Meeting the Needs of Children in the Child Welfare System with Mental Health Challenges Part I

19th Annual Research Conference February 23, 2006 Jan McCarthy National TA Center for Children's Mental Health Georgetown University Center for Child and Human Development





Who Are the Children and		
Families (cont'd)		
Race/ethnicity of Children in Foster Care		
 White-Non Hispanic 	39%	
 Black-Non Hispanic 	35%	
 Hispanic 	17%	
Two or more races-Non Hispanic	3%	
Unknown	3%	
American Indian/Alaskan Native	2%	
 Asian-Non Hispanic 	1%	
 Hawaiian/Pacific Islander-Non Hispanic 	0.2%	

Representation of 5 Racial/Ethnic Groups in Foster Care Over-represented African American 2.43

	2113
Native American	2.16
Under-represented	
 Latinos 	.79
Non-Latino Whites	.76
Asian/Pacific Islanders	.39
Source: 11/04 working paper by Robert B. Hil	I published in Race Ma

Source: 11/04 working paper by Robert B. Hill published in *Race Matters Consortium*, "Over-representation of Child of Color in Foster Care in 2000"

Living Arrangements of Children in Foster Care

Foster Family Home (relative)		23%
Institution	10%	
Group Home		9%
Pre-Adoptive Home		5%
Trial Home Visit		4%
Runaway		2%
Supervised Independent Living		1%

Outcomes for Children Leave Foster Care	Who
Reunification with Parent(s) or Primary Caretaker(s) Adoption Living with Other Relatives Emancipation Guardianship Transfer to Another Agency Runaway Death of Child urce: AFCARS Report, FY 2003	55% 18% 11% 8% 4% 2% 2% 0.2%



Mental Health Needs/Services for Children in Child Welfare

Previous state and community level studies indicate 35% to 85% of children in care have significant mental health needs.

SOURCE: Marsenich, L., Evidence-based Practices in Mental Health Services for Foster Youth, California Institute for Mental Health

Data Available from the National Survey of Child and Adolescent Well-Being

- 1st national longitudinal study to determine outcomes for children and families in child welfare
- Examines characteristics, needs, experiences and outcomes of child/family
- Authorized by the PRWORA of 1996
- Gathered information associated with 6,100 children in 92 localities

NSCAW Data Availability

 First publicly available data set to assess health, mental health, development and service use of a nationally representative sample of infants, children, and their families who have had contact with child welfare system.

NSCAW Mental Health Need and Access

Number of children studied	3,803
Ages	2 - 14
Living in own homes	90%
 Living in foster, group, 	
or residential care	10%
SOURCE slides 11-13: Burns, B. et al. 2004 Mental heal	th need and access

SOURCE slides 11-13: Burns, B. et al. 2004 Mental health need and access to MH services by youths involved with child welfare: A national survey. Journal of the American Academy of Child and Adolescent Psychiatry 43:8: 960-970.

NSCAW Mental Health Need and Access (cont'd)

47.9% of children/youth had significant emotional/behavior problems (Need was defined by a clinical range score on the Child Behavior Checklist)

 Only 25% of children/youth with significant emotional/behavior problems received specialty mental health care in previous 12 months

NSCAW Mental Health Need and Access (cont'd)

NSCAW provides documentation of the magnitude of the problem:

- Large gap between service need and service use
- Failure of human service sectors to obtain mental health services needed by group of very high risk children and youth

Additional Analyses of NSCAW Data

Children with a clinically significant externalizing score on the CBCL were more than twice as likely to have a caregiver with an alcohol, drug, or mental health problem.

Source: Anne M. Libby, University of Colorado

Additional Analysis of NSCAW Data (cont'd)

This demonstrates benefits of a whole family approach to treatment:

- to address both child and caregiver needs
- to support interaction between the two
- to prevent children from being separated from their parents, e.g., drug and alcohol treatment facilities for the whole family.

Source: Anne M. Libby, University of Colorado

Additional Analysis of NSCAW Data (cont'd)

Analysis of linkages between child serving systems in 92 PSUs:

- Showed that increased coordination between MH and CW is associated with:
- greater use of services by children with highest level of need
- decreased racial/ethnic disparities in receipt of MH care
- Source: Michael S. Hurlburt, CASRC, San Diego

17

Additional Analysis of NSCAW Data (cont'd)

Developmental Delay and Service Use N=3,327, ages 0 - 10

- 24% developmentally delayed on at least one measure (cognitive development, language development, or adaptive skills)
- Only 38% with developmental delay were using developmental services

SOURCE: Zimmer, MH, Panko LM. 2006. Developmental status and service use Among children in child welfare system. Archives of Pediatrics and Adolescent Medicine 160 (2):183-186.

Potential Solution for Developmental Needs

2003 Amendment to CAPTA requires states to develop a system for referring every child under age 3 with substantiated abuse or neglect to Part C of IDEA.

Child and Family Services Review (CFSR)

Key Principles

- Individualized services to meet unique needs
- Community-based services
- Family-centered practice
- Strengthening parental capacity to care for their children (especially important for children with emotional/behavioral needs)

Child and Family Services Review (cont'd)

The CFSR Process:

- Focuses on well-being (PH, MH, Education)
- Identifies need for MH reform
- Provides opportunity for reform
- Encourages participation of other systems, c/b agencies, families



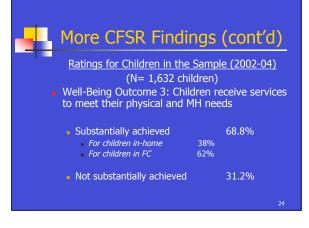
More CFSR Findings Primary Reasons for Case Openings (2001-04)

(N = 2,416 children)

Four major factors:

- Child's behavior (11%; 41% of children age 13 +)
- Parent's behavior (including neglect, excluding child abuse)
- Family's mental and physical well being
- Child abuse

23



More CFSR Findings (cont'd) 2002-04 Content Analysis of Systemic Factors (N=35 states)

Service Array

- MH assessment and treatment services are not sufficient to meet children's needs 31 states
- Key services for parents are lacking (including substance abuse svcs) 30 states
- Lack of culturally appropriate services 18 states

Special MH Analysis of CFSRs

Conducted by:

- National TA Center for Children's Mental Health Georgetown University Center for Child and Human Development
- Technical Assistance Partnership for Child and Family Mental Health American Institutes for Research
- At the request of SAMHSA and ACF Workgroup



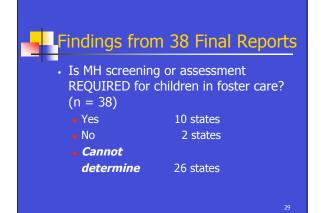
Findings from GU and AIR Analysis

Final Reports – 4 Areas of Interest

- Does state policy require MH screening/assessment of children in foster care?
- Do children in FC receive initial formal MH screenings or assessments?

28

- Are services provided to meet the MH needs of children in the CW system (FC and In-home)?
- Is there a lack of MH services to meet needs of children in CW?



Findings from Final Reports (cont'd)

- Do children in foster care RECEIVE mental health screenings or assessments? (n=38)
 - Yes
 - No 0 states
 - Practice is mixed 32 states 5 states

1 state

Cannot determine

Findings from Final Reports (cont'd)

Access to assessment when entering care:

Some CFSR site visits found children who had experienced significant trauma, e.g., gun shot wounds, sexual abuse, victimized and rejected, appeared depressed or had symptoms of ADHD, did NOT receive MH assessments when they entered care.

Findings from Final Reports (cont'd)

 Are services provided to meet mental health needs of children in foster care, and in own homes? (n=38)

```
• Practice is mixed 38 states
```



Program Improvement Plans (PIPs) [N=28] States are working on solutions to the problems: PIPs provide opportunity to correct problems identified in Final Reports 2/3 of PIPs identify strategies to improve <u>assessment</u> of MH needs and to expand <u>service array</u> and <u>service</u> <u>capacity</u>

 All 28 PIPs mentioned MH issues and most (25) set goals and action steps to address them

Program Improvement Plans (cont'd)

- 2/3 of PIPs showed collaboration across systems to address cross-system problems
- 1/3 of the PIPs proposed a comprehensive strategy for improving MH services

Issues for Further Consideration and Study

- Cultural competence addressed in very few Final Reports and PIPs in relation to MH and SA services – requires further study
- Evidence based practices very little data about concerted efforts to use evidence based MH practices

More Trends in Child Welfare

- Moving toward family-centered practice
- Use of child and family teams (including multiple families in child's life)
- Growth of kinship care
- Collaboration with other child-serving systems – especially mental health
- Privatization

Balancing the Solutions

- Children and families in child welfare need effective MH services.
- Improvements are clearly needed.
- However, states and communities also are responsible for building a mental health system that will adequately serve all children (those in child welfare and those not)

Balancing the Solutions

Some state child welfare systems essentially have become the children's mental health system, making child welfare the main route to mental health care.

 A broader, system-wide view will address MH services for children involved with the child welfare system AND the development of community-based services for all children and families.

Litigation, Consent Decrees, Settlement Agreements – Another Reform Strategy

Braam Settlement Agreement State of Washington

- Six year period of litigation
- Settlement agreement signed in 2004
- Oversight panel appointed in 2004-first meeting in 12/04
- Purpose to improve the conditions and treatment of children in the custody of Washington's state foster care system

Braam Settlement Agreement

The class includes:

children in the custody of DCFS who are now, or in the future will be, placed by DCFS in three or more placements and those children in the custody of DCFS who are at risk of three or more placements.

Braam Settlement Agreement (cont'd)

Six areas of the settlement agreement:

- Placement Stability
- Mental Health
- Foster Parent Training and Information
- Unsafe or Inappropriate Placements
- Sibling Separation
- Services for Adolescents

Braam Settlement Agreement (cont'd)

Panel Role and Responsibility In collaboration with Washington's Department of Social and Health Services and with substantial input from Plaintiffs, in each of the six areas the Panel is to:

- Establish outcomes, benchmarks, action steps and professional standards
- Monitor compliance with outcomes, benchmarks, action steps

Braam Settlement Agreement (cont'd)

<u>Mental Health Goals (established in the original agreement)</u>

- An initial physical and mental health screening within 30 days of entry into care.
- Plans to meet special needs of children in custody will be included in the child's Individual Service and Safety Plan.

Braam Settlement Agreement (cont'd)

- Mental Health Goals (cont'd)
 Children in custody shall receive timely, accessible, individualized and appropriate mental health assessments and treatment by qualified mental health professionals consistent with the child's best interest.
- Continuity of treatment providers will be maintained, except when it is not in best interest of child.

45

Braam Settlement Agreement (cont'd)

For additional information see:

Oversight Panel's website – <u>www.braampanel.org</u>

Plaintiff's website - www.braamkids.org

Washington DSHS link -

http://www1.dshs.wa.gov/ca/about/imp __settlement.asp



Jan McCarthy National TA Center for Children's Mental Health Georgetown University 202/687-5062 jrm33@georgetown.edu