THE MENTAL HEALTH NEEDS OF CHILDREN IN FOSTER CARE: A CASE OF BENIGN NEGLECT?

Summary of a Forum on the

Findings from a Cohort Study of Children in the Child Welfare System

A Presentation by John Landsverk, Ph.D.
and Comments from a Panel Discussion

April 11th, 1996
Cowles Auditorium, Hubert Humphrey Center
University of Minnesota, Minneapolis, Minnesota

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We also acknowledge support for this forum from the Bush/IV-E grant and the Center for Urban and Regional Affairs (CURA). Their contributions made it possible for a very large audience to attend, cost free.

The panel participants, Anne Damon, Assistance Commissioner, Children's Initiative, Minnesota Department of Human Services, Anne Gearity, MSW, LICSW, BDC, Brian Guidera, Division Manager of Children's and Family Services, Hennepin County, and Linda Nelson, Program Consultant, Children's Mental Health Services, Minnesota Department of Human Services, added an important dimension to the conference. We appreciate their time and interest.

Yvonne Pearson contributed her excellent editorial skills to provide us with proceedings of this event.

Esther Wattenberg, Director
Center for Advanced Studies in Child Welfare
July 1996

BACKGROUND REMARKS

While the conflicts around how to reform the child welfare system rise to the level of sharp policy debates, one position stands out with clarity: the number of children in foster care and the extent and complexity of the problems faced by them and their families require effective collaboration between the child welfare and mental health systems.

There is a growing recognition that child welfare and children's mental health share concerns around the same families and children drifting through these two systems, sometimes in simultaneous episodes and sometimes in independent episodes. Systematic collaboration is yet to be fully developed.

It is generally recognized that child welfare remains more or less detached from the services offered by mental health agencies. Yet, all along the pathways of a maltreated child, through the thicket of decisions about the permanency plan for that child, there is evidence of trauma from abuse and neglect, separation and grief.

Anecdotal evidence gathered from front-line workers in child welfare indicate that increasingly children in out-of-home care are more violent, destructive, or aggressive than in the past. Whether or not a child's behavior is assessed as "disturbed" or "delinquent" may determine where they end up -- in a child welfare or corrections system.

For a high proportion of children who come under the State's guardianship during their foster care placements, their mental health needs are not systematically assessed.

A comprehensive analysis of the mental health services used by children in foster care in Minnesota is not available, at this time. Other states have begun studies to discover the relationship between type of abuse and the link to mental health services, noting that sexual abuse absorbs the highest rate of referrals and neglected children the least, even though the cumulative effect of neglect is the most damaging to a child's psycho-social development. (See, Charles Glisson, *Judicial and Service Decision for Children Entering State Custody: The Limited Role of Mental Health*, Social Service Review, June 1996.)

It is, therefore, important that we have the opportunity to examine, in detail, the findings of one of the nation's most rigorous studies on the uses of mental health services of children in foster care.

This forum presents a fundamental question: Has sufficient attention been paid to the psychological needs of maltreated children?

Esther Wattenberg

EXECUTIVE SUMMARY

The interdisciplinary Center for Research on Child and Adolescent Mental Health Services[1] is studying a cohort of children in out-of-home placement in San Diego County to examine the children's need for and use of mental health services. The initial phase of the study included 1,221 children placed in out-of-home care between the months of May 1990 and October 1991. Out-of-home interviews were conducted with 78 percent of these children at about five to eight months and again at about 18 months. An intervening data point was also obtained for about half of the children. Of these children, 334 have subsequently been enrolled in a longitudinal study which is expected to continue until the children are 21 years of age.

The study looked at the variables of: age at which children entered foster care; race/ethnicity; type of alleged maltreatment; and type of placement. It used the Denver Developmental Screening Test to assess children aged 0 to six regarding whether they should be referred for further assessment for developmental problems. The Vineland Adaptive Behavioral Scales was used to assess socialization, activities of daily living, and motor skills. The Achenbach Child Behavior Checklist was the major measure of behavior problems. Use of mental health services was measured by parent report. Finally, type of maltreatment and other variables were taken from the case record.

The child welfare system is a gateway into the mental health system. Children's chances of getting mental health services were increased enormously when they were removed from home [Slide 12].

The study found that children in foster care exhibit significant developmental and mental health problems, and there are high rates of mental health service use among children in foster care. Moreover, clinical factors (defined as behavior problems) do predict service use, although service use does not vary by type of behavior problem. However, there are also significant non-clinical factors that predict whether children get help. Children who are sexually and physically abused appear to be presumed to have a greater need for mental health services than children who come in with an allegation of neglect. In addition, minority status appears to play a role both in coming into the foster care system and in receiving mental health services. While type of maltreatment does not predict very well the level of need for mental health services, it does predict the receipt of services, with sexual or physical abuse receiving more attention than neglect. Similarly, race/ethnicity does not predict need for services, but does predict receipt of services, with Caucasians receiving more attention than African Americans or Hispanics. The need for

services appears to be essentially the same among three racial/ethnic groups (Anglo, African American and Hispanic).

Of interest is the finding that children were not more likely to drop out of services after they were reunified with their families.

The study also found that using services is associated with positive change over time in children who are in foster care. Those children who were continuously in treatment show the greatest gain in terms of dropping out of the borderline range on the Child Behavior Checklist. However, preliminary results show that the group of children coming in for reasons of neglect are not doing well between the times of the first and last interviews.

Among children over the age of two, most saw clinical psychologists. The use of clinical psychology was attributed to Medicaid reimbursement regulations.

There is clearly a need for systematic screening of children entering foster care across a range of domains, including developmental, behavioral, and social. This is particularly true in the developmental arena. There is also a need for systematic monitoring of problem levels, over time, of children who remain in foster care, and a need to efficiently monitor developmental, behavioral, social and adaptive functioning outcomes for children in foster care who are receiving services.

Guidelines should be used to systematically link children with appropriate services, and greater flexibility and creativity in treatment choices for children in foster care should be considered.

Finally, an equal amount of attention needs to be paid to the functioning and needs of children, either when they are under the custody and care of the child welfare system, or with their families in a family preservation or reunification arrangement. Emphasis is needed on the well-being of children and the ameliorative services that are provided to them. At the same time, aggressive pursuit of reunification back into a family that has been healed enough to receive a child and help it grow up in a protective environment should not be dismissed.

A Note from the Panel Discussion

Anne Gearity said, "The developmental needs of children in foster care are enormous [and] the system inadvertently creates further neglect or trauma. ... The genuine developmental needs of children often get neglected for the sake of the particular focus on the crisis of placement, and then as the crisis of placement gets resolved or continued, the children stay poor in their own developmental functions."

INTRODUCTION

The interdisciplinary Center for Research on Child and Adolescent Mental Health Services began a study six years ago of a cohort of children in out-of-home placement. The study was designed to examine the children's need for mental health services, whether they received the services, and the factors that predicted receipt of services. The Center, one of two in the country funded by the National Institute of Mental Health (NIMH), focuses on collaboration between academic researchers and public agency policy-makers, managers, and front-line workers.

The study is taking place in San Diego County, the second largest county in California. It contains San Diego City, the sixth largest city in the country. Thus, the county is very urban and has all of the problems that are attendant on urban life in the contemporary United States. At the same time, the fact that it is geographically bounded by Mexico, the Pacific Ocean, the desert, and Camp Pendleton establishes the environmental complexity of San Diego County.

In San Diego County, as in other counties across the United States, there are a number of components to the systems of care which serve children. It is important to understand the child welfare system, which is one of these components, in the context of these other systems. The other systems attend to education, general health, juvenile justice, mental health, education for severely emotionally disturbed (S.E.D.) children, and services for substance abuse. The systems of care must also be viewed from a developmental perspective, keeping in mind the age at which children enter the various systems.

The education and general health systems tend to offer primary care, that is, preventive services, and deal with a broad population without regard to risk. Children in these systems are as a whole at low risk for mental health problems. They generally enter the general health system as pre-schoolers and the education system at five years of age, and are equally divided between males and females.

The child welfare and juvenile justice systems both offer secondary services, in which a target population has been identified as being at high risk for developing mental disorders and social and emotional problems. They enter the child welfare system because of substantiated maltreatment, most often before they are school-age, and are equally divided between males and females. Children enter the juvenile justice system for status offenses and other legal issues, most often during adolescence, and males outnumber

females.

The mental health systems, the specialized mental health segment of education for SED children, and the substance abuse systems give tertiary care, that is, care to children who have already been identified as having developed mental health or sociopsychological problems. The children receiving care in these systems are most often male, and, in the substance abuse system, most often enter as adolescents. Children probably enter the mental health systems near the end of their middle school years. [slides 1 and 2 combined; Slide 3]

Although there is little data available, it is believed that most of the children coming into the juvenile justice system during their adolescent years come from families that interface one way or another with the child welfare system. A state study done of San Diego which looked at open cases in the juvenile justice system found that 71 percent of the children came from families that had been known to child welfare at an earlier point in time.

THE STUDY

Subjects

The initial phase of the Foster Care Mental Health (FCMH) Project studied 1,221 children in long term out-of-home placement. These children entered foster care through the Hillcrest Receiving Home, where most children who enter the child welfare system in San Diego are first taken. Only a small proportion of children entering the child welfare system remain in long term foster care. Three out of four return home very early.

During the eighteen months between May 1990 and October 1991, 4,650 children entered Hillcrest and were removed from home for at least three days. Cases were opened on about 59 percent (2,755) of those children. Of the original 4,650 children, 29 percent, or 1,352 children were dispositioned to out-of-home care. At five months, this number had decreased to about 26 percent, or 1,221 children.

The FCMH project conducted a first out-of-home interview with 78 percent of these children in long-term placement at about five to eight months. Project staff followed these children over time and conducted a last out-of-home interview around the eighteenth month. For about half of the children they also got an intervening data point. Of these children, 334 have subsequently been enrolled in a longitudinal study funded by the National Center on Child Abuse and Neglect which is expected to continue until the children are 21 years of age. [slide 4]

Variables

The study looked at the variables of:

- Age at which children entered foster care. About 55 percent of the children in the study cohort entered foster care before school age. [slide 5]
- Race/ethnicity. Of children entering the cohort, 45 percent were Caucasian, which is about ten percent below the proportion of Caucasians in San Diego according to the 1990 census. Hispanics constituted 19 percent, or roughly equivalent to their percentage in the population at large. Asian Americans constituted about four percent, or half of their proportion in the population. African Americans constituted about 32 percent of the cohort, despite the fact that only about six to seven percent of San Diego County's population is African American. This over-represented of five to six times is typical in the child welfare system across the country. [slide 6][2]
- Type of alleged maltreatment. Neglect and caretaker absence constituted the

type of alleged maltreatment for over half of the subjects, physical abuse about 20 percent, sexual abuse about 11 percent, and multiple and protective issues about 14 percent. [slide 7]

- Type of placement. Two out of three children were in a licensed foster care placement at the time of the first interview (five to eight months). One-third of the children were with relatives. Half of those were with a grandmother, and forty percent were with the mother's sister. [slide 8]

Measures

The study tried to use measures of need for mental health services that could be used by any general health sector or child welfare department. It used the Denver Developmental Screening Test to assess children aged 0 to six regarding whether they should be referred for further assessment for developmental problems. The Vineland Adaptive Behavioral Scales was used to assess socialization, activities of daily living, and motor skills. The Achenbach Child Behavior Checklist was the major measure of behavior problems. Use of mental health services was measured by parent report. Finally, type of maltreatment and other variables were taken from the case record.

FINDINGS

Factors Affecting Out-of-Home Placement

Race/ethnicity had an enormous influence on placement. The estimates of race/ethnicity were calculated after controlling in a logistic regression for age, gender, and reason for referral. Although about 51.6 percent of the population was Caucasian according to the 1990 census, only about 39.5 percent of the children removed from home were Caucasian, dropping to 39.1 percent actually placed out of home. Hispanics represent 28.9 percent of the population, but represent only 20.4 percent of children placed out of home. Asian-American children represent only 4.6 percent of out-of-home placement even though they represent 11 percent of the population. African Americans represent only 8.5 percent of the population but 28.1 percent of the children who are reported and removed and 31.9 percent of the cohort that is placed out of home.[3]

Factors Affecting Reunification With Biological Parents

Reunification from kinship care and foster care appear to be very different processes. At eighteen months, 36.8 percent of children had been reunified from foster care, and 31.6 percent had been reunified from kinship care. Factors affecting reunification were as follows:

- The older children were less likely to be reunified.
- If children came into the system with two parents, they were three times more likely to be reunified than if they did not come in with two parents.
- If children came in with nonbiological parents, they were four times less likely to be reunified.
- Children coming from single, female head-of-household families were clearly much less likely to be reunified.
- Sexually and emotionally abused children were more likely to be reunified than children who came in for reasons of neglect. [slide 9]
- Children with socioemotional problems were significantly less likely to participate in family reunification. Children with mental or emotional problems severe enough to warrant a DSM (Diagnostic Statistical Manual) diagnosis or some other indicator of severity were one-half as likely to be reunified. Children at the clinical cut point on externalizing problems, aggression, or delinquency as measured on the Achenbach Child Behavior Checklist were only

one-half as likely to be reunified.

- Developmental problems, physical handicap problems, and acute physical problems showed no impact on reunification.

Use of Mental Health Services

Need for Services. Although an extremely high proportion of the cohort, two out of three children, scored in the problematic range on the Denver Developmental Screening Test, study data suggests that only about two percent of these children are being further assessed for developmental problems. Thus, developmental problems are being largely missed in this cohort of children entering the foster care system. Most of the children showing need for assessment and potential intervention on developmental problems were children under the age of six. [slide 10]

One out of two children who were in the age range between two and seventeen showed behavior problems in the problematic range, that is, problems severe enough that they look worse than 95 percent of a community sample.

Sixty percent of the six to seventeen-year-olds showed problems in social competency.

The need for services appears to be the essentially the same among three major racial/ethnic groups (Anglo, African American, and Hispanic). [slide 11] This echoes findings of three earlier studies in the socioeconomically and racially diverse counties of San Diego, Santa Cruz, and Monterey.

Children who end up in kinship placement consistently look better, at a statistically significant level, across all measurements of psychosocial functioning than do children who end up in licensed foster care. This does not necessarily indicate that children in kinship care are less traumatized; children who are selected into kinship care may be more likely to be less troubled, even though they do show evidence of being troubled.

Type of maltreatment does not seem to predict level of need for mental health services.

Receipt of Services. The child welfare system is a gateway into the mental health system. A very large proportion of children received mental health services. One out of five children between the ages of two and three were receiving mental health services, and one out of two between the ages of four and five were receiving services. By the age of eight, seventy to eighty percent of children were receiving mental health services. Children's chances of getting mental health services were increased enormously when they were removed from home. [slide 12]

Types of Providers Most Often Used. Among children over the age of two, most saw clinical psychologists (about sixty percent of the cases). Psychologists were being used mostly because of Medicaid reimbursement regulations. Most of the children were seen for individual 50-minute, once-a-week therapy sessions. Younger children were seen frequently in play therapy. The average number of visits over six months was sixteen. Only about ten percent had four visits or fewer. Thus, when services were initiated, children received them pretty continuously. [slide 13]

Factors Predicting Receipt of Services. A logistic regression analysis was used to examine which factors predict receipt of mental health services. The findings were as follows:

- Reason for referral. This was a powerful predictor. Children coming into the system because of physical or sexual abuse were very likely to get services. Children entering the system because of neglect or caretaker absence were significantly less likely to get mental health services. This factor also predicts how much services children receive. Children coming in because of sexual abuse receive 18.8 visits over six months. Children who come in because of neglect or caretaker absence receive only 13.4 visits over six months. Moreover, regardless of the presence of behavior problems, children who have been sexually abused receive mental health services. In contrast, children coming in because of neglect or caretaker absences must show significant behavior problems before they get referred for mental health services. Two out of three of these children who score above the clinical cut-point on the Behavior Checklist receive services, but only one out of three who scores below the cut-point gets services. [slide 14]

Comment

Maltreatment as a type does not seem to predict very well the level of need for mental health services, although it may be that children selected into the foster care system have been so severely maltreated that they are at the same level of problems regardless of type of maltreatment. Nevertheless, children who have been sexually or physically abused are more apt to receive mental health services than are children who have been neglected. There appears to be an assumption that children who come in for reasons of neglect may not need active, positive, ameliorative services, an assumption in a sense that they can heal themselves simply by being in a more rich, enhanced, non-neglectful environment. One could say that neglected children are again neglected.

- Race/Ethnicity. First, Caucasian children were much more likely to get services than were Latino or African American children. While 65 percent of Caucasian children were receiving mental health services, less than fifty percent of African American and Hispanic children were receiving services. [slide 15] Second, once they got into treatment, Caucasian children were likely to get more services than other groups. [slide 16] Third, Caucasian children who were below the cut-point on the Behavior Checklist were more apt to receive services than African-Americans who scored below the cut-point. Of Caucasian children scoring in the lower one-third of behavior problems, 68 percent were receiving services, while only 46 percent of Hispanic children and 33 percent of African American children in that category were receiving services. [slide 17]

Comment

This study has not been able to detect any significant difference in problems between three major racial/ethnic groups. The Caucasian children, the African-American children, and the Hispanic children look on average the same. Possible explanations for the fact that Caucasian children are more apt to receive services are: gatekeepers are more likely to refer Caucasian children; parents of Caucasian children are more likely to perceive mental health services as important; parents of minority children are more likely to perceive services as inaccessible or inappropriate; or service providers are more likely to service Caucasian families.

- Behavior Problems. Children with a greater need for services as determined by the Achenbach Child Behavior Checklist were more likely to get services; that is, children who were above the borderline cut-point on the Checklist were more likely to receive services. However, there was no difference associated with externalizing and internalizing problems. At the same time, there were many children receiving services who scored below the cut-off point on the Checklist. Thus services were broadly provided rather than specifically linked to problem behaviors. [slide 18]
- Age. Older children were more likely to receive services.
- Gender. There were no significant gender effects. [slides 19, 20]

Service Provision Over Time. Between the first and last interviews, about one-third of children over the age of two received no services. About 36 percent were receiving services at both points in time. In general, there is a lot of

continuity over time. [slide 21] Service provision over time was also examined after reunification, both for children placed with kin and those in foster homes. Children were not more likely to drop out of services after they were reunified with their families.

Summary of Findings

Children in foster care exhibit significant developmental and mental health problems, and there are high rates of mental health service use among children in foster care. Thus foster care is a gateway to mental health services. Moreover, clinical factors (defined as behavior problems) do predict service use, although service use does not vary by type of problem. However, there are also significant non-clinical factors that predict whether children get help. Children who are sexually and physically abused appear to be presumed to have a greater need for mental health services than children who come in with an allegation of neglect. In addition, minority status appears to play a role both in coming into the foster care system and in receiving mental health services.

The study also found that using services is associated with positive change over time in children who are in foster care. Those children who were continuously in treatment show the greatest gain in terms of dropping out of the borderline range on the Child Behavior Checklist. However, preliminary results show that the group of children coming in for reasons of neglect are not doing well between the times of the first and last interviews. [slide 23]

POLICY AND SERVICE DELIVERY IMPLICATIONS

First, there is clearly a need for systematic screening of children entering foster care across a range of domains, including developmental, behavioral, and social. This is particularly true in the developmental arena. San Diego County provided very little systematic assessment and referral for developmental problems. If you consider that 55 percent of children enter foster care prior to entering school, you wonder what it means for school readiness if developmental problems are not assessed and addressed. In San Diego, the Center has been running studies at a new receiving home, the Polinsky Center. Three well-trained pediatricians are not detecting developmental problems. It appears that five or ten minutes is not sufficient to detect behavioral problems. They brought in a masters level developmental specialist who said she needs 45 minutes to an hour to assess for developmental problems in most cases. Thus the health care delivery system that should be assessing for developmental problems is not doing this task well. The pediatricians in San Diego County do not use any standardized measure of developmental assessment.

Second, there is a need for systematic monitoring of problem levels over time of children who remain in foster care. While many children in San Diego County were getting mental health services, there was virtually no objective independent monitoring of these children that would tell whether services are doing well for them.

Third, there is a need to efficiently monitor developmental, behavioral, social and adaptive functioning outcomes for children in foster care who are receiving services. This is particularly true as we move into a managed care environment.

Fourth, there is a need for guidelines to be used in systematically linking children who show need with appropriate services.

Fifth, there is a need to consider greater flexibility and creativity in treatment choices for children in foster care. Most mental health services in San Diego County were in the form of single, weekly visits. There was virtually no use of groups and little creative, customized mental health services delivery for children.

Sixth, there is a need to discuss the impact of nonclinical factors on service use in terms of access to services, acceptability of services, and perception of need for services by "gate-keepers." The type of maltreatment or race/ethnicity should probably not show any impact on the use of services.

Finally, the major emphasis in child welfare planning for most part over the last decade has been upon family preservation and reunification. An equal amount of attention

needs to be paid to functioning and needs of children when they are under the custody and care of the child welfare system. This means a much better integration with mental health services, health services, and particularly, developmental services. The notion has roughly been that we need to lower risk for maltreatment, get children back to families as quickly as possible, and they'll do OK in the long run. The data from this study regarding problems in psychosocial functioning indicates that much more aggressive intervention needs to be mounted with these children whether they are reunified with parents, remain in long term foster care, or are adopted. There is real healing that needs to go on. We need emphasis on the well being of the children and the ameliorative services that are provided to them, while at the same time aggressively pursuing reunification back into a family that's been healed enough to receive a child and help it grow up in a protective environment. [slide 24]

SUMMARY OF PANEL AND AUDIENCE RESPONSES TO PRESENTATION

A panel of experts, as well as audience members, responded to Landsverk's comments and recommendations. The following is a summary of these comments.

Training and Collaboration

Byron Egeland, a professor at the University of Minnesota's Institute of Child Development, suggested that not only children who enter the foster care system should be better screened, but so too should there be better screening and training for foster care workers. Children going into the foster care system have pretty serious problems, and in many instances foster care workers don't know what they're getting in for or how to deal with children who have these kinds of problems.

Anne Gearity, a clinical social worker in independent practice, added that all the community players need to be educated in the mental health needs of children in foster care. This includes the school players, the child welfare players, the mental health players and the physical health players. "There needs to be genuine collaboration, where all the community players see themselves as part of the replicated family...We need to construct a family without walls essentially, and to have all players...have an understanding that is not competing or contradictory."

Anne Damon, assistant commissioner in the Minnesota Department of Human Services, noted that training of workers is a very important role that the state can play. She said, the "state has an important role in policy setting, training, and technical assistance to workers."

Damon also spoke of the need to improve the link between children's mental health services and child welfare, saying that services need to be provided on a more consistent basis. Minnesota has made a commitment to collaborative models and at some point needs to "decide if it's going to be a project or if it's going to be system reform. If it's going to be system reform, then life is going to look a lot different ten years from now, and I think it needs to."

Linda Nelson, program consultant in the Children's Mental health Services, Minnesota Department of Human Services, described the collaborative efforts, noting the 1989 Children's Comprehensive Mental Health Act, which provides for coordination of services at the levels of state, county, and individual children and families and mandates

services. She discussed the Children's Mental Health Collaborative legislation, a massive endeavor to bring schools, private providers, the juvenile justice system, county social work, and public health systems together to create a system at the county level that is more efficient and serves more people. There are currently fifteen approved collaboratives serving 24 counties in the state.

Damon also announced that therapeutic support for foster care, defined as individual, group, family and multifamily therapy as well as skill building, is one of the mandated services in each county and that the service will become reimbursable by medical assistance as of July 1.

Treatment of Neglect

Egeland believes there is a "gross under-reporting of neglect," and that in his experience neglected children, particularly girls, do not have acting out problems, but rather internalizing problems. These don't come to people's attention until many years later. Thus the nature of the problems that neglected children have may be one reason why they don't get served. "Unfortunately I think neglected kids are still neglected."

Landsverk noted that there is "an enormous fascination in this country on the part of academic clinicians about sexual abuse, its consequences and its treatment, but there is no particular fascination about the mental health treatment of children from neglectful families." The attention to treating sexual abuse is disproportionate to the kinds of problems children have who are coming into the child welfare system. Neglect is the major reason for referral, while sexual abuse is a much smaller proportion, probably about ten to fifteen percent.

Gearity said, "I was very interested in John's reporting that physical and sexual abuse are what get attended to when we know that neglect is actually evidence of the failure of attachment input in that the neglect family isn't doing their job." She noted that treating neglect is really a developmental treatment, since neglect often "looks like developmental delays." However, managed care, since it pays only for a return to pre-morbid functioning, has been very unfriendly to developmental case plans. "It's really a policy issue, that as a community we have to be very alert to. That model does not address developmental fixations, which again is neglect, so there's very little way for mental health to know how to treat it." Moreover, she noted, "The developmental needs of children in foster care are enormous [and] the system inadvertently creates further neglect or trauma. ...The genuine developmental needs of children often get neglected for the sake of the particular focus on the crisis of placement, and then as the crisis of placement gets resolved or continued, the children stay poor in their own developmental functions."

Diversity

An audience member raised a concern regarding how cultural values affect assessment, as well as the need for mental health services to be looked at in a variety of ways, including traditional ways of healing within different cultural contexts that families can identify with.

Brian Guidera, a division manager in Hennepin County's Children's and Family Services Department, noted that the County has a number of competing issues with which to struggle. Even though Hennepin County is a resource rich community, does business with a large number of agencies, and spends substantial money on services, if they are to make collaborative relationships work they are going to have to draw on more people than they have drawn on in the past. He emphasized the need to draw on more people of color, and to build more structured interactions with a variety of both professional and non-professional people. He also emphasized the need to be clear on the outcomes they want to achieve for children and families.

Guidera said that Native-American children represent about 14 percent of Hennepin County's foster care children and many are being served by agencies that work primarily with Native Americans.

Landsverk believes there may be access issues for people of color and he questioned whether there are enough clinicians of color in San Diego to respond within the system. He also noted that parents from different cultural backgrounds may view the provision of mental health services differently.

NOTES

1. Staff at the Center for Research on Child and Adolescent Mental Health Services are: David Chadwick, M.D., Center for Child Protection, Children's Hospital; Shirley Culver, M.S.W., Sand Diego County Child & Adolescent Mental Health Services; Inger Davis, Ph.D., School of Social Work, San Diego State University; Ann Garland, Ph.D., Department of Psychiatry, University of California, San Diego; Richard Hough, Ph.D., Sociology, San Diego State University; Ivory Johnson, M.S.W., San Diego County, Children's Services Bureau; John Landsverk, Ph.D., Center for Child Protection, CHHC and School of Social Work, SDSU; Allen Litrownik, Ph.D., Psychology, San Diego State University; Rae Newton, Ph.D., Sociology, California State University - Fullerton; Joseph Price, Ph.D., Psychology, San Diego State University. Much of their work takes place at the Children's Hospital, the University of California at San Diego and San Diego State University. In addition, much of the study's data collection was done with the collaboration of San Diego County, particularly the Department of Health Services, Social Services, and Mental Health Services. The primary funding sources are the National Institute of Mental Health and the National Center on Child Abuse and Neglect.

2. Native American children in San Diego County are automatically referred to Native American social service agencies, both for family reunification services and for adoption services. Thus they are not included in this study.

3. These statistics on race/ethnicity differ from the earlier statistics because some of the group home children have been taken out of the calculations.

SLIDE 1

TYPOLOGY FOR CHILD AND ADOLESCENT SYSTEMS OF CARE

LEVEL	SYSTEM	REASON FOR ENTRY	RISK FOR MH PROBLEMS
Primary	General Health Education	Phys. Health Care Education	Low
Secondary	Child Welfare Juvenile Justice	Maltreatment Legal	High High
Tertiary	Mental Health Education S.E.D. Substance Abuse	MH Treatment MH Treatment SA Treatment	Identified Identified Identified

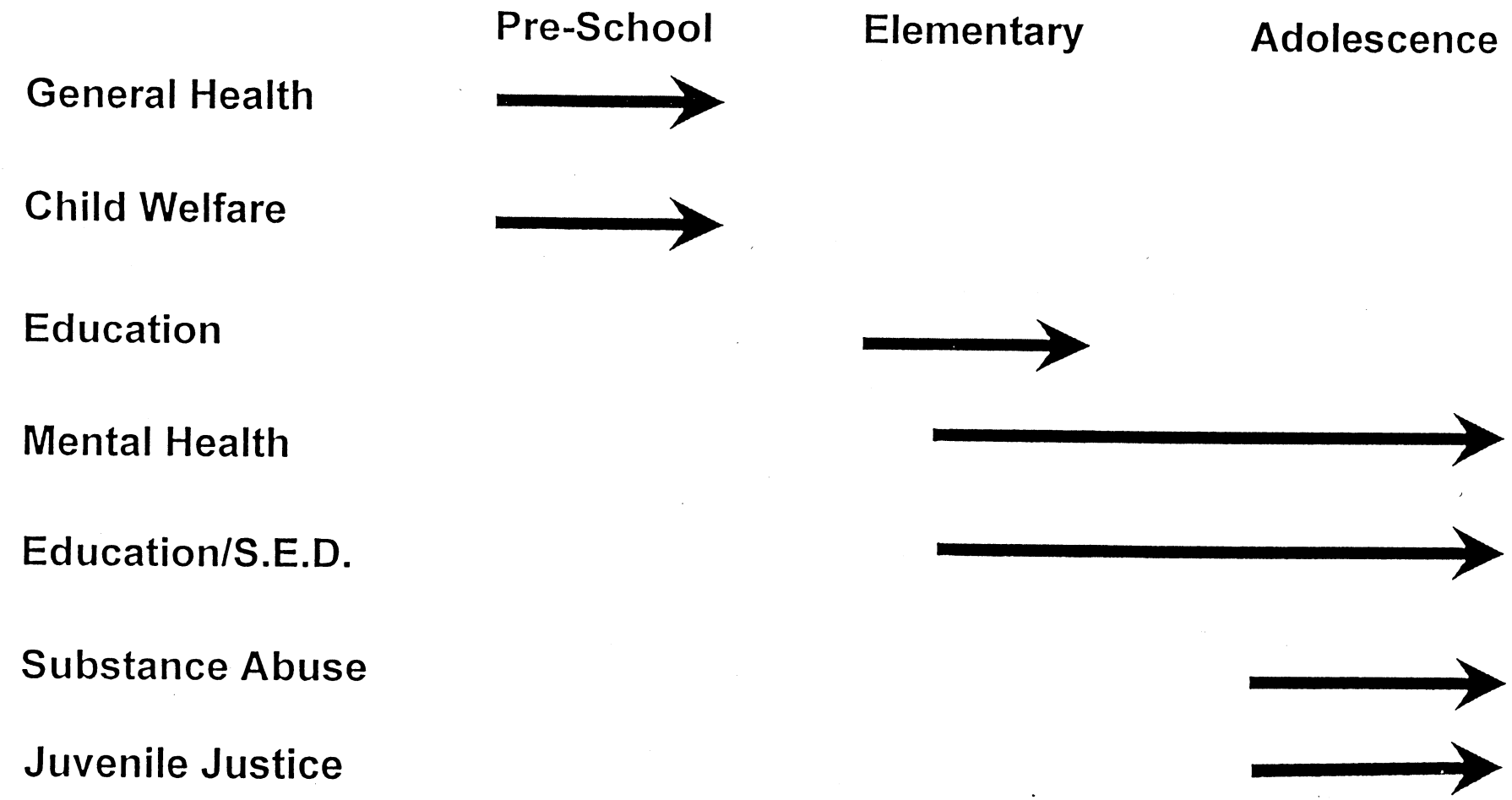
SLIDE 2

TYPOLOGY FOR CHILD AND ADOLESCENT SYSTEMS OF CARE

LEVEL	SYSTEM	MODAL AGE FOR ENTRY	MODAL GENDER
Primary	General Health Education	Young (Pre-school) Five years	M = F M = F
Secondary	Child Welfare Juvenile Justice	Young (Pre-school) Adolescence	M = F M > F
Tertiary	Mental Health Education S.E.D. Substance Abuse	? ? Adolescence	M > F M > F M > F

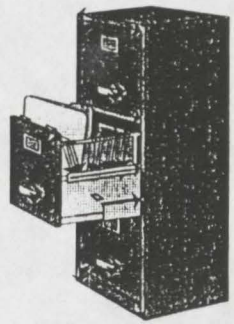
SLIDE 3

Development and Entry into Child and Adolescent Systems of Care



FOSTER CARE MENTAL HEALTH PROJECT/ LONGITUDINAL STUDIES PROJECT DESIGN

Through the doors of Hillcrest
Receiving Home 5/90 through 10/91
(N = 4,650)

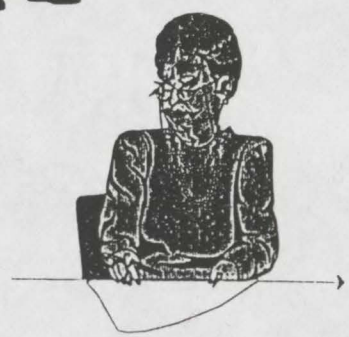


Case Opened
(N = 2,755, 59%)

Dispositioned to
Out of Home Care
(N = 1,352, 29%)

In Out-of-Home
Care
at Five Months
(N=1,221, 26%)

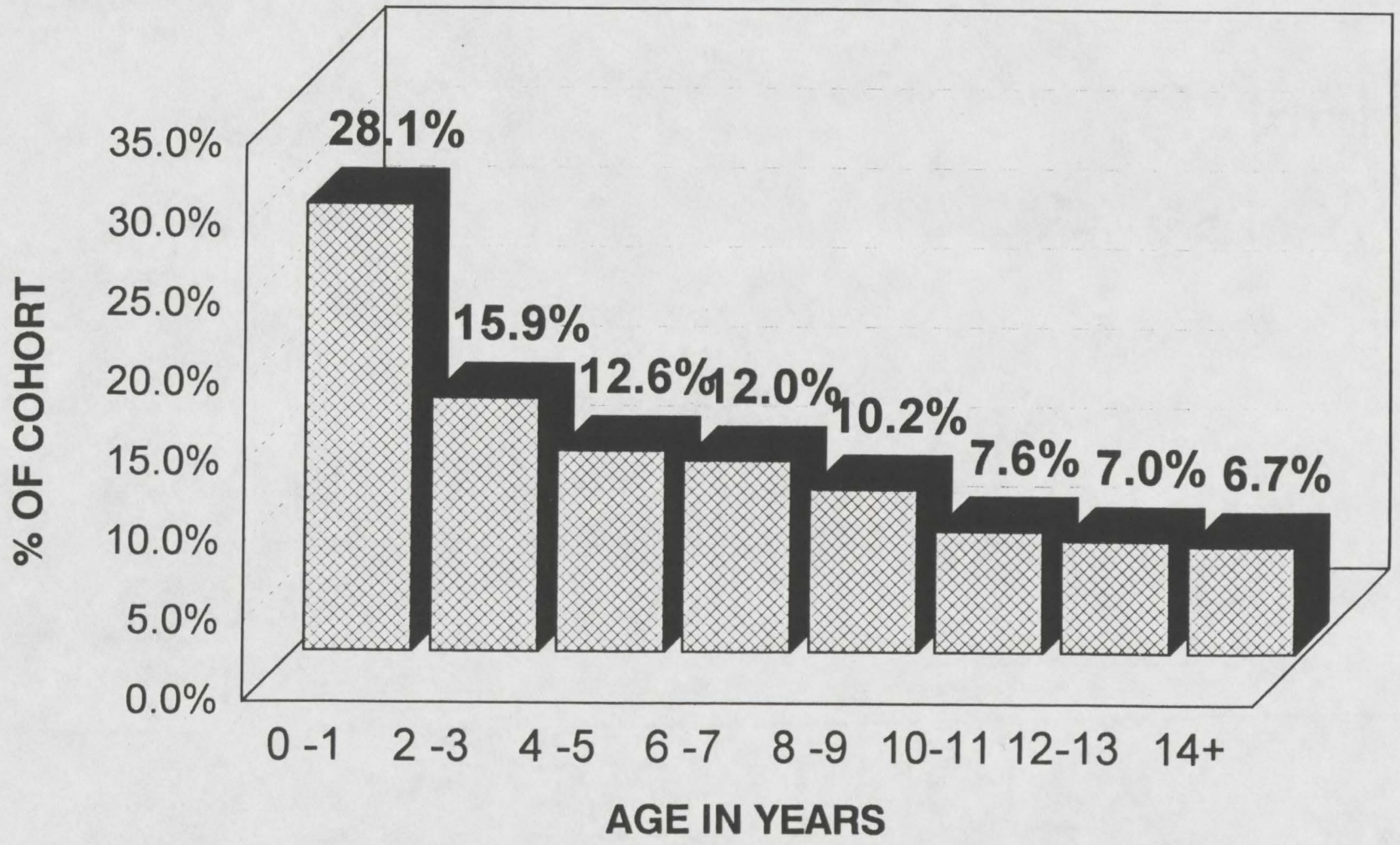
First Out of Home Interview
(N=947 or 78%)



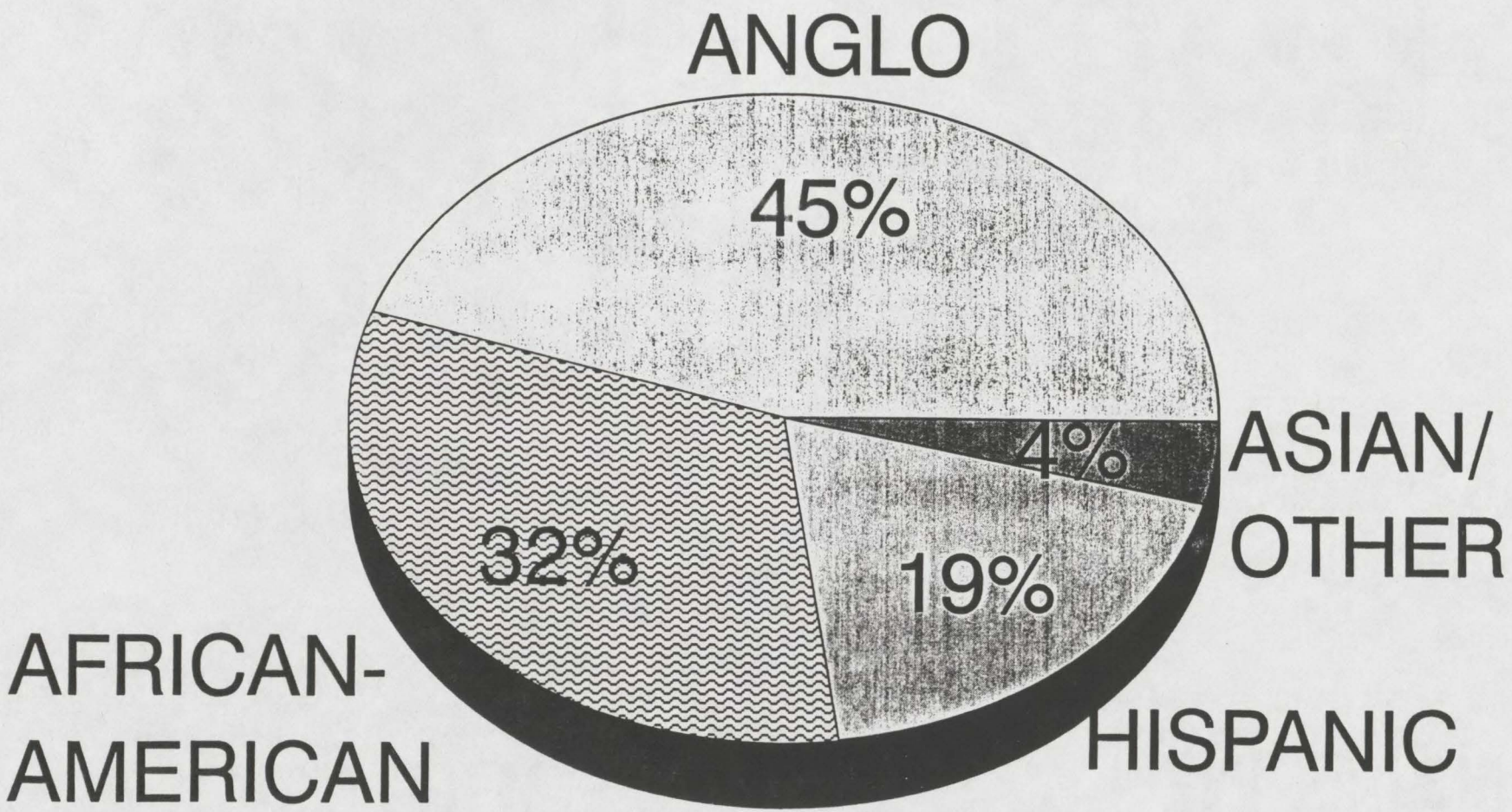
Second Interview
(N = 749, 79%)

SLIDE 5

FCMH COHORT
AGE DISTRIBUTION AT SYSTEM ENTRY

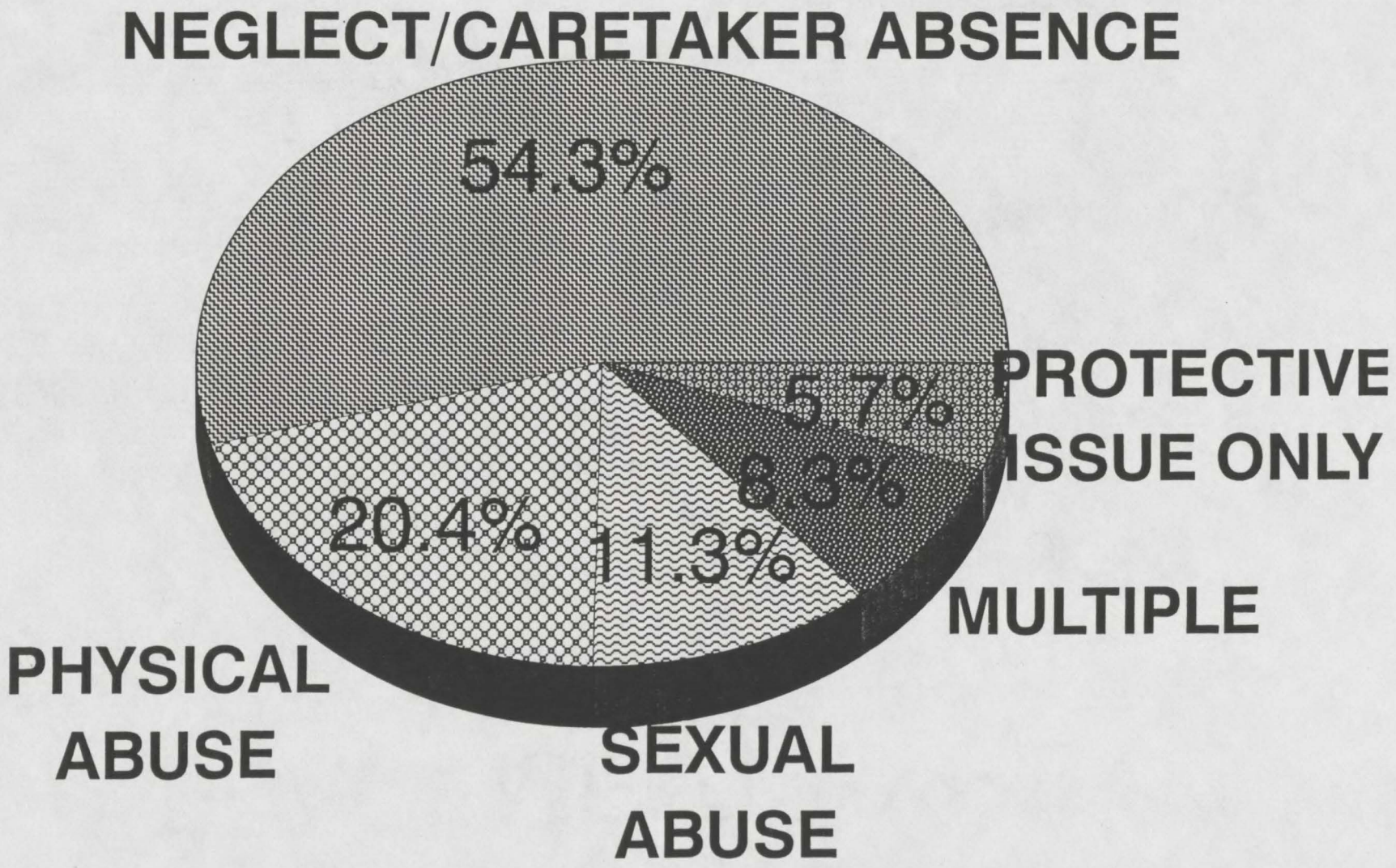


RACE/ETHNICITY

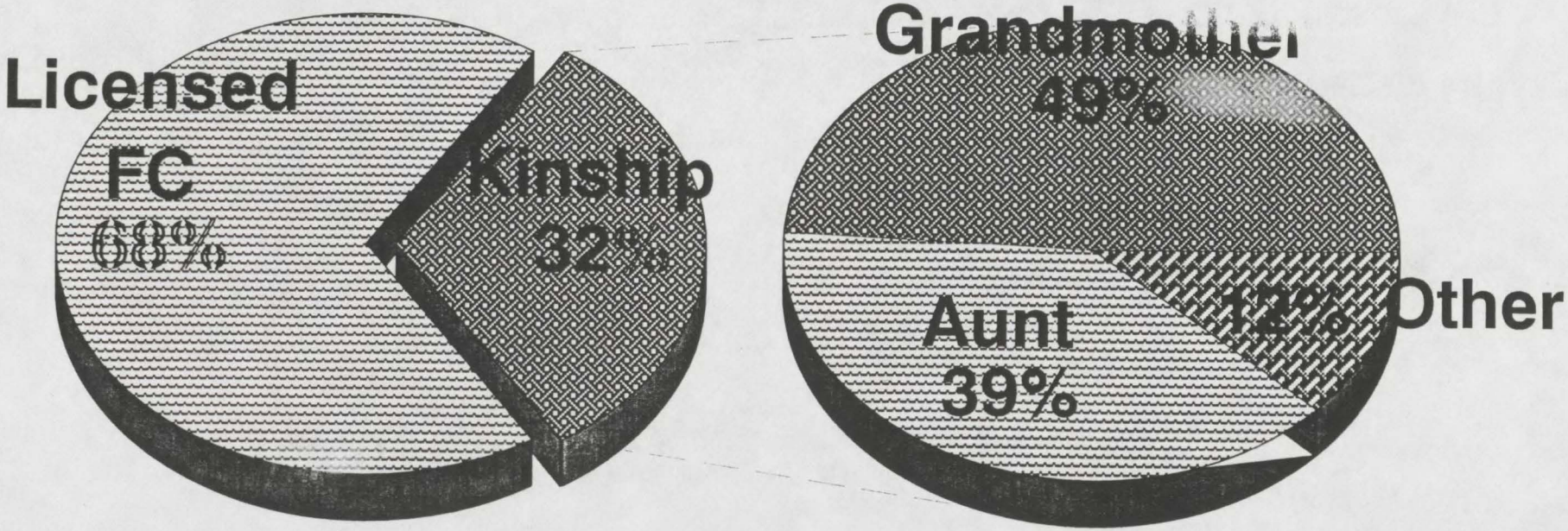


SLIDE 7

TYPE OF MALTREATMENT

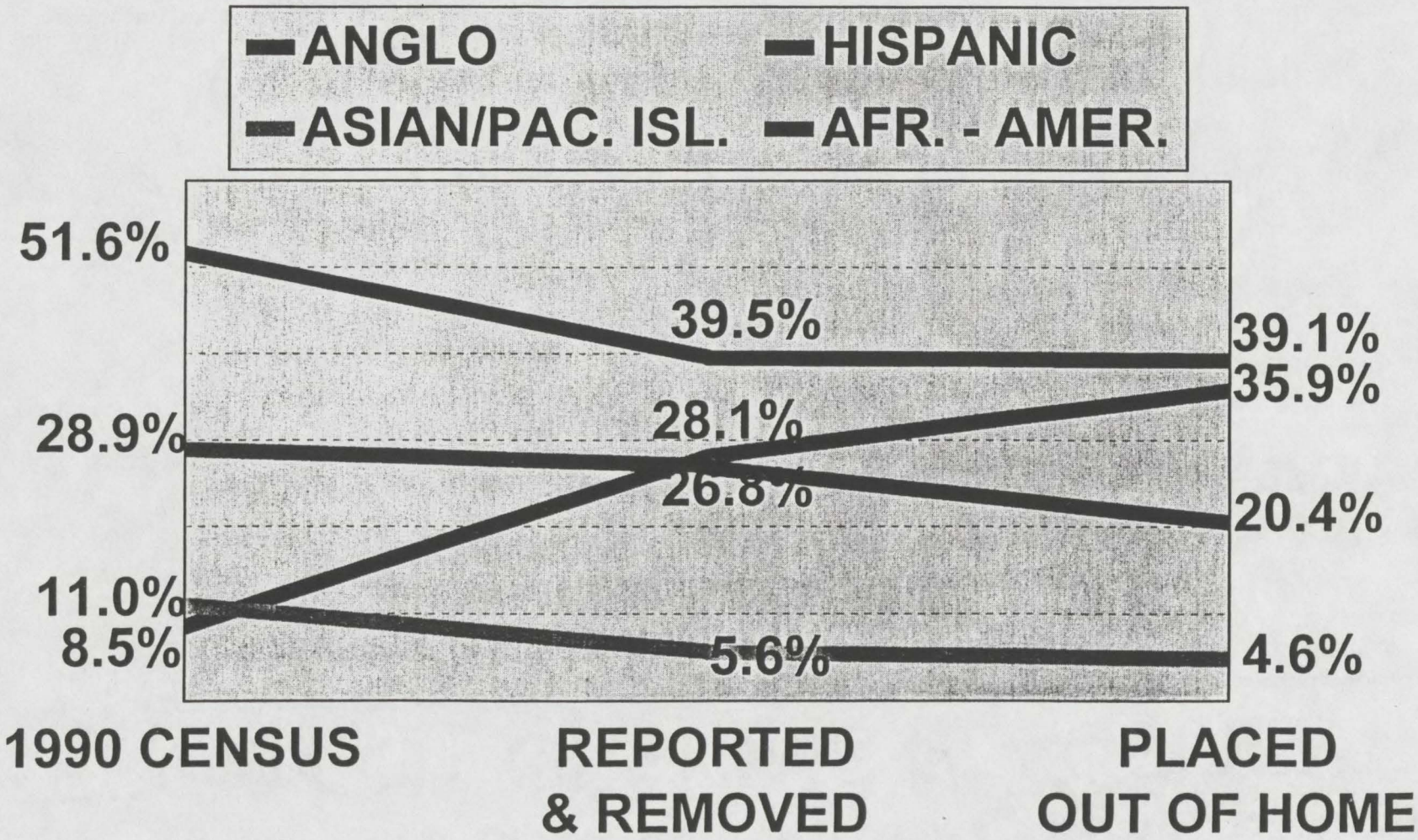


PLACEMENT TYPE



SLIDE 9

PATHWAYS INTO FOSTER CARE



PATHWAYS TO REUNIFICATION FROM OUT OF HOME PLACEMENT

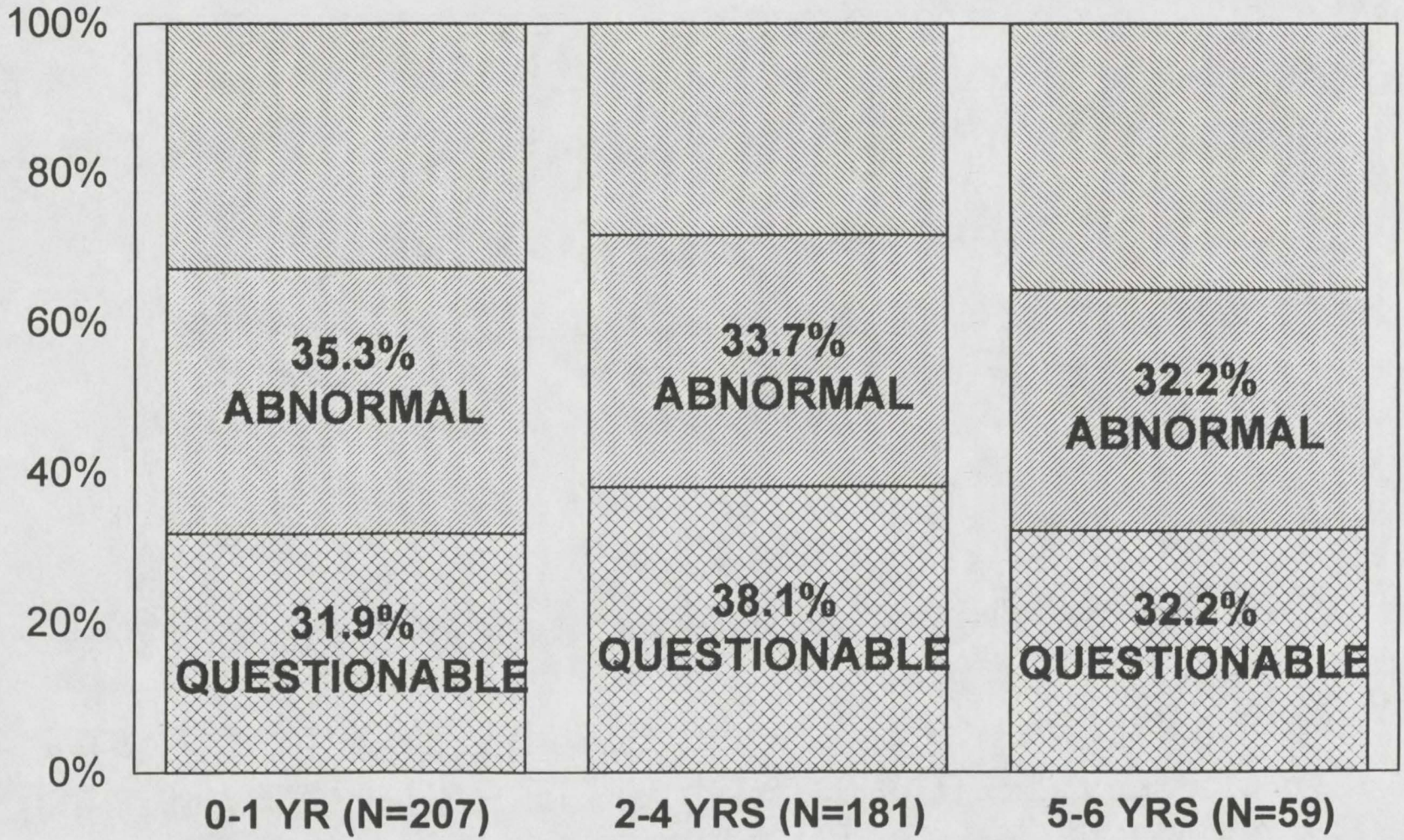
- 36.8% reunified from **Foster Care**
- 31.6% reunified from **Kinship Care**

- **Predictors of Reunification from Foster Care (N = 372)**
  - Age (years) (OR=.93)
  - Two parents at entry (OR=3.11)
  - Non-biological parents at entry (OR=.27)
  - Sexual Abuse (OR =2.90)
  - Emotional Abuse (OR=2.45)
  - Emotional/Behavior Problems (Case File) (OR=.49)
  - Externalizing Problems (CBCL) (OR=.48)

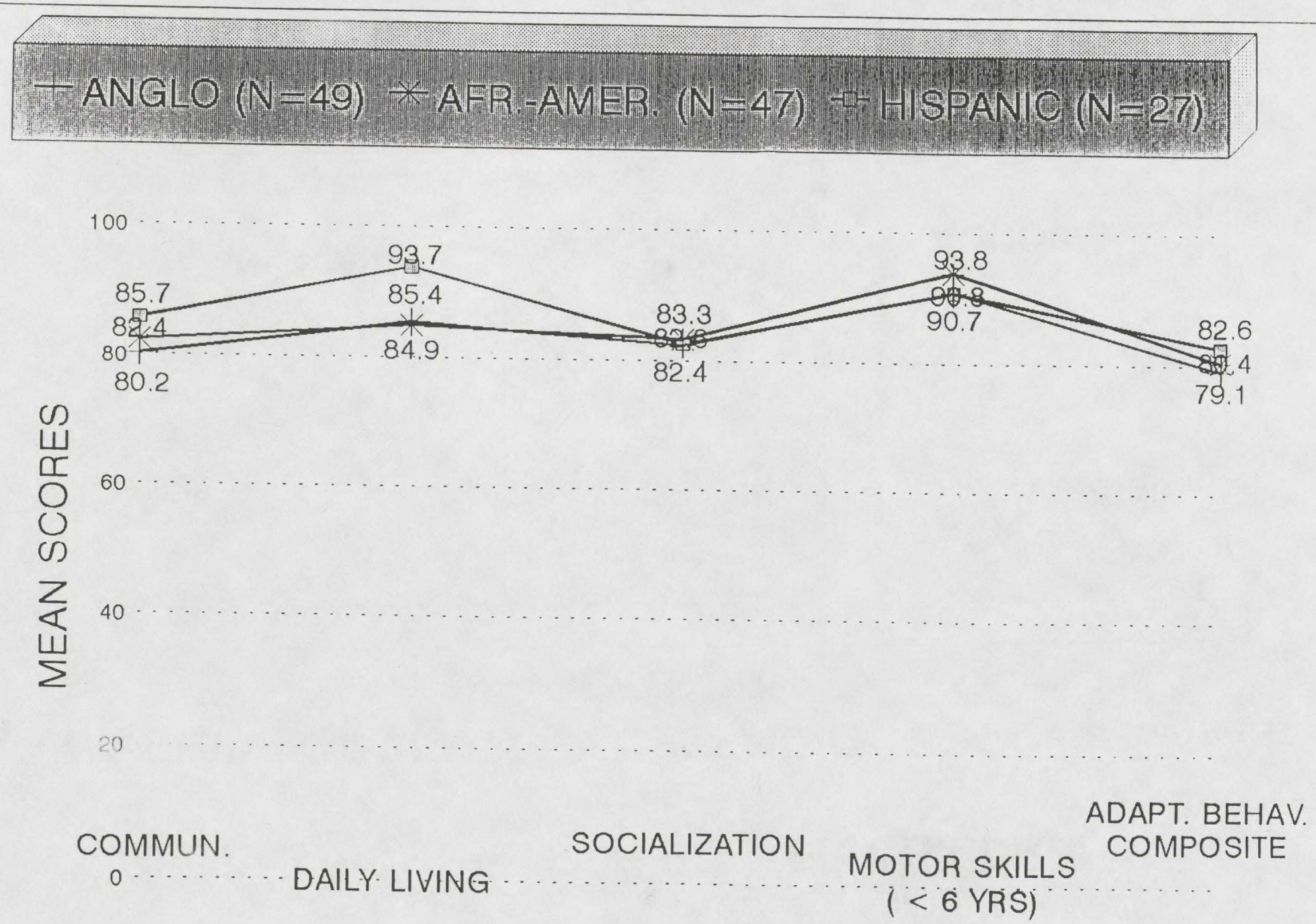
- **Predictors of Reunification from Kinship Care (N=297)**
  - Caretaker Absence (OR=.43)
  - Emotional Abuse (OR=2.66)
  - Emotional/Behavior Problems (Case File) (OR=.51)

SLIDE 10

GLOBAL SCORES FOR FOSTER CHILDREN ON THE DENVER DEVELOPMENTAL SCREENING TEST - II (Revised) BY AGE GROUP

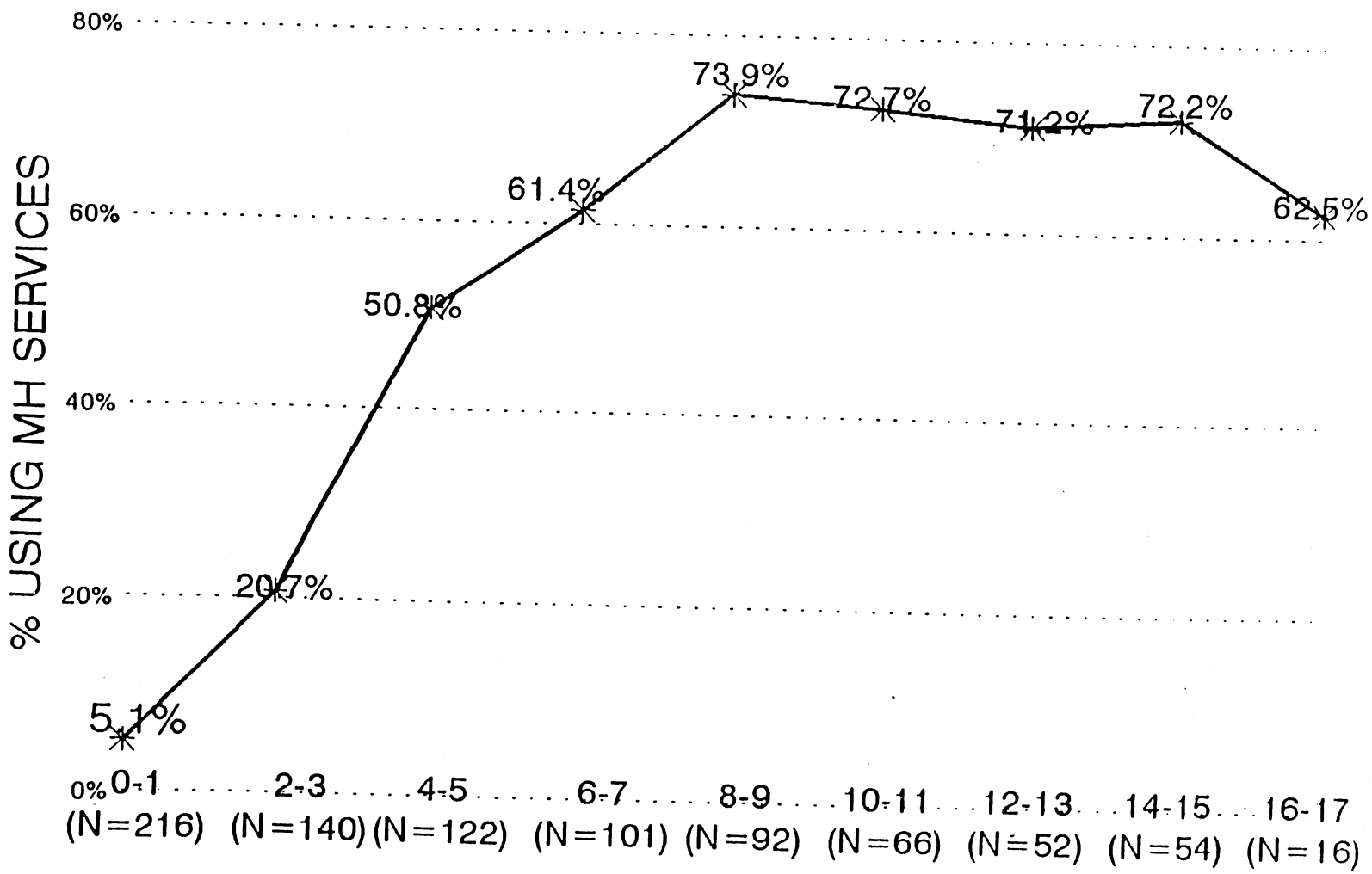


FOSTER CARE MENTAL HEALTH SCREENING PROJECT
VINELAND ADAPTIVE BEHAVIOR SCALE STANDARD SCORES
MEAN SCORES BY RACE/ETHNICITY - SAN DIEGO ONLY



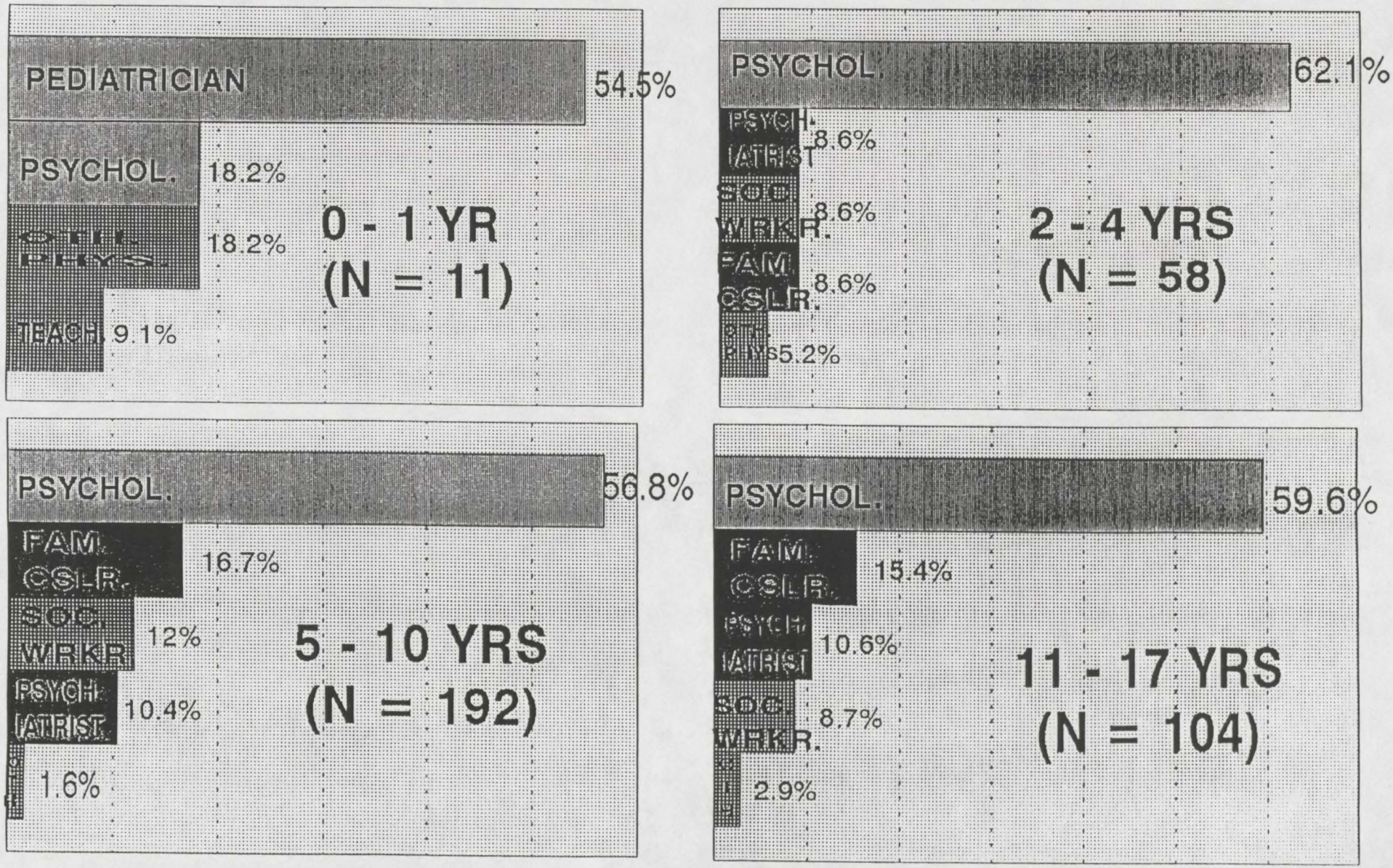
SLIDE 12

FOSTER CARE MENTAL HEALTH STUDY ANY MENTAL HEALTH SERVICE USE BY AGE GROUP



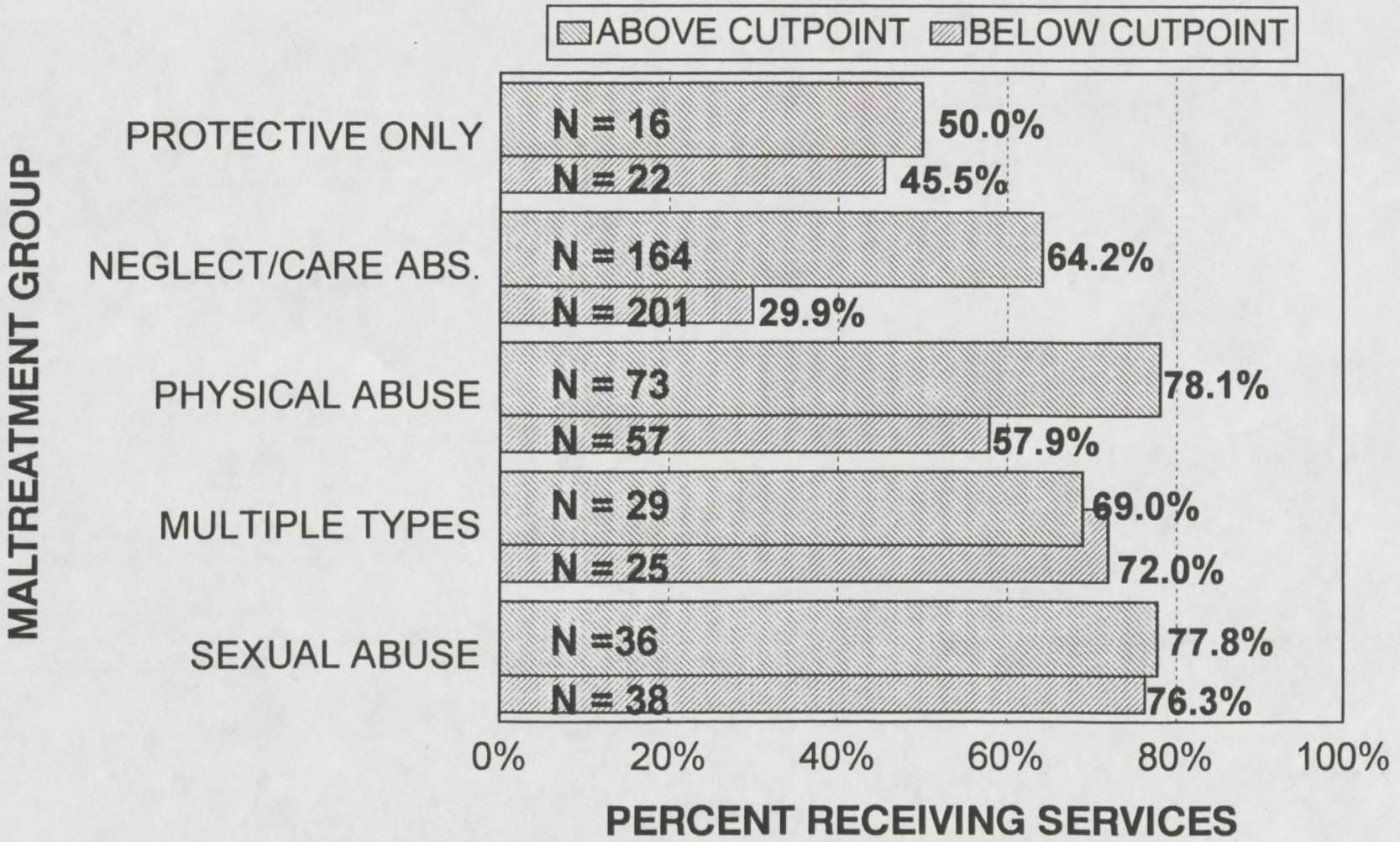
SLIDE 13

HELP SEEKING FOR FOSTER CHILDREN
TYPES OF PROVIDERS MOST OFTEN USED



SLIDE 14

USE OF MENTAL HEALTH SERVICES BY MALTREATMENT GROUP AND BY CLINICAL STATUS ON THE CBCL



RATES OF MENTAL HEALTH USE BY RACE

RACE/ETHNIC GROUP	N	% USING SERVICES
Caucasian	303	65.3
African American	213	49.8
Hispanic	129	45.7

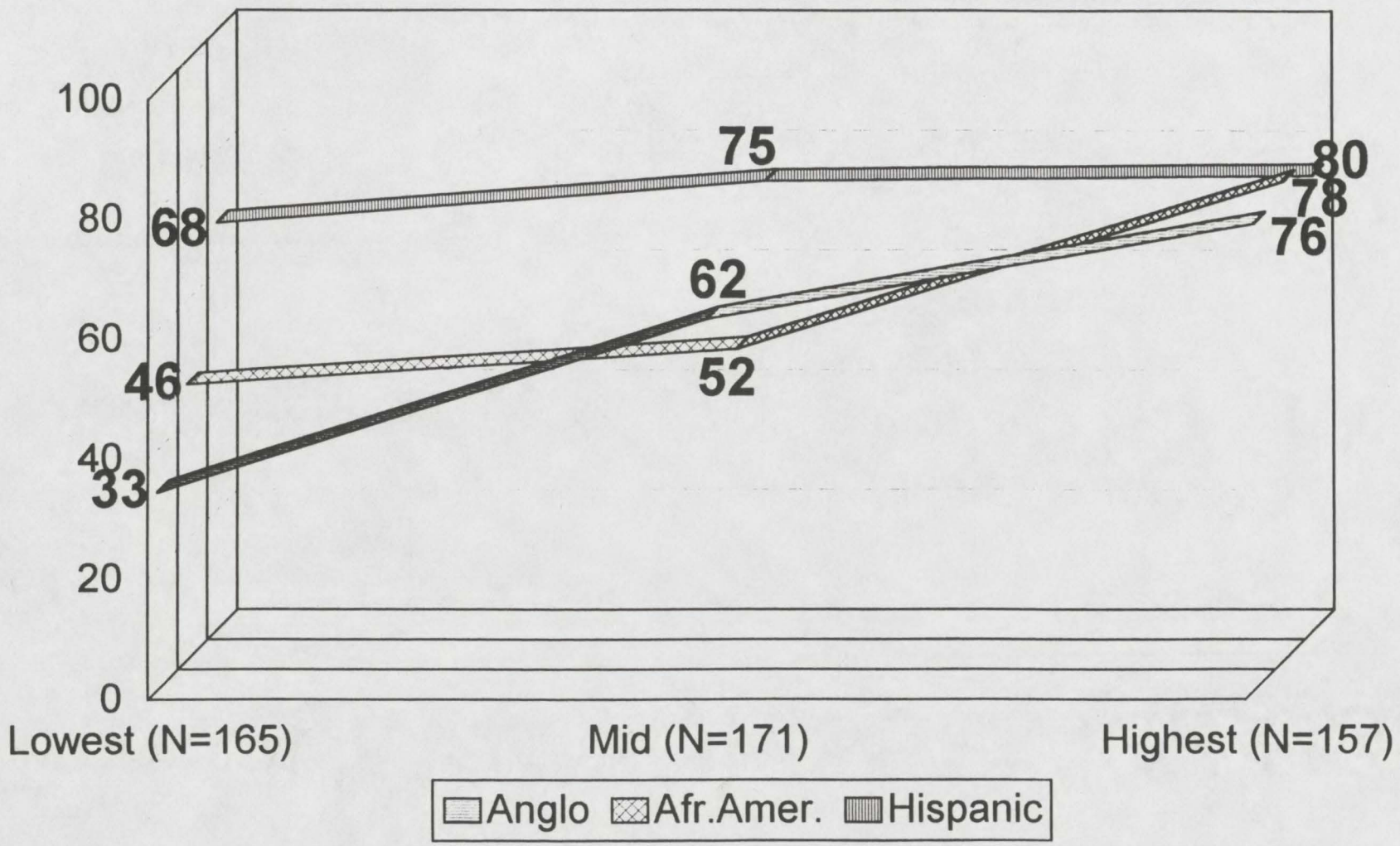
SLIDE 16

FREQUENCY OF SERVICE USE

Racial Group	N	Mean number of visits in 6 months	SD
Caucasian	176	17.0	12.0
African American	97	13.4	17.0
Hispanic	57	14.1	8.9

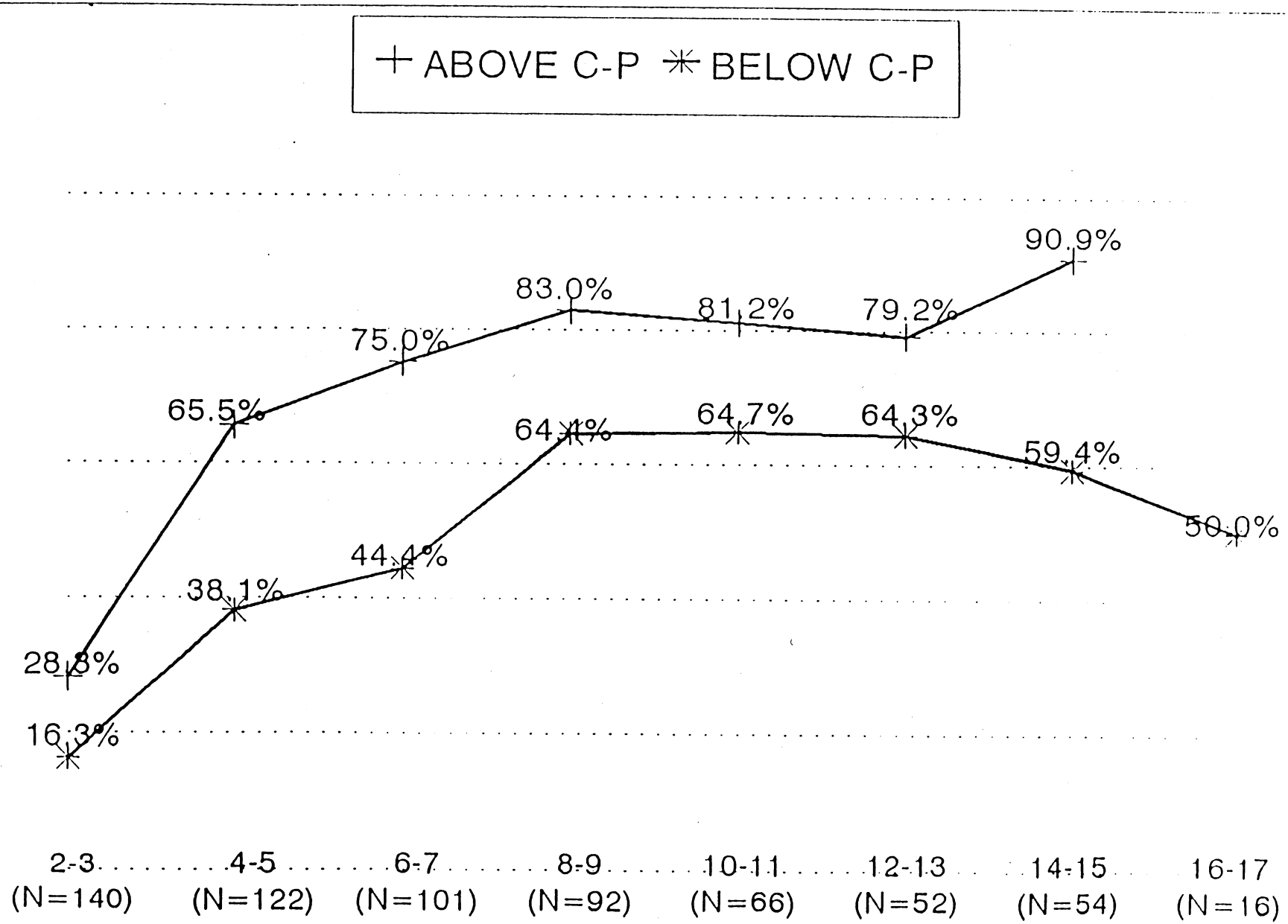
SERVICE USE

By Race and CBCL Status



SLIDE 18

FOSTER CARE MENTAL HEALTH STUDY
ANY MENTAL HEALTH SERVICE USE
BY CBCL TOTAL BEHAVIOR PROBLEMS - BORDERLINE CUTPOINT



LOGISTIC REGRESSION ANALYSIS PREDICTING USE

INDEPENDENT VARIABLE	b	ODDS RATIO	CONFIDENCE INTERVAL	Sign. (p<)
Age group (2 yr. intervals)	0.34	1.41	1.27 - 1.55	0.00001
CBCL above cut-point	1.06	2.87	2.03 - 4.11	0.00001
Sexual Abuse	0.91	2.50	1.35 - 4.56	0.005
Neglect	-0.46	0.63	.44 - .92	0.02
African American*	-0.51	0.60	.40 - .91	0.02
Hispanic*	-1.34	0.36	.22 - .60	0.00001

* - Comparison Group is Caucasians

Nonsignficant variables: Gender, Phys. Abuse, Caretaker Absence, Emot. Abuse

SLIDE 20

FACTORS ASSOCIATED W/ USE OF MENTAL HEALTH SERVICES BY CHILDREN IN FOSTER CARE

- REASON FOR REFERRAL
  - √Sexual Abuse
  - √Physical Abuse
  - –Neglect
- AGE
  - √Older
- RACE/ETHNICITY
  - √Caucasian
- GENDER
  - –No significant effect
- BEHAVIOR PROBLEMS
  - √Above borderline cut-point on CBCL

√ = More likely to receive services
– = Less likely to receive services

MHSFACT

MENTAL HEALTH SERVICE USE BETWEEN FIRST AND LAST INTERVIEWS

No Services at Either	32.5%
Services at Both	35.9%
Discontinued Services	14.2%
Began Services	13.4%

SLIDE 22

MENTAL HEALTH SERVICE USE BETWEEN FIRST AND LAST INTERVIEWS by Type of Placement

	Kin -> Kin (n = 93)	Kin -> Reun (n=42)	FP -> FP (n=155)	FP ->Reun (n=96)
No Services	49.5%	40.5%	21.3%	28.1%
Continued Services	31.2%	21.4%	50.3%	41.7%
Discontinued Services	10.8%	11.9%	9.7%	24.0%
Began Services	8.6%	26.2%	18.7%	6.3%

SLIDE 23

SUMMARY

- Children in foster care exhibit significant developmental and mental health problems.
- There are high rates of mental health service use among children in foster care.
- Clinical factors (behavior problems) do facilitate service use.
- The following non-clinical factors facilitate service use:
  - Sexual abuse
  - Physical abuse
  - Race/ethnicity
  - Age
- The following non-clinical factors inhibit service use:
  - Neglect
  - Minority Status

SLIDE 24

POLICY & SERVICE DELIVERY IMPLICATIONS

- Need for systematic screening of children entering foster care for developmental, behavioral, social and adaptive functioning problems

- Need for systematic monitoring of problem levels over time for children who remain in foster care

- Need for efficient monitoring of developmental, behavioral, social and adaptive functioning outcomes for children in foster care who are receiving services

POLICY & SERVICE DELIVERY IMPLICATIONS (Continued)

- Need for guidelines to be used in systematically linking children who show need with appropriate services
- Need to discuss the impact of non-clinical factors on service use in terms of access to services, acceptability of services, and perception of need for services by "gate-keepers"
- Need to consider greater flexibility and creativity in treatment choices for children in foster care