try to run away and go to his house, you know?

When asked if she understood mental health or any of the issues she was facing at the time,

Kealoha expressed resentment for being ignored and denied therapy for so long.

> Um, we have a family therapist who was being paid for individual sessions. So now there's 13 of us, remember? But instead of doing the individual sessions, he did in partners, he did family meetings, and he did family therapy. He never would ask us what's going on in here or are you okay. And then, when I turned 12, I told him about my sexual abuse. It was happening from when I moved in, I was like, 7, I was being molested. Then finally, when I turned 12, it turned into rape, and I tried to say something. He went and told my grandmother, instead of following certain procedures and precautions that he should have followed. He went and told her, and I became the target of violence again. I hate to say this, but I have so much hatred towards that woman *[her foster mother]*. I can truly never forgive her. I don't know if I will ever be able to forgive her no matter how much therapy I go through, no matter how many times she says sorry. Because to me, it's not sincere, you know? But the way she turned a blind eye to what was going on in the home. She had her favorites, just like every foster family does. You know, in my experience, mental health was not discussed. It was not talked about, nope. I guess it always just depends on the family you end up with.

When Kealoha was in high school, she was arrested for drug use and sent to a juvenile facility,

which provided the framework for her first safe place to address her traumas:

> In juvy, even if a memory just popped up into my head and I wanted to talk to someone about it, I could. It was amazing, you know? People were there to listen to me, and only there in juvy. And that's a crappy thing to say, that I needed juvy to be understood because our system is crap. Being a ward of the state and actually incarcerated with the juvenile detention center, I guess, was where I was getting the treatment and the therapy that I actually should have gotten you know. I love that place. Honestly. It helped me a lot as a kid, helped me grow, it helped me, you know? But for foster care homes I have not a lot of positive things to say. But as for juvy, that place it pushes you, and these kids, and anybody who ends up there, and you know? It's sad because I don't wish incarceration on anybody, especially a kid. They should never be locked up, you know? But if the state had that kind of curriculum and the program, these foster kids could really

> get far. They aren't doing anything right; they are doing a hundred things wrong. But no one cares what I have to say.

Once again, she echoes the sentiment of her desire to be heard. However, Kealoha also expressed that she did not think therapy would have helped her as a child because she could not understand it. However, by the time she felt she was of an age to understand mental health, she was already addicted to drugs, had dropped out of high school, and was suicidal. Even though she felt she would not have understood the concept of mental health as a child, Kealoha was very much dealing with mental health from the time of separation.

Kealoha also was very concerned being stigmatized and categorized as a victim. She claimed that she ignored what other people said or thought about her, yet she was consumed with ensuring people did not think negatively about her. She only referred to any mental health struggles only in the past tense, stated she was a "messed up child, but is okay now," and was very careful not to violate any social norms regarding victim identity.

> I was always..., and I don't like to sound like the victim. I never will. I'm a victimless person. Like I know, I am a victim of the system. Okay, I know that. But I won't play it, and I won't see it. And I won't, you know, argue it. I acknowledge it for myself. And it's something that I wouldn't really say, but I'm saying it to you, you know? I was a constant victim in the home.

Before continuing, it is important to note that Kealoha did not qualify as a traumatic placement. Her story further highlights the basic level requirements of placement, as she did not experience intense violence or any officially reported sexual trauma. This lack of active trauma means that she did not qualify for individual therapy and mental health resources. However, it is clear she was in need of mental health treatment as she demonstrates many signs of being traumatized from her childhood, not to mention the abuse she went on to face after placement with a relative.

Thomas

Thomas was placed in state custody at the age of four when he and his two younger siblings were taken from a Taco Bell after they were found negotiating for free food. Thomas' parents both struggled with drug-addiction and were extremely negligent. At the time, Thomas and his siblings were extremely underweight. His younger sister was only four months of age and Thomas was charged with the responsibility of caring for her and his younger brother who was three. Thomas recalled begging neighbors and restaurants for milk. Many nights, he resorted to giving her water he fetched from the toilet because he could not reach a sink. Thomas recounts being in over 7 different homes after entering the system. He struggled considerably with his mental health during his placement in state custody and was stigmatized because he did not process his experience the way he was expected to.

> As far as most people were concerned, I was just an angry and violent child by nature. There were a multitude of problems that could have contributed to my behavior that now that I'm an adult, and I can think back and rationalize most of the things that happened to me. But at the time, I was just written off, as, you know, a violent, suicidal angry child. And in my opinion, there's no reason for any seven to ten-year-old to contemplate suicide. No seven-year-old should wake up and say to themselves in the morning, hey, I want to die.

Thomas was diagnosed with bipolar, obsessive-compulsive disorder, and attention deficit disorder. He was placed on medication at a young age, despite his apprehensions and contempt for his medicine. Thomas also expressed struggling with his mental health in school.

> I wouldn't so much say my mental health was discussed, as it was just forced upon me. You know, from the very young age of probably about six to seven, I'd already started taking medications for ADHD, bipolar, um, you know, psychotic tendencies. And none of that was ever discussed with me. I never had the option to say, no, I don't want to be taking Ritalin or Adderall at the age of seven. It was just, it wasn't so much discussed with me, as it was imprinted on me. This is what you have and this is what the adults are going to do about it. So I remember that I would sit there in class crying because I couldn't figure out why companies wouldn't make the textbooks the same size. Why didn't they stack together? And I would just hyper obsess over the smallest things to the point where I would just have breakdowns in the middle of class. No, I would like freak out if my pencils weren't sharpened to the exact same length. And because of that, I was, you know, pointed out as a problem child. I had, you know, obsessive-compulsive

> tendencies. I would get mad at the drop of a hat and act violently towards classmates and towards teachers. I would scream; I would just lose my mind up until about the end of the day when my medication started to wear off. And then after that, I would just be left with headaches, fatigue, and a sense of guilt that I had just, you know, acted in such a way the entire day. But it felt like it was out of my control. I felt like I was another person. But there was never anybody there who would try to calm me down. Or, you know, nobody there seemed to think that my behavior was a problem with my mental health. They seem to think it was a problem with me as a person.

Thomas experienced extreme negligence under his care in state custody, which likely was another cause of his distress. Instead of providing a safe place to recover and process from the trauma he endured with his biological parents, Thomas experienced new forms of trauma in the foster care system that extended far beyond just mental health inequities.

> Their idea of parenting under the foster care system was to put me in a diaper and not let me use the bathroom because I was a misbehaving child. I was forced to sleep in a hallway with nothing but a pillow. And there were times where I had found out that my little brother had been locked in a closet with nothing but a bowl of water for three days. So to say that I was getting any sort of checkup or being taken to the doctor did not exist. In another home, I was on the top bunk of a bunk bed and fell off and broke my arm on a dresser falling off. And it took about a week and a half to convince my foster parent Sandra that I was not faking and that my arm was hurt before she finally took me to a doctor. There the doctor had questioned her about why it had taken her a week and a half to take her foster child to the hospital for a broken arm. In my experience, the foster parents are very reluctant to take the children to doctors because if any sort of medical professional can see what condition these children are in, they would probably raise flags to the higher-ups and CPS, which would affect the dollar of the foster parents.

However, he also repeatedly expressed his need to be heard and to process his emotions. When asked what treatment he would have liked, Thomas revealed three desires:

> I think that I should have received, one, anger management. There was nothing like that that was ever given to me as an option. Anything that I had due to anger was automatically tried to be suppressed with drugs. So anger management, definitely. I think trauma therapy really would have done wonders for me. To really be able to talk to someone and understand, you know, what I went through. Because I just reacted, you know, to the things that had happened prior to foster care and during foster care. It was almost like a primal animal instinct. I was trying to protect my siblings and my family, and that made CPS my enemy. But yeah, I was never sat down and explained, you know, what had happened to me, what had happened to my siblings, and what exactly was that I was trying to protect people from. So I think trauma, trauma therapy really could have done wonders for me. And on top of that, um, you know, probably just regular therapy,

> not talking to a psychiatrist. You know? Not trying to figure out what medication and not trying to figure out what mental problem I have. I just needed somebody who I knew that I could trust to talk to.

When asked what he would tell someone in custody right now, Thomas stated, "so the only way that I could explain what to do is that you have to make your own voice heard, and you have to speak louder than the government's willing to speak for you." Over ten years later Thomas was removed from state care and allowed to return to his biological mother's home in Washington state when he was 15. However, shortly after this, his mother died of a drug overdose, and at 18 Thomas was left alone again to care for his two younger siblings. At that time, his siblings were 14 and 17. His younger brother was eventually removed from his care when he was arrested multiple times for drug offences and incarcerated. His younger sister later went to live with her stepfather in another town. Thomas remains in contact with all his siblings and is helping his brother meet his parole requirements.

Leilani

Leilani was placed in state care at the age of six. She had experienced intense abuse by her stepfather and stated that when she was removed from her home, her "stepdad broke [her] legs and like six of [her] ribs and then [she] sustained like, cigarette burns and stuff and then the healing process took months." Her biological mother fought to regain custody and divorced her stepfather. However, the state denied her case. Shortly after being removed, Leilani was placed into a permanent foster home with extended family members. Permanent foster placements with extended family members are extremely common in Hawaii, as there is a shortage of foster homes. After her permanent foster placement, she does not recall any further state check-ins despite still being a ward of the state.

> I still have memories of myself crying, like having to meet with my new foster families. And I still have memories of my first caseworker, I even remember her name, and I

> remember telling her that I wouldn't cry this time. So I know it was really traumatic for me. Not only that, but in the house that I was permanently placed in, I was sexually assaulted and abused by my foster dad.

In addition to having to deal with the abuse of her foster father, Leilani was also struggling with depression, post-traumatic stress disorder, and anxiety. Leilani was clinically overweight as a child and felt that she was stigmatized for it.

> Like I was aware that something was up with my body, my mental state, but nobody wanted to acknowledge it. Every time I'd go to adults, they would just say that I wasn't feeling well. And the same thing happened over and over. Like when I had appendicitis, I was told that it's because I eat too much and stuff, and no one would take me to the doctor. And the same thing happened when I had pneumonia. They said it was because I was overweight.

Not only did she feel her weight played a role in her maltreatment by her foster parents, but also her ethnicity. She stated, "I feel like I was treated differently when I was a kid because I was more like dark Hawaiian and Asian looking. And then my sister was more fair, and like Portuguese Hawaiian. And they treated her a lot differently because she looked like my dad." Leilani asked to see a therapist; however, she was treated by a family friend who openly disliked her stepfather, and she did not feel that she could express herself with her.

> Well, I asked to see a therapist once, and I saw this person named Dr. Theresa. But it got too overwhelming for me because she only wanted to talk crap about my stepdad because of what he did to us. And so I stopped seeing her after two tries because it was just too much. Other than that, I never really had any therapy for any of my mental illnesses or disorders.

Like many of the other youth I interviewed, Leilani said her childhood was marked by loneliness and not being understood by the adults around her. She felt as though she was labeled as rebellious and out of control. Leilani struggled with self-harm and suicidal thoughts starting in middle school and lasting until college. Leilani remembers only one adult who she felt understood by, a teacher.

> Now that I think about it, there is one person in my life who was like a father figure to me. It was my eighth-grade Hawaiian language teacher. He really tried to be there for me. And I still keep in touch with him now. So that was like a very, very healthy relationship that I had outside of my house. Other than that, in school or in my home, I don't feel like the adults wanted to understand me. It was easier for them not to acknowledge those emotions and behaviors and use physical force instead of trying to understand why I was behaving the way it was.

Leilani sought out therapy in college and had a therapist help her unpack a lot of her childhood trauma.

> My mental health wasn't discussed growing up. I didn't even know I had clinical depression and major depression and anxiety till I went to a psychologist when I was in college after my foster dad committed suicide. And I felt like, yes, this is how I had felt like my whole life, but now I understand. I had all these ups and downs feelings, and everybody kind of just ignored it.

When asked what care she would have wanted the state to give her to help her process her trauma Leilani expressed her desire to be listened to and supported by the state.

> Yeah, I think physically, it was when my step dad abused me, and I had to heal up on my own. Because when I was put into state care, it was because I almost died. Like he tried to drown me several times and then bring me back to life just to see how long I could hold my breath. So that *(medical)* care would have been super big for me. I definitely needed serious care for that. But then, when I was in, I guess, middle school to high school is when it would have been crucial for me to have mental medical support via mental support. You know, therapy or a psychologist, maybe. Because there was just so much chaos going on in my foster house, some kind of stability and comfort would have really been appreciated on my end.

As an adult, Leilani herself has taken in two foster children. Since her time in state custody, she has noticed improvements in the state's care but still feels like there is a long way to go before the state has a working system:

> The state needs to acknowledge that these kids, like the majority of them, are not in foster care for no reason. Obviously, there's some trauma behind the reason that they were placed there. Which means that as children, their brains are still not formed as an adult. This means that they can't really understand the emotions that they're feeling and the traumas that they've really been through. We weren't able to process it the way an adult would. And so knowing that, the state should already have a therapist on hand, like some partnership or something for the kids, because they need that kind of support immediately in going into foster care. You know, it's very traumatic. Can you imagine being ripped

> away from the only people that you know, even if they treated you like shit? You know, I mean, it's frickin traumatic. Like the fact that they don't have a therapist lined up already, that is just a huge no-no for me. I didn't have access to the therapy I needed as a child, and now that I have two foster kids myself, I am trying to do things better for them. I think there's still a lot of flaws to the system honestly. Like they have gotten more vigilant, and you know, they check in more often. But like, even with my foster kids, I was trying to get him a therapist for like, four months before I actually got them one. And it had to be approved through them. So it made it even harder because they weren't even trying to find one or help. I think these kids in general just need that support. They need a nurturing person in their life. They need somebody that shows that they care and can help them. Yeah, overall, I tell them that I want them to just push through. You know, just push through because it's going to be okay. But I don't know what to say beyond that.

Daphne Walker

In contrast to Kealoha's, Thomas's, and Leilani's stories, Daphne entered the state system numerous times starting as an infant but was eventually placed into private foster custody at the age of eight. Daphne's mother suffered from schizophrenia so Daphne spent most of her early years being homeless or being in state custody. She recalls placement in 22 homes, 19 of which were in her first eight years of state custody. Despite being so young, she recalls the trauma of being removed from her mother with intense clarity.

> When you're taken away from your mom, she's getting arrested and you're seeing her put in handcuffs, and there's lights flashing everywhere. And then they're like putting you in a separate police car. It scars you mentally just watching that happen. And the first time it was like, jarring, but then you kind of get adjusted to it. The last time we were actually visiting a church. Me and my brother were pulled away from my mom. And then put us in a CPS car and the police are holding her back. She's screaming. It was very traumatic. But it's like a little bit of a relief because at least we'll get some food, a warm bed, and have a little roof over our heads.

Daphne and her brother decided to remain in custody when she was eight and voted to have their mother's rights removed. It is common for judges to ask children (through their legal representatives) to share their desires of placement in custodial court. This is one of the many factors the judge includes and does not necessarily determine custody but can be used to sway the decision.

Daphne was placed in a private religious foster care where she received top care and treatment. After switching from Child Welfare Services into a private organization, Daphne immediately had access to weekly therapy and mental health resources. She was caught up on her vaccinations, and someone even paid for her braces.

> Now I was like playing soccer because, at first, I was very malnourished when I entered the system. And I'm actually in school. Obviously, my mom had no formal education. So I couldn't read, I couldn't write, I was poor at math. We've never obviously been a part of a preschool or anything like that. So we had no context of what it meant to take naps and just be normal kids. And so it was very much trying to catch up. We both we sent back a year, had extensive tutoring. But it felt good to be smart. When I first started school and I was eight and a half and kids would say spell CAT. I said KAT and everyone laughed at me in school. By the end of the year, I could spell CAT. It felt so good to read books and to be smart and to be articulate.

Daphne graduated as valedictorian and attended a prestigious university with a degree in journalism. Her story provides a stark contrast to the other stories of youth that remained in state-funded institutions. However, children should not have to rely on the luck of placements to have a successful life.

Speaking with the System: Interviews with state workers

Another critical perspective in understanding the foster system in Hawaii is that of the state workers. Even though the state workers expressed genuine concern for their clients, the DHS Statewide worker visit surveys show that as little as 77% percent of foster youth in Hawaii received their monthly visits, even though the national standard is 95% (State of Hawaii Department of Human Services Social Services Division, 2019). When I asked one of the state workers if she thought the system in place was functioning at addressing the medical and mental health needs of the youth, she stated:

> Sometimes in the mental health field, we have to jump through all these hoops. They have to progressively get worse before we can actually do something. So like we don't have very good mental health services. Okay, we don't. And sometimes we have to send our kids to the mainland. The kid got to slam their head into the side of the wall five

> times before they finally helped the kid. Like, why never help them the third time he did dat? Why never send them then? And why you gotta wait for the fifth one. Why? Cuz there are plenty kine papers or because its expensive? I don't understand. So it's always a fight for us, for the kids. Because, you know, CPS is responsible for these children. Like if something happens to these kids, we *(the social workers)* are responsible, and we don't want to get sued. We are the people who get slammed in the newspapers when a lot of people don't realize that there are other players in the playing field, when people don't know that we've tried to do all these things with these barriers, right.[2]

Both state welfare workers expressed that the mandated check-ins and responses are being done as required, even with the lack of resources. However, child welfare services published that only 39% of their responses were considered completed and timely responses (State of Hawaii Department of Human Services Social Services Division, 2019). Additionally, the national goal for the absence of maltreatment in foster care is 99.7%. However, the state of Hawaii only achieved this goal in three of the last five years (State of Hawaii Department of Human Services Social Services Division, 2019). This statistic translates into over 30 children experiencing extreme maltreatment in Hawaii's foster care system per year. When hearing the stories of Kealoha, Thomas, Leilani, and Daphne, it can be easy to blame social workers for not achieving what is expected of them by the state. However, the state continually has approximately 20% of its positions as vacancies and is in constant need of help (State of Hawaii Department of Human Services Social Services Division, 2019). In Hawaii, each worker has up to 44 cases a month, which means they would be responsible for more than one child a day. Many social workers care deeply for the children in their custody and display a form of kinship to the children and their coworkers.

> But we need to figure this out because if that was my kid, I don't want my kid killing themselves because the state got no money. And a lot of social workers have that attitude. Like, you know, this is my kid. We need to do what's best for them. And we need to not wait till they're 14 or 15. If we could address this when they were 11, then why not? Because anything beyond 18 there isn't anything we can do. So let's address it instead of waiting until they're 15 years old and they commit a crime?

[2] The language used here is Hawaiian English Pidgin.

These social workers were aware of the issues of resources and medical disparities. They are also mindful that they cannot properly help children within the current framework of the system. They plead for more resources and fewer barriers to treatment.

Discussion:

During these interviews, there were a few themes that highlighted the significant needs of foster youth resources. The most common theme was the lack of addressing mental health. Specifically, foster youth expressed concern that mental health was never addressed or explained to them and that they were not listened to or checked in on. This issue is clearly demonstrated in the stories of Daphne, Thomas, Leilani, and Kealoha. Additionally, there were significant feelings of resentment and judgments directed at the state, specifically the Hawaiian state foster care system for neglecting their healthcare. Many also expressed the desire not to allow stigma or shame to shape their identities. For example, Kealoha, Daphne, and Thomas mentioned concern regarding stigmatization in their narratives. Finally, the youth all expressed the desire to be heard, which related to their accounts of negligence from their case workers. While these interviews highlight clear areas of need, the most effective method of understanding foster youth's greatest needs is to hear their stories and hear them describe firsthand their own needs.

Every interviewee expressed that the children are not being addressed directly, and they want to be heard. Based on foster youth narratives, social workers primarily meet with teachers and foster parents to get information about the youth's behaviors and situations. They rarely directly talked with the child themselves and never about their mental health needs. One of five youth had state workers directly communicate with them, and none of the two state workers described talking to the child. Even those who received therapy said it felt forced and that it was

"there to control their behaviors rather than to help them process."[3] It is important to find a way to make every child in state care feel heard, because some are not lucky enough to be supported by the foster parents and not traumatized enough for therapy.

> And I can say in the form of checkups, whenever I was checked up upon, it wasn't necessarily that they were talking to me, they were talking to the foster parent about me, so I don't think they ever spent time to really listen to my situation and hear my side of the story because you're just a kid in the foster care system. They don't really care what you have to say.[4]

In addition to not being addressed, these youth are left to navigate their own mental health without professionals' help. Thomas stated that he "was diagnosed with bipolar and told I was psychotic at seven. I felt like a lot of that was environmentally created. But I was stuck with that sort of stigma for a long time." Daphne stated that "I never told anyone my mom was schizophrenic, not even my fiancé, because I was told it was hereditary and because it's still a stigma like, oh, she's crazy, she'll have a breakdown." Leilani expressed relief after finally seeking out therapy in college and understanding what she had been dealing with since she was six. The lack of professional help and support forced these young adults to deal with stigmatization and mental health crises that they were not equipped to handle at their ages.

The state foster care system forced these youths to navigate their own mental health issues and stigmas. Even if the participants did not expressly acknowledge it, it was clear a large portion of their attention went into continually navigating the stigmas of state custody and struggles with mental health. Interestingly, many are very intelligent with navigating their traumas and pain in socially acceptable ways, as not to be perceived as violating the norms for pain. This performative nature is enforced through the state check-ins as seen in the case of Kealoha.

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[3] Thomas
[4] Thomas

Additionally, the need to feel heard and understood is a fundamental human need. Linguistic communication and connection are primary expressions of humanity, but these children were not being addressed directly. They want to be heard and are demonstrating this desire both through their words and actions. Even though social workers meet with the teachers and foster parents, their primary goal is to get information about behaviors and situations, not the client's mental health. The federal government is aware and has been aware for the past 30 years of the disparities continually faced by foster youth yet is not allocating the financial and medical resources necessary to enact change.

Even though most social workers are aware of the inequities and issues and are trying their best to fix them, children are being left behind in the system. However, aimlessly criticizing the state workers, as, without more resources, changes cannot come. There is an immense need for trauma-informed care and basic phycological services for every child and parent. The state should extend this training to state workers, foster parents, therapists, and doctors if we want to eliminate further mental health disparities faced by foster youth. Additionally, there is a need for access to high-quality health care and mental health services with trauma-based care available to every child who enters state care.

Receiving proper medical care should not be decided by chance or luck of placement. It should not be determined by the level of trauma or violence being displayed. Universal medical care and mental health treatment should be available to all foster youth because the nature of separation is always traumatic. If unaddressed, this trauma will grow into further mental health issues, many of which could be addressed at an earlier stage. While these stories do not reflect the entirety of foster youth, they can help provide insight into the medical and mental health resource disparity that is clear, and hopefully, bring awareness to the necessity to reform the

system in America. To end, here is a quote from Daphne when asked what changes she would make to improve the foster care system.

> My time in CPS was so underfunded, but my time *(in the private home)* was much better. It was therapeutic, with higher funds. They paid the parents more money. The parents had training. All the kids were dealing with some sort of trauma related to mental health. So we've got to beef up the state's mental health services, they have to beef up their training for foster parents, they have to do better screenings for foster parents. They have to really infuse a lot of money and resources because what I hear since I've aged out is "this isn't my issue." Well, it will become your issue when we're in your prisons or on your streets, or stealing from you to make ends meet. And then if there any type of incidents that occur, whether it's murder, etc. it will become your problem if you don't address them when we are younger. I seen studies that say that almost half of all individuals that are homeless spent time in the foster care system. That's unacceptable. So that's my message to the broader public is if you think it's not your problem today, it will become your problem at some point.

Conclusion:

This thesis sought to examine the barriers to mental and physical healthcare faced by foster youth through examinations of foster youth narratives. In doing so it magnifies the voices of foster youth in Hawaii and supplies insight into the obstacles they face in receiving treatment. It serves to better understand the hindrances to obtaining proper healthcare treatment and subsequent persistent trauma responses that foster youth carry, highlighting how all forms of trauma, including passive trauma, require treatment. These stories demonstrate the need for immediate change within the system to better support foster youth. It is essential to note that these ethnographies are not reflective of the experience of every foster child as the sample is limited in size and region. However, these narratives do highlight the common experiences that many foster youth in Hawaii share. Many foster youth reported feeling unheard, lacking access to therapy and mental health treatment, and feeling forced to navigate their own stigmas. These key commonalities highlight the need for an increase in trauma-informed care and more individualized state check-ins to better support our foster youth's health.

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