Mental Health Service Utilization and Outcomes for Children and Youth in the Child Welfare System

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A Webinar presentation
The Center for Human Services
UC Davis Extension

March 30, 2010
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Overview of Today’s Presentation

- Importance
- Purpose of Study
- Literature Review
- Methods
- Key Findings
- Implications
Importance

High need for mental health services among children in the CWS:

- Experiences of trauma, maltreatment, being placed in out-of-home care

- 50%-80% have a mental health diagnosis vs. 25% of the general child population

- More likely to use public mental health services than children using Public Assistance or SSI
Importance

- **Mental health services for child may impact family maintenance and reunification processes**

- Lack of research on:
  - Mental health service utilization and
  - The impact of mental health services on family stabilization outcomes for children and youth in the CWS
Purpose of Study

Among children and youth in the CWS & MHS:

1) Describe **demographic** and **system-related** characteristics
2) Describe **clinical need** for mental health services
3) Describe **mental health service utilization**
4) Evaluate **impact of mental health services** on family stabilization
5) Explore **factors related to collaboration** between the CWS and MHS
Literature Review

Demographic Characteristics Associated with Mental Health Service Use among Children in CWS

- Male
- Older ages
- White (compared to African American & Hispanic/Latino)
System-Related Characteristics Associated with Mental Health Service Use Among Children in the CWS

- Physical abuse, sexual abuse, abandonment
- Multiple out-of-home placements
- Group care
- Longer time in out-of-home placement
Literature Review

Clinical Need for Services Among Children in the CWS and MHS

- Externalizing behavioral problems (i.e. oppositional defiant disorder, conduct disorder, ADHD)
- Adjustment disorders
- Anxiety disorder
Literature Review

Rates and Types of Mental Health Service Use Among Children in the CWS

Approximately 50% of children and youth in the CWS are also in MHS.

Outpatient services are most common.

Children in kinship care tend to receive fewer mental health services.
Literature Review

**Family Stabilization Outcomes May Be Affected by Mental Health Services**

- Lack of information on association between mental health service use and family reunification or family maintenance

- Mental health of child may influence reunification processes

- Need for more research
Literature Review

Collaboration between the CWS and MHS may be *impeded* by:

- Communication problems
- Lack of organizational support and resources
- Desire for system autonomy
Literature Review

**Collaboration between the CWS and MHS** may be *facilitated* by:

- Formal infrastructures
- Development of shared vision and mission
- Commitment from agency leadership
- Widespread involvement
- Cross-training
- Mental Health Services Act (Prop. 63)
Study Partnerships

- Faculty at School of Social Work at San Jose State University
- Santa Clara County experts in the CWS and MHS
- Advisory Group meetings guided study processes and tasks
Methods

Mixed Methods: Quantitative and qualitative

Quantitative:
- Secondary analysis of closed cases (Jan-Dec, 2004) in merged CWS/CMS and MHS dataset
- N=1,127 for total sample
- N= 520 children in both CWS and MHS (46%)

Qualitative:
- Interviews in CWS (N=6),
- Focus groups in CWS (N=3)
- Interviews in MHS (N=6),
- Focus groups in MHS (N=3)
Methods: Quantitative

**Measurement and operational definitions of key variables:**

- **Clinical Need:**
  - 6 DSM-IV diagnostic categories
    1) Adult type disorder
    2) Adjustment disorder
    3) Childhood disorder
    4) Other
    5) Deferred
    6) None

- **Mental Health Service Utilization:**
  - 3 modes of service
    1) Outpatient (measured in hours)
    2) Inpatient (measured in days)
    3) Day Treatment (measured in half-days)
Methods: Quantitative

Measurement and operational definitions of key variables cont’d:

- Treatment Completion:
  - 2 categories
    - Treatment completed
    - Treatment not completed

- Family Stabilization:
  - 2 categories
    - Family stabilized (either reunification or maintained)
    - Family not stabilized (all other outcomes)
Methods: Quantitative

**Analysis**

- **Descriptive**
- **Bivariate:**
  - Comparing children in both CWS and MHS to those only in the CWS
- **Multivariate:**
  - Identifying variables related to mental health service utilization and family stabilization while statistically controlling for the influence of other variables
Methods: Qualitative

- **Case study** qualitative design

- **Sampling**
  - Combination of random sampling and convenience sampling

- **Data Collection**
  - Semi-structured interview guide

- **Analysis**
  - Analysis of transcribed notes
Methods: Partnerships

Advisory Group members:

- Assisted in **merging data** from the CWS & MHS
- Clarified **meaning of variables**
- Assisted in quantitative **data cleaning**
- **Identified errors** in data entry
- Provided feedback on questions for **qualitative interview guide**
- Provided feedback on results and **implications for policy and practice**
Results: Descriptive & Bivariated

Children referred to MHS had greater likelihood of:

- Older age at entry into CWS
- Entry into MHS was an average of 1.47 years after CWS entry
- Physical or sexual abuse, although most common was caretaker absence/incapacity
- No gender differences
- No racial/ethnic differences
Results: Descriptive & Bivariate

Clinical need:
- 38.5% adult-type disorder (girls more likely)
- 27.3% adjustment disorder
- 17.7% childhood disorder (boys more likely)
- 16.6% Other, deferred, or none

Services:
- 91.5% outpatient services
- 3.9% day treatment
- 0.2% in-patient
- Average dosage of treatment for outpatient 18.8 hours
Results: Multivariate

Factors that predicted utilization of outpatient services:

- **Age at entry into CWS:**
  - Children entering at an older age received more outpatient services

- **Type of maltreatment:**
  - Caretaker absence or incapacity (vs. neglect) related to less services
  - Sexual abuse (vs. neglect) related to less services

- **Service type at case closure**
  - Children with Family Maintenance received more services

- **Diagnosis**
  - Children diagnosed with childhood disorder received more services than children with other diagnoses
Results: Multivariate

Factors that predicted mental health treatment completion:

- **Age at entry into CWS:**
  - Children entering at younger age *more* likely to complete treatment

- **Diagnosis:**
  - Adjustment disorder or deferred diagnosis *less* likely to complete treatment (vs. childhood disorder)

- **Ethnicity:**
  - Latinos marginally *more* likely to complete treatment (vs. Whites)

- **Dosage of mental health services**
  - Children receiving more services *more* likely to complete treatment
Results: Multivariate

Factors that predicted **family stabilization:**

- **Age at entry into CWS:**
  - Children entering at a younger age *more* likely to be stabilized

- **Type of maltreatment:**
  - Caretaker absence or incapacity (vs. neglect) *less* likely to be stabilized
  - Sexual abuse (vs. neglect) *less* likely to be stabilized

- **Time in the CWS**
  - Children in the CWS for less time *more* likely to be stabilized

- **Service component at case closure**
  - Children with Family Maintenance services at case closure *more* likely to be stabilized
Results: Qualitative

Five themes centering on collaboration between the CWS and MHS

1) Current collaboration is limited, although valued

“There’s a lack of collaboration, I’ve never been to a meeting with social workers. The systems are not working together. It’s just individuals wanting something from someone.”

“We’re selling ourselves short by not seriously trying to collaborate…We could make a huge dent on our social problems by collaborating.”

“We need to see each other as going down the same path.”

“We need to educate each other and treat each other as partners and not get locked into silos.”

“We’re both interested in helping, but we never talk.”
Results: Qualitative

2) Some formal collaborative structures exist

- Out-stationed mental health workers at the Family Resource Center and Children’s Shelter
- The Resources for Intensive Services Committee (RISC), a weekly committee involving mental health, child welfare and probation that reviews cases to decide on level of care and services.
- Referral processes for children with higher needs described as more formal than those for less intensive services.

- System of Care
- Wraparound
3) **Differing system goals**

- “There are inherent tensions. In mental health, they usually rely on the client to identify issues. In child welfare, we have specific issues that we feel need to be addressed because of timelines.”
- “They [mental health system] don’t always understand the demands within the child welfare system—and the consequences, like not getting the kid back. This is a system clash that has not been rectified.”
- “Historically there are two sets of different goals for each agency, the child welfare system focuses on parenting, and mental health is therapeutic, they can be at odds sometimes.”
- “We just have different needs and different perspectives on the system—legal vs. mental health.”
Results: Qualitative

4a) Factors that *impede* collaboration

- **Communication problems**
  - “There’s a lack of structure. I’ve never been in a meeting with social workers.”
  - “It’s hard to get everyone in the same place at the same time; scheduling a time to meet is difficult.”
  - “There are no opportunities for line staff to communicate with one another. There is no annual or bi-annual communication forum to talk about what each system is doing.”
Results: Qualitative

4a) Factors that impede collaboration:

- Problems with joint treatment planning
  - “If a therapist is working with a family, they should meet regularly with the social worker and develop treatment goals and discuss how needs are being met. The way it is now is the therapist sends a written report to the court and doesn’t talk to the social worker; there is no mechanism to talk together.”
  - “When I really want things to work well…I invite myself to participate in a therapy session and we can all talk about whether the problems that brought them into the system are being addressed.”
4a) Factors that impede collaboration

- **Funding restrictions**

“For families in the voluntary Family Resource Centers, they often only have services for three months, and we sometimes have to spend a lot of time getting them Medi-Cal, and then there is often a waiting list to see the mental health worker, so we can eat up the time that they have just trying to get them services.”

“The parents cannot get counseling if they do not have custody of the child, but they cannot get their children back unless they get counseling.”
Results: Qualitative

4a) Factors that *impede* collaboration:

**Individual-level factors**

- “We have different training backgrounds. We never call the parent a client, or a consumer or a patient; these are different mindsets.”

- “Mental health comes from a different perspective and different training, and we are coming from our perspective and sometimes it is difficult to get the two perspectives together…sometimes you can and I think a lot of the time it has to do with the personalities of the workers.”

- “It depends on the social worker on the other side, sometimes it [collaboration] is good and sometimes it is difficult.”
4a) Factors that *impede* collaboration

**Lack of mental health services**

Access to services is difficult at times. There are limited services and waiting lists and the time frames in child welfare often make it difficult for families.

“They [mental health system] don’t have a lot of kids programs. They don’t have specializations, like sexual abuse or Post Traumatic Stress Disorder.”

The child welfare system feels there is a large gap that is not being served, but mental health has to deal with Medi-Cal requirements—this includes an SED diagnosis in order to be served. This is an Axis I diagnosis; there has to be clear impairment in two or three areas of functioning.
4b) Factors that facilitate collaborative practice:

- Commitment from organizational leaders
- “We need more management interaction, they need to develop a plan that filters down to the line staff.”
- “We need better coordination, the top levels need to establish policies.”
- “It flows from the Board of Supervisors and county executives to make collaboration a value in our county so that it is monitored.”
Results: Qualitative

4b) Factors that *facilitate* collaborative practice:

- **System infrastructure**
  - “Having a list of service providers would be really helpful...there is no central way of knowing the services. There are services we don’t know about.”
  - “There’s a lot of institutional knowledge contained by certain workers, one worker may be really knowledgeable about what is available and what should be happening, but then when that worker goes—there goes the knowledge.”
  - “We have an educational rights specialist to advocate for kids who aren’t getting what they need in the educational system. Having something similar in mental health would help a lot.”
Results: Qualitative

4b) Factors that *facilitate* collaborative practice:

- **Cross-training**

  “The need for cross-training is bad. A lot of mental health workers don’t understand the court process and how difficult that can be.”

  “Knowing the mental health criteria that exist would be helpful.”

  “We need to understand the types of services they [mental health] provide.”
Results: Qualitative

5) Potential impact of *Mental Health Services Act*

“Hopefully it will get us talking and thinking through these programs and how to leverage resources.”

“I hope that it [Proposition 63] brings additional resources and ease in accessing these resources.”

“There were meetings between mental health providers and the child welfare system to talk about Proposition 63 and how to coordinate it with their System Improvement Plans. We were talking about our goals and objectives together and this was a first.”
Implications for Practice

Need for greater attention on mental health needs of older youth in CWS and MHS:

- Youth who were older at age of entry into the CWS were more likely to be referred to MHS and received more outpatient services than younger children.

- However, average of 1.47 years until MH services are received.

- And, children entering at younger age were more likely to complete treatment and more likely to have family stabilization as case outcome.
Implications for Practice

Efforts to improve collaboration between CWS and MHS may improve service access and effectiveness:

- Structured opportunities and infrastructure for collaboration
- Support from leadership
- Cross-training
Implications for Research

Future research:

- Assess impact of specific types of outpatient mental health services on outcomes
- Assess impact of specific collaborative practices on outcomes
- Examine mental health service utilization and outcomes for older youth (current CalSWEC study)
- Examine impact of Mental Health Services Act on collaboration between CWS and MHS (current CalSWEC study)
Discussion and Questions