KU SCHOOL OF
SOCIAL WELFARE
The University of Kansas

Mental Health and Substance Abuse Services to Parents Of Children in Foster Care
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Principal Investigator
Terry Moore, MSW

Project Researchers (listed alphabetically)
Stephanie Bryson, MSW, Project Coordinator
Michelle Levy, MSW, Research Associate

Office of Child Welfare and Children's Mental Health
Twente Hall ♦ 1545 Lilac Lane ♦ Lawrence, Kansas 66044-3184
Tel: (785) 864-4720 ♦ Fax: (785) 830-8026
Website: http://www.socwel.ku.edu/occ/

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EXECUTIVE SUMMARY

Providing services to child-welfare involved parents who have mental health or substance abuse issues is a common and multifaceted challenge. In a recent General Accounting Office report (GAO, 2006), states reported that the *most important* challenge to improving outcomes for children was providing mental health (MH) and alcohol and drug (AOD) services to families. In FY2006, KU School of Social Welfare researchers conducted interviews with key stakeholders and reviewed state and federal policy to better understand the nature of MH and AOD services to Kansas parents of children in foster care.

At the present time, research on this topic is lacking. To ensure that services to parents of children in foster care are provided in a manner that maximizes positive child welfare outcomes, much more remains to be known.

The purpose of this initial study was to develop a research design for a continuing study of services to parents of children in out-of-home care. To do so, University of Kansas School of Social Welfare (KU SSW) researchers conducted a thorough literature review of services to parents of children in foster care; stakeholder interviews with child welfare contractors, mental health providers, substance abuse providers, and SRS; a review of state funding strategies, policy, and contract requirements; and a feasibility study of administrative databases, including MMIS and AIMS.

KEY FINDINGS

- Though not always readily acknowledged, the child welfare and foster care systems are not oriented toward assisting biological parents to make necessary changes to reunify with their children.

- Foster care contracts specify no contractual obligations toward birth parents with regard to mental health and substance abuse services.

- Lack of training and experience may limit workers' abilities to identify mental health or substance abuse issues among parents. In addition, workers may lack the incentive to work with parents who can be especially difficult to engage. Moreover, workers may believe that parents must access services for themselves in order to prove their motivation to earn their children's return.

- While foster care, mental health, and substance abuse providers all recognize that the lack of services to parents of children in foster care is a problem, no one system appears to accept responsibility for this population.

- The absence of state and federal standards, a general lack of accountability measures, and the lack of dedicated funding streams make service provision

a hit or miss proposition. While many can recognize this as a problem, only a handful of all agencies are currently working to solve the problem.

- While parents are not the focus of foster care intervention, they are critical to child well-being regardless of the outcome of the case—whether reunification or another permanency arrangement.

RESEARCH QUESTIONS

1. What are effective program models for serving parents who need mental health and substance abuse services?

2. What is the level of need for mental health and substance abuse services among parents of children in foster care?

3. What services are provided to parents of children in foster care?

4. How do services affect child welfare outcomes, particularly permanency outcomes?

5. What challenges do foster care providers encounter facilitating receipt of services?

6. How are child welfare, mental health, and substance abuse systems collaborating around services to parents?

7. What barriers do parents experience when trying to obtain services?

8. What worked for parents? What services or supports facilitated stable reunification?

WORK PLAN FOR FY2008

1. *Expanded literature review of MH and AOD services to parents of children in foster care*

   Promising practices such as shared treatment plans and co-location of therapists will be explored as well as innovative program models such as shared parenting.

2. *Quantitative analysis of administrative databases*

   Using information from the Adult Risk Assessment fields of the KIDS database, researchers will select a sample of parents with identified MH and AOD needs. After matching the sample in MMIS, AIMS, and KCPC, service utilization data for substance abuse and mental health services will be analyzed to determine 1) average type, duration, and intensity of services; and 2) the relationship between type, duration, and intensity of services and permanency outcomes.

3. *Case reviews/case interviews*

Thirty in-depth reviews of cases with child or parental substance abuse or mental health needs are being conducted between January and June 2007. Parent data from these reviews will be analyzed to determine need for services, appropriateness of services delivered, emphasis on services in case plans, and emphasis on services among foster care caseworkers.

4. *Questionnaires administered to foster care supervisors*

Researchers will design and administer an online survey of foster care supervisors. The purpose of the survey is to gather data on common problems and successes faced by workers and supervisors in: 1) assessing parents' needs for substance abuse or mental health service; 2) facilitating access to services; and 3) working with collateral service providers toward treatment goals. The survey will document systems integration and funding stream challenges, as well as those things which appear to facilitate the receipt of timely, appropriate services.

5. *Focus group with parents of children in foster care*

Researchers will recruit from foster care providers (after care programs) a sample of parents whose children reunified and remained reunified for at least one year. Researchers will conduct focus groups or interviews with parents to determine the most salient factors in promoting successful and stable reunification. In addition, focus groups will document parent experiences with substance abuse or mental health services. Focus groups will contribute novel findings to the research literature, which remains largely without such study, despite the importance of parent perspectives.

**MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
TO PARENTS OF CHILDREN IN FOSTER CARE**

INTRODUCTION

In FY 2006, through a contract with the Kansas Department of Social and Rehabilitation Services (SRS), University of Kansas School of Social Welfare (KU SSW) researchers conducted a study of the Child in Need of Care (CINC) Non-Abuse/Neglect (NAN) population in Kansas. This study sought to describe the CINC NAN population and identify the needs of CINC NANs as they enter the foster care system.

A major finding from the study of the CINC NAN population was the presence of significant mental health and substance abuse problems among parents of children in care. Of 255 cases, nearly 44% of all cases reviewed involved a parent with indications of drug or alcohol use significant enough to be considered *abuse* (rather than merely substance use). Moreover, only 8.6% parents in the case review sample were receiving substance abuse treatment. Similarly, almost 19% of parents in the sample had noteworthy mental health diagnoses; however, less than half, 8.4%, were receiving treatment at the time of the child's intake.

Substance abuse and mental health needs pose serious challenges to permanency. However, timely, appropriate services may ameliorate these challenges. To better understand the nature of services to parents with mental health and substance abuse problems, KU SSW researchers undertook a preliminary study of services to parents of children in care.

STUDY PURPOSE

The purpose of this study is to develop a research design for a continuing study of services to parents of CINC NANs in out-of-home care. The primary goal of the parent study is to understand and describe current patterns of service provision to parents of children in foster care, and to examine the impact of these services on case outcomes. The study will clarify 1) the mental health and substance abuse needs of parents of children in foster care; 2) the nature and financing of service delivery to these populations; 3) barriers to service provision; and 4) innovative approaches to services. The deliverable for this year's preliminary study is a written research design that specifies: 1) research questions to be addressed and 2) research methods, including sources of data.

METHODS

The primary sources of data for the development of the research design included:

- Review of literature on services to parents of children in foster care;

- Evaluation of state funding strategies, policy, and contract requirements;

- Key stakeholder interviews with child welfare contractors, mental health providers, substance abuse providers, and SRS;

- Examination of administrative databases, including MMIS and AIMS; and

- Information from case reviews and case stakeholder interviews.

Literature Review -The purpose of the literature review was to document the state of knowledge regarding the provision of services to parents of children in foster

care. In addition, mixed-method studies on mental health services to parents were examined to gain insight around approaches to methodology.

Financial, Policy and Administrative Analysis - Evaluation of state funding strategies, policy and contract requirements included a review of foster care service provider contracts for Youthville, KVC, St. Francis Academy, and TFI. The Adoption and Safe Families Act, Child Welfare Service Review (CFSR), Program Improvement Plan, and SRS Outcomes were examined for any provisions related to services for parents.

Key Stakeholder Interviews - Key stakeholder interviews provided an opportunity to clarify and expand on information gathered. Officials interviewed included administrators and supervisors from SRS, representatives from each of the child welfare contractor agencies, experts from the Community Mental Health Centers (CMHCs) and representatives from the substance abuse treatment community. The Administrator/Key Informant Interview Guide is included in Appendix A.

Administrative data – Researchers investigated several potential administrative databases to assess which might provide viable source data for the study of parent mental health and substance abuse service utilization. Databases examined included FACTS, KIDS, the Medicaid database (MMIS), the CMHC Automated Information Management (AIMS) database, and the Kansas Client Placement Criteria (KCPC) database.

In-Depth Case Reviews –As part of the current (FY 2007) CINC-NAN study, researchers selected for in-depth review 30 CINC NAN cases. The purpose of the case review is to document service need, services delivered, and any barriers encountered by youth or parents seeking services. Case review criteria included cases in which the child or parent had an identified mental health or substance abuse need. The parent portion of this in-depth case review is one of three proposed data collection activities included in the parent study research design. The case review data collection tool may be found in Appendix B. Questions relating specifically to the parent study are highlighted.

FINDINGS

Presented below are findings from this preliminary study of mental health and substance abuse services to parents of children in out of home care. Information is summarized by data source.

LITERATURE REVIEW

The most common outcome of foster care is the reunification of a child with his or her biological family (Wulczyn, 2004). To successfully reunify, families must "expeditiously demonstrate change" (Smith and Donovan, 2003). In child welfare, "change" is typically demonstrated through the completion of numerous goals and activities by children and their parents. Commonly, permanency plan goals include provisions about participation in services such as parent education, substance abuse, and/or mental health treatment. Much of a foster care worker's job revolves around developing and monitoring families' service plans (Smith & Donovan, 2003). Despite the intrinsic nature of services to child welfare, surprisingly little is known

about use of substance abuse or mental health treatment by parents involved with the child welfare system, and how these services affect child welfare outcomes (Berson & Armstrong, 2000; Berson, Roggenbaum & Vargo, 2001; Green, Rockhill, & Furrer, 2006, Hohman & Butt, 2001).

What is evident is the existence of significant mental health and substance abuse issues among parents involved with the child welfare system. Approximately 70% of child welfare parents have at least one mental health problem (Faller & Bellamy, 2000). Comparatively, substance abuse exacerbates seven of ten cases of child abuse/neglect (National Center on Addiction and Substance Abuse, 1999). The presence of substance abuse and/or mental health issues in families can also slow or prevent the achievement of permanency. Children placed due to parental alcohol or drug abuse experience longer lengths of stay in out-of-home placement, have more frequent placement changes, and are less likely to be returned home or placed for adoption (Magura & Laudet, 1996). In an Oregon study, parental drug involvement was the most common reason children did not go home (Portland State University, 1998). Wells and Guo (2004) found that mothers' mental health problems decreased the speed of reunification. Custody loss for parents with mental illness is as high as 70-80% (Joseph, Joshi, Lewin & Abrams, 1999).

Providing services to child-welfare involved parents who have mental health or substance abuse issues is a common and multifaceted challenge. In a recent General Accounting Office report (GAO, 2006, p. 9), states most frequently identified "providing an adequate level of services, more specifically mental health and substance abuse services, for children and families" as the *most important* challenge

to improving outcomes for children. Common service delivery issues reported in the literature include barriers to access, systemic challenges to collaboration, and low rates of treatment success. Successful service provision for this population stems from the appropriate identification of needs, and this is where the review of literature begins.

Identification of Need

Services to parents of children in foster care are driven by the identification and perception of parental needs. Commonly, child welfare assessments and casework focuses primarily on the abused or neglected child. Yet it is more often parents who have the majority of "work" to do in order to achieve successful family reunification. The opportunity to identify parents' needs occurs with the initial family assessment and continues through the life of the case. In order to recognize a need for services, workers must possess knowledge and skills in understanding mental illness and substance abuse, including the intricacies of addiction, courses of treatment, barriers to intervention and how these issues affect parenting. Faller and Bellamy (2000) note that many child welfare workers are not trained to recognize mental health issues. Similarly, Tracy (1994) suggests that workers often have limited training and knowledge about parental substance abuse. Thus, workers are ill equipped to assess level of risk and to develop appropriate case plans (Tracy & Farkas, 1994).

Moreover, accurate identification of parental needs is complicated by worker attitudes and presumptions about mental illness and substance abuse, particularly the belief that the presence of these conditions is incompatible with parenting. Kenny

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(2004) found that child welfare workers were conflicted about engaging with addicted parents; they described the parents with whom they worked as "deceitful," "unreliable," "uncooperative" and "unpredictable." Kenny also found that workers had a low expectation for success with these families. Parents with mental illness may be labeled as "crazy," assumed to be violent, and face the erroneous belief that they can change their behavior willingly (Risley-Curtiss, Stromwall, Hunt, & Teska, 2004).These conjectures are even reflected in ASFA, through the provision that allows states to forego reunification in cases of parental mental illness (Risley-Curtiss et al., 2004). Given the pervasiveness of such stigma, it is not surprising that mothers are reluctant to acknowledge a need for help with parenting due to a fear of losing custody (Nicholson, Biebel, Hinden, Henry, & Stier, 2001; Nicholson, Sweeney, & Geller, 1998; Sands, 1995). Indeed, at least one study suggests that the *most* pervasive factor affecting parents' access to and participation in services is the stigma that accompanies mental illness (Nicholson, Biebel, Hinden, Henry, & Stier, 2001). Conversely, the significance of children and parenting can serve as a "foundation for recovery" (Cook and Steigman, 2007) for parents challenged by either substance abuse or mental health issues motivating their participation in treatment (Nicholson, Sweeney, & Geller, 1998; Oyserman, Mowbray, Meares & Firminger, 2000).

Multiple stressors and co-occurring problems complicate the identification of need and service provision. Families with substance abuse and mental health issues struggle simultaneously with parenting, family violence, inadequate housing, and poverty (Marsh, Ryan, Choi, & Testa, 2005; Marsh, D'Aunno & Smith, 2000). These

co-existing stressors intermingle to create a complex web of service needs

(Chipungu & Bent-Goodley, 2004). Families with multiple problems often require the

services of several different agencies, thereby increasing the chances that they will

encounter multiple barriers to service.

Barriers to Service

Three main barriers to services exist: availability, accessibility, and

appropriateness. *Availability* of services refers both to the existence of a service and

whether parents are able to begin the service in a timely manner. As mentioned

previously, a lack of appropriately trained substance abuse and mental health

providers impedes the child welfare system's ability to address adequately the needs

of the children and families they serve (GAO, 2006). The U.S. Department of Health

and Human Services (HHS, 1999) acknowledges a chronic shortage of substance

abuse and mental health providers, particularly in rural areas. Despite a federal

mandate that pregnant and parenting women receive priority for treatment, these

individuals frequently must wait to access services (GAO, 2003). Clients who need

mental health assessment are forced to wait for long periods or in some cases, are

not able to access services at all (Shireman, 2003).

Accessibility of services, or ease of use, depends on factors such as

transportation, child care, language, and cost. Cost issues include not only family

financial resources but insurance status, co-payment requirements, and time off

from work to attend treatment. In examining barriers to mental health and substance

abuse care, Sturm and Sherbourne (2001) found that the most frequent unmet need

was mental health services. The primary concern about mental health treatment was

the cost of treatment. Economic barriers were highest for uninsured individuals but also high among privately insured who frequently face gatekeeping limitations on services (Sturm & Sherbourne).

Another category of barriers includes factors related to service *appropriateness*. Service appropriateness refers to the fit between identified need and suitability of services, including duration, intensity, quality, and focus of the intervention. Few substance abuse facilities currently meet the needs of women, who are the majority of child welfare clients, both as mothers and as individuals (Tracy & Farkas, 1994). Culturally appropriate effective mental health treatment options are also reported to be in short supply (HHS, 1999).

The potential impact of these barriers to service is striking. The Child Welfare League of America (1998) reports that child welfare agencies obtain substance abuse treatment for only a third of individuals who need it, and among this group only 10% are able to access services within one month or less. Green and colleagues (2006) found the average time to service for substance abuse treatment was four months from the outset of the child welfare case. They also determined that parents who entered treatment faster were more likely to remain in services longer and complete treatment regardless of history, risk factors, or frequency and type of substance use (Green, Rockhill, & Furrer, 2006).

Systems Collaboration

Addressing barriers to services is complicated by the fact that mental health and substance abuse treatment is typically provided outside the child welfare system. The systems of child welfare, mental health, and substance abuse are each

responsible for outcomes that are influenced by each system's policies, administration, and resources (Raghavan, Inkelas, Franke, & Halfon, 2007). In addition to the general challenges of interdisciplinary collaboration (i.e. communication, information sharing, confidentiality), there are major differences in these systems' goals, philosophies and timeframes. These differences can lead to potential challenges in service provision to parents.

In substance abuse and mental health, the "client" is commonly defined as the individual, while child welfare recognizes their "client" as either the child at risk or the entire family (Hunter, 2003). Moreover, substance abuse treatment is focused on the adult's relationship with the drug. All other issues, including parenting, are treated as secondary (HHS, 1999). Mental health systems have also been charged with neglecting the role and needs of parents (Tracy, 1994; Risley-Curtiss et al., 2004). Risley and colleagues (2004) note that while mental health providers typically render diagnoses, they rarely assess individuals' functioning as parents.

Both mental health and substance abuse systems recognize that the problems they treat are chronic conditions with high relapse potential which may require lifelong recovery (Hunter, 2003). While substance abuse providers view relapse as an inevitable part of recovery, child welfare's intense focus on timeframes translates to less tolerance of setbacks (HHS, 1999). The time necessary for effective treatment may clash with child welfare permanency timelines, limits on receipt of welfare benefits, and children's developmental needs for stability and permanency. Young, Gardner, and Dennis (1998) have described these competing timelines as the "four clocks" of child welfare-involved families. For dually-diagnosed

parents or those involved with more than one system, attempting to meet numerous (and potentially conflicting) goals of multiple service providers may be overwhelming.

The courts must be acknowledged as another "system" that plays a crucial role in service delivery. As Webb and Harden (2003) acknowledge, the legal system often has the "final word" about services. Court-ordered assessments or services are not always perceived as needed by parents or workers and may or may not facilitate permanency.

Service Monitoring and Impact on Parenting

Once services are initiated, the child welfare system's goal shifts to monitoring their provision, facilitating family progress, and assessing the impact of services on parenting capacity. Without demonstrated progress in resolving the problem that led to out of home placement, accessing and receiving services are insufficient criteria for reunification (Ryan, 2006). An ongoing challenge during this phase of the child welfare intervention is to determine when, or if, services have sufficiently prepared families for reunification.

Prior research has shown that 70-80% of parents with children in foster care referred for a substance abuse assessment complete the evaluation as required (Gregoire & Schultz, 2001; Portland State University, 1998). However, rates of treatment completion for these same parents drop to 20-30% (Gregoire & Schultz, 2001; Portland State University, 1998). Treatment completion for parents involved with child welfare services has been associated with age, employment, legal issues, physical symptoms, drug of choice (Ryan, 2006) and support of a significant other (Gregoire & Schultz, 2001). It is important for child welfare workers to understand

these factors so that they may work to facilitate parents' success in treatment. Completion of substance abuse treatment is a key predictor of the decision to reunify. Karoll and Poertner (2002) developed specific indicators of progress in substance abuse recovery and parent readiness to reunify.

Treatment progress and "success" with mental health services is more difficult to surmise because mental health encompasses such a broad range of diagnoses and conditions, with varied courses of treatment and prognoses . However, a group of "expert" researchers who study parents with severe and persistent mental illness agreed that the severity of symptoms and chronicity of the condition were more important considerations than diagnosis (Ackerson & Venkataraman, 2003). As with substance abuse, there are low rates of parent treatment completion in mental health. In an Oregon study of parents with children in foster care, 62% of parents attended less than half of a recommended mental health intervention (Portland State University, 1998). Additionally, readiness for reunification is more accurately gauged through individualized assessment of functional abilities (Ackerson & Venkataraman, 2003). Nicholson and colleagues (2001) note that workers need more training in how to evaluate client risk and progress in situations involving parents with mental illness. Ackerson & Venkataraman (2003) call for more balanced understanding of the nature of serious and persistent mental illness, including recognition of levels of recovery and the cyclical nature of disorders that may require more intensive treatment and social support at certain times.

Impact of Services on Child Welfare Outcomes

While the presence of substance abuse or mental health *problems* in child-welfare involved families has been found to adversely affect the timeframes for family reunification, substance abuse *services* have been found to positively impact family reunification. Less clear is the effect of mental health *services* and services for co-occurring problems on child welfare timeframes and the achievement of family reunification.

Substance abuse treatment completion is a significant predictor of family reunification and is also associated with faster reunification (Smith, 2003). Successful treatment has been found to differentiate between failed and successful reunifications (Miller, Fisher, Fetrow, & Jordan, 2006). In examining the association between parental service participation and return home, one of highest return home rates (78%) was associated with completion of inpatient drug/alcohol treatment (Portland State University, 1998). Conversely, non-completion of treatment is strongly associated with low return rates, continued substance use and eventual loss of parental rights (Portland State University, 1998; Gregoire & Schultz, 2001).

The impact of mental health services on reunification is more difficult to determine. A study of reunification predictors in Florida found that parents with an SMI diagnosis were less likely to successfully reunify. However, there was no indication of whether or not services were delivered (Becker, Larsen & Jordan, 2002). In Oregon, mental health interventions tended to associate with return home rates lower than the state average (Portland State University, 1998).

Multi-problem families – the majority of child welfare involved families- have difficulty achieving reunification (Marsh et al., 2006). An Illinois demonstration found that even parents who completed treatment and addressed parenting frequently still did not reunify with their children (Ryan, 2006). Researchers are beginning to identify additional factors that may impede service provision and eventual reunification. Wells and Guo (2004) showed that the speed of reunification for single mothers with children in foster care is impacted by family income. Mothers indicated difficulty in "managing work, meeting agency requirements and experiencing fear, grief, or paralysis over the possible loss of their children." A study of mothers in substance abuse treatment showed that those women involved with child welfare have greater service needs related to their own trauma and victimization (Grella, Hser, & Huang, 2005). Clearly, the issue of services to child welfare-involved parents is complex and not yet fully understood.

Focus on Parents

Despite a current focus in child welfare on a "family-centered approach" and the redefinition of parents as "partners," parents of children in foster care may not be getting the attention they need or deserve in order to reunify successfully. Smith and Donovan (2003) postulate that child welfare workers typically view work with the children in care as their core responsibility. With heavy caseloads, staff turnover, and numerous responsibilities competing for workers' attention, it becomes easy for workers to substitute phone calls or letters for visits with parents or provide a list of services as a sufficient means of meeting needs. These researchers go so far as to

suggest that caseworkers may even ignore parents who do not initiate contact as a coping mechanism for dealing with their perpetual lack of time and resources.

Parents involved with foster care also fail to receive adequate attention from researchers. Parent experience with foster care, defined as "parents' perceptions of and involvement in various services in which they must participate in order to recover children from foster care" is largely unstudied (Alpert, 2005). In a study of the impact of services on child welfare outcomes, researchers clearly acknowledged that families might offer very different opinions than the results obtained from service providers (Marsh et al., 2000). For example, in a study on therapeutic foster care, parents identified barriers to family participation as lack of access to transportation, inconvenient scheduling and location of meetings, and limitations created by professionals (Jivanjee, Sieverin-Held & Siepmann, 1999). Workers, on the other hand, focused on parental behavior and systemic agency barriers.

Three small studies have focused on parent perspectives regarding substance abuse, mental health, and parenting issues. In 2003, Ackerson interviewed 13 parents with mental illness to identify the factors that they believe enabled them to maintain or regain custody. Themes that emerged from this study included: problems with diagnosis and treatment, stigma and discrimination, chaotic interpersonal relationships, strain of single parenthood, custody issues, relationships with children, social support and pride in being a parent. Sun (2000) conducted in-depth interviews with eight mothers to "explain the recovery journey of substance-abusing mothers in the child welfare system." Findings from the study included mothers' dreams of a mainstream life; entering/staying in the other world; factors

related to substance abuse, such as childhood abuse, multiple stress and losses; AOD-using peers and the "vicious cycle" of substance abuse. In 1997, Akin and Gregoire conducted semi-structured interviews with 11 women who were involved with the child welfare system to identify worker and service system qualities that contributed to parent recovery and family reunification. Parents recognized system shortcomings as reinforcing powerlessness, feeling that no one cares and unrealistic expectations. Parents named worker characteristics that facilitated success as trust, availability, caring, faith, sharing power, providing direction and knowing addiction.

Currently missing from the literature are parent accounts of obtaining and utilizing treatment and supportive services — including barriers and factors that contributed to their success. The study under proposal here will address this important oversight in the child welfare research base.

POLICY, FINANCIAL, AND ADMINISTRATIVE ANALYSIS

Federal, state and local policies significantly impact the provision of mental health and substance abuse services to parents of children in foster care. The major policies and practices reviewed for this study include:

- The Adoption and Safe Families Act of 1997

- Children and Family Services Review documents

- Program Improvement Plan documents

- Federal and state financing of child welfare, mental health and substance abuse services

- SRS outcomes

- State foster care contracts

The Adoption and Safe Families Act of 1997

The most influential legislation in the past ten years, the Adoption and Safe Families Act of 1997 (ASFA) emphasizes the "safety, permanency, and well being of children and their families" (DHHS 2000, v). Its two explicit goals are "to move children who are stranded in the child welfare system into permanent placements and to change the experience of children who are entering the system today" (DHHS 2000, 9). While family reunification remains the initial case goal for most children currently in foster care placements, ASFA prioritizes child safety over family preservation. The law explicitly states, "Child safety is the paramount consideration in decision-making regarding service provision, placement, and permanency planning for children" (DHHS 2000, 9).

Like the Adoption and Child Welfare Assistance Act of 1980, the intent of ASFA is to "free" children for adoption, not to encourage lengthy drawn-out efforts to remediate parents or the social problems besetting them (Woodman 2002). In keeping with this goal, ASFA alters significantly the timeframes in which parents must complete case plan goals, including substance abuse and mental health services. Before ASFA, the first permanency hearing (to determine the child's legal status and placement) occurred within 18 months of the child's out-of-home placement. Under ASFA, the first permanency hearing must be held within 12 months. Moreover, when a child has been in placement 15 of a 22-month period, the caseworker may initiate the procedure to terminate parental rights (unless there are compelling reasons to do otherwise). Fifteen months is thus a proxy for the

maximum allowable statutory period in which parents may demonstrate competence, notwithstanding judicial discretion.

Qualitative research suggests that ASFA's truncated time frames have placed considerable pressure on child welfare workers, court systems, and parents— particularly low income parents, parents with substance abuse problems, and parents of color (DHHS 2000). In the absence of substantive structural help for low-income parents, workers may feel forced into an antagonistic role as investigator rather than helper, particularly in a time of diminishing social service allocations (Gelles, 2000). A study of three Washington, D.C.-based child welfare agencies found the following:

> With a focus on child safety and away from the family unit, there seems to be less emphasis on services to resolve parental problems necessary to maintain the family. Caseworkers must cope with difficult and chronic family problems, and often lack resources and services to adequately address family needs. Yet they must achieve the goals of safety and permanency for a child, and make decisions on where the child will be placed within the timelines set by law. As a result, time is at the forefront of permanency decisions. Gone are the days when extended periods were granted to assist parents in resolving their problems in order to reunify the family. Instead, workers are pressed to expedite a family assessment and case plan for the family. However, with large caseload sizes, workers have less time to spend with families. Parents can be difficult to engage after a child is removed from the home, particularly when drug or mental health problems are an issue. If parents are apathetic and unresponsive to initial attempts for treatment, workers have little time to spend providing personal support or handholding. If parents are not able to meet case plan goals to rectify problems that brought their child into care within 15 months, they risk losing parental rights to their child. Unfortunately, substance abuse and mental health problems are not easily resolved in short time periods (U.S. DHHS 2001, Chapter 5: 6).

If qualitative data are accurate, these unintended consequences may disproportionately affect low income parents, mostly women (Woodhouse 2002); parents of color (Roberts 2002, Morton 1999); children of color (Barth 1994; Courtney 1994; Wulczyn et. al 2001); and most importantly for our study, parents

with substance abuse problems (Hohman and Butt 2001) and mental illness (Nicholson, Biebel, Hendon, Henry, and Stier, 2001).

Interestingly, in a recent study of variables which differentiated between failed and successful reunifications, parental utilization of substance abuse treatment was found to be a highly significant predictor of *failed* reunification (Miller, et al., 2006). The authors of the study state: "…our results suggest that children of parents engaging in substance abuse treatment within three months postreunficiation are at increased risk for reentering care." The authors conclude that current policies, such as ASFA, which are aimed at expediting reunification "might run counter to best practice with the children of such parents" (2005, p. 270).

The proposed study will provide insight into these issues by examining the relationship between permanency outcomes and substance abuse or mental health treatment.

The Child and Family Services Reviews (CFSRs)

Child and Family Service Reviews monitor child welfare programs by measuring outcomes in child safety, permanency and well-being. According to Milner, Mitchell, and Hornsby (2005), the CFSRs are intended to evaluate child welfare practice on four broad themes:

- Family centered practice
- Strengthening parents' capacity to provide for their children's needs
- Individualizing services to children and families and
- Community based services

Despite the family-centered language of the CFSRs, what remains unclear is the extent to which outcomes and outcome measures focus on parents. Among the seven CFSR outcome measures listed below, only one outcome, #5, explicitly mentions parenting capacity.

1. Children are, first and foremost, protected from abuse and neglect.

2. Children are safely maintained in their homes whenever possible and appropriate.

3. Children have permanency and stability in their living situations.

4. The continuity of family relationships and connections is preserved for children.

5. Families have enhanced capacity to provide for their children's needs.

6. Children receive appropriate services to meet their educational needs.

7. Children receive adequate services to meet their physical and mental health needs.

Services to parents would fall under this outcome domain. Recent revisions to CSFR statewide indicators have improved these measures by providing greater detail about the experiences of children in entry rather than exclusively exit cohorts (See Appendix C for a listing of current indicators.) However, mental health and substance abuse services to both children and parents continue to be monitored only through stakeholder interviews and case reviews.

While it could be argued that several CFSR outcomes *should* involve an assessment of parental capacity—especially outcomes two, three, four, and five— the degree to which parental involvement, assessment, and service provision are

monitored and achieved varies greatly by state. In general, these are weak areas in child welfare. In a study of 190 clinical assessments of child welfare-involved parents, researchers found that evaluations of birth or bio parents were: 1) completed in one session; 2) rarely included a home visit; 3) used few sources of information other than the parent; 4) cited no previous written reports; 5) rarely used behavioral methods; 6) stated purposes in general rather than specific terms; and 7) emphasized weaknesses over strengths in reporting results (Budd, Poindexter, Felix, and Naik-Polan, 2001). The essential features of sound parental competency assessments among parents with serious and persistent mental illness are summarized by Jacobsen, Miller, and Kirkwood (1997).

Findings from Child and Family Services Reviews appear to corroborate the need for better assessments of parenting capacity, particularly the recognition and treatment of mental health and substance abuse problems.

CSFR Reports Find AOD and Mental Health Gaps

In both the 2001 and 2002 reviews of 32 states' CFSRs, mental health assessments and services were found lacking for both children and families. According to a publication from the National Child Welfare Resource Center, "Family-focused services are often unavailable. Often only a child will receive mental health services, and other issues and concerns within the family are not adequately addressed. Often there is not adequate treatment for adults and youth who are perpetrators of sexual abuse, substance abuse treatment services for families, counseling and treatment for domestic violence, or respite care" (2004, p. 18). In a more recent review of 38 states' CSFR Final Reports, researchers found "minimal

discussion of mental health services being developed and provided for birth families"
(McCarthy, Marshall, Irvine, and Jay, 2004, p. 17).

Moreover, states recently identified substance abuse services as an important gap in services. While parental substance abuse was reported as a factor in cases in 32 states and was *the* factor that brought the child to the attention of CPS in 16 to 61% of cases, substance abuse services were found to be lacking. According to Young, Gardner, Whitaker, Yeh, and Otero, "Substance abuse was frequently seen as an underlying problem that was often not addressed in sufficient depth by the services provided to families in the child welfare system" (2005, p. 1). Also, reentries were frequently attributed to substance abuse relapse. Despite mention of inadequate services, CSFRs contained little discussion about the reasons underlying gaps in services, although the separation of assessment and services in some states was mentioned. Also mentioned was the lack of coordination between funding streams for substance abuse treatment. In some states, there are as many as 15 separate funding streams. Financing of services will be discussed in the next section of this report. First, specific findings from Kansas CFSRs are presented.

Kansas CSFR Report

In Kansas, the final report on the Child and Family Services Review noted the following:

- a need for drug and alcohol treatment services in some areas;

- slow initiation of services;

- waiting lists for mental health and substance abuse services due to limited availability;

- a need for specialized mental health services (i.e. crisis bed, attendant care, respite care);

- a need for better recognition of substance abuse issues and inclusion of these issues as part of the reason families come to the attention of SRS;

- a need for better coordination between child welfare and the substance abuse treatment system.

Most germane to this proposed study was the acknowledgement by stakeholders that "services to parents were not always being provided as identified." The CFSR report states, "The focus tends to be on treatment for the child while excluding the parents' issues. Family focused services were sometimes lacking…Stakeholder interviews revealed that children are often removed from the home due to drug and alcohol abuse and lack of resources to treat the addictions while the children remain with the family. Parents are less likely to receive the needed treatment if they do not have private insurance that covers the treatment" (Young et al., 2005, p. 18).

States not in conformity with CFSR outcomes must develop and implement Program Improvement Plans (PIPs). Of 28 PIPs reviewed in 2004, almost all (89%) included goals and action steps related to mental health services (Young et al., 2005). The Kansas PIP focuses on increasing training to child welfare personnel so they can recognize the need for mental health or substance abuse services and use available screening and assessment tools. The PIP also challenges area directors to develop an action plan to increase the number of mental health and substance

abuse services for children. Services to birth families are not mentioned in the Kansas PIP.

Federal and State Financing of Child Welfare, Substance Abuse, and Mental Health

Financing of mental health and substance abuse services presents a major barrier to the effective provision of services to parents. The lack of a dedicated funding stream for services to parents of children in foster care compromises access to treatment for parents with addiction, mental illness, and other mental health issues that impact parenting. Payment for substance abuse or mental health evaluation and treatment for child welfare-involved parents varies on a case-by-case basis depending upon parent means, insurance status, and community resources. Discussed below are financing arrangements for foster care, mental health, and substance abuse services.

Foster Care and TANF

Title IV-E and Title IV-B are the major sources of federal funding specifically dedicated to child welfare. The largest source of federal funding for child welfare, Title IV-E, is an open-ended entitlement for foster care maintenance (room and board) and adoption assistance. Title IV-E funds cannot be utilized to pay for services to children or parents. This creates a tension in a system that prefers work with children in context of family and community but invests most resources in the provision of out of home placement" (Wulczyn & Orlebeke, 2006). However, recently, the federal government has allowed states to apply for Title IV-E waivers

which allow funding to be used more flexibly, including for partnerships with mental health services and initiatives to support substance abuse treatment.

In contrast to Title IV-E, Title IV-B funds, which can be used for services and support to prevent or shorten stays in foster care (including family support, family preservation, reunification and adoption), are capped and "extremely limited" (Christian, 2006). Kansas receives about $6 million through Title IV-B. Federal fiscal policy directs majority of support toward per diem foster care placement with funds for prevention and treatment inadequate. In a recent GAO report (2006), states reported that family support services (including those that might prevent removal or help with reunification) were the services most in need of increased federal, state or local resources.

Non-dedicated federal funds include social Service Block Grant, TANF and Medicaid. While children in state custody are categorically eligible for Medicaid (third party liability still applies), their parents are not. Medicaid services are delivered fee-for-service in a managed care environment. Medicaid services are now under the Health Policy Authority. A new state plan was submitted July 1, 2006 and may change the current status of service delivery.

Recent chances in federal policy related to child welfare financing will shift more of the cost of child welfare to the states and impose additional requirements that may further impede effective service delivery to parents. The Child and Family Services Improvement Act (CFSIA) of 2006 amended Title IV-B to add new requirements for case worker visits with children in foster care. By 2011, states must

ensure that at least 90% of children in foster care will be visited monthly at the child's residence with financial penalties for failure to meet this goal. New federal funding for this mandate is sparse ($0 in FY 2007, $5 million in FY 2008) and distributed without regard for states' existing performance in this area. While regular case worker visits are arguably important, there is a fear among child welfare experts that workers who are already stretched for time may have even less time or incentive to work with parents.

Increased work participation requirements for TANF will also impact states' use of these funds for child welfare. Kansas is identified as a state that relies heavily on TANF for purposes other than economic self-sufficiency. Kansas' work participation rate is below 50%. In FY 2004, Kansas spent $29.5 million in TANF funds on child welfare. The estimated current work participation rate 36%. Potential TANF penalties include $5.1 million reduction in TANF or required $9.2 million increase in state spending.

Mental Health and Substance Abuse
In Kansas, funding typically is more problematic in the mental health arena than in the substance abuse arena due to RADAC being a "payor of last resort." The Kansas Medical Assistance Program Provider Manual details eligibility and billing procedures for alcohol and drug abuse community-base services. Provision 8100 clearly states "Alcohol and drug abuse community-based services are exempt from co-payment requirements (p.8-1).

One new targeted federal funding initiative may help parents beset with substance abuse problems. In 2007, grants will become available for regional

partnerships providing services to children and families affected by methamphetamine and other substance abuse. Funding for this program starts at $40 million for FY 2007 and totals $145 million over a five year period. The description of services that may be funded includes "substance abuse treatment; early intervention and preventative services; counseling; mental health service; parenting training; and replication of successful model of long-term family-based substance abuse treatment." Grants will require state matching funds.

At the present time, mental health services to parents are financed through private insurance, out-of-pocket payment (on a sliding scale at most CMHCs), Medicaid, and Medicare. Stakeholders in Kansas could name no dedicated funding stream specifically for parents of children in foster care who are seeking mental health services or assessments. Some stakeholders reported inconsistencies in the sliding scale practices at CMHCs. As mentioned, parents of children in care are not categorically eligible for Medicaid. Stakeholders interviewed for this study said that most parents of children in foster care would not qualify for TANF on their own, and would lose TANF once children were placed in care. Thus, only parents with SSI or SSDI were likely to receive Medicaid or Medicare-financed mental health care.

Child Welfare Contracts for Reintegration-Foster Care Services

To assess the contractual obligation of private contractors to provide services to parents of children in foster care, researchers reviewed the contracts of the five foster care providers in the state of Kansas (DCCCA, KVC, St. Francis Academy, TFI, and United Methodist Youthville). Broad findings are listed below:

- All contracts include family-centered and family-driven language; however, contracts differ widely in the emphasis placed on family-centered care. Two contracts were particularly focused on family-centered care. The proposals from these contractors listed specific examples of ways in which the agency either provides direct mental health services to parents or works to help parents advocate for their families in accessing community services.

- All contractors provide in-home family services. Treatment modalities vary between contractors and are not specified by some contractors. Some contractors appear to rely more on case management while others are more clinically-oriented.

- All contracts mention inclusion of birth parents in developing the family plan and assessing family needs.

- One contract specified the point at which family needs are assessed. Within seven days of the initial referral, a case manager meets with parents to determine the need "for referral for further professional assessments from community healthcare organizations supports/services including substance abuse intervention, mental health services, and developmental disability identification."

- One contract specified the role of resource families in assisting birth/bio families: "The resource family must not only understand the needs of both the child and birth family so as to offer a caring environment for the child, but also provide some targeted direct parenting supports or mentoring for the family."

- One contract outlined agency responsibilities as "being present for initial mental health appointments, assessments, and critical health appointments." This agency also proposed to assist bio families in budgeting for the cost of services and helping them access sliding fee scales or community funds.

- Some contractors (e.g. St. Francis) require that if the agency is paying for mental health or other services, parents must request funds and submit a budget for the agency's approval.

- In all contracts, birth families are expected to provide information, attend MH and AOD appointments, and assume responsibility for their own scheduling and transportation. Most contracts include a discussion of "empowering" parents to work with community partners.

- All contractors support family choice in the selection of community-based providers. When possible, contractors try to give preference to providers established prior to the foster care or services that can be accessed by the family after permanency.

Barriers to Mental Health Services

Historical barriers to mental health services for both children and their families noted in contracts include:

- Limited number of therapists in region

- Long waiting periods for appointments

- Lack of community-based services and few crisis services

- Difficulty coordinating care with CMHCs

- Overwhelming amount of paperwork that must be completed prior to intake in CMHCs (for children)

- No priority given to parents seeking mental health services in CMHCs

- Obtaining documentation of mental health services and progress reports

- CMHCs not in the regional contractor catchment area and family therapy thus impossible to coordinate

- Lack of cultural competency among CMHCs that are unwilling to serve foster care clients who are "culturally different"

- Differing goals between the two systems. CMHC's are focused on symptom remission and the contractors are focused on promoting safety and permanency within ASFA timelines and on minimal standards rather than optimal standards

- Children coming into care because they needed CMHC or CDDO services

- CMHCs and CDDOs lacking access to resource family beds when families they were working with were in crisis

- All children receiving SED-CBS services had the same treatment plans; no individualization

- Lack of attendant care, respite care, in-home family treatment

Barriers to Substance Abuse Services

Historical barriers to substance abuse services for both children and their families noted in contracts include:

- Lack of treatment for parents and children in rural areas

- Difficulty getting children screened quickly for services, especially when inpatient treatment is needed

- Waiting lists for inpatient substance abuse (parents)

- Differences in information sharing by substance abuse providers

- Scheduling meetings between the foster care provider, subcontractors, and parents when parents encounter barriers to services

- Some CMHCs—in order to recoup reimbursement— will divert clients referred to the CMHC by AOD specialists and treat the clients themselves rather than returning the client to AOD specialists

Troubleshooting Efforts

Current foster care contractors have developed stop-gap measures to deal with some of these problems.

- Most contractors have subcontracted with private practitioners and hired their own staff to provide necessary mental health and substance abuse services.

- Some contractors have developed memoranda of understanding (MOU) between their agency, CMHCs, and private providers. These MOUs specify the timeframes in which an initial assessment must be made.

- The CMHCs and St. Francis Academy have agreed that billing staff will forward encounter data which documents the type and frequency of services provided.

- Several regions have an established partnership plan with their respective CMHCs which lays out roles and responsibilities for each agency and expectations regarding communication flow.

- Most contractors hold meetings quarterly with CMHC staff and
  representatives to review cases, resolve problems, and discuss new services.

- Some contractors have annual on-site visits to subcontractors to examine
  agency policies and procedures and to ensure quality assurance.

Stakeholder Interviews

Interviews with representatives from SRS, the five Kansas foster care
providers, mental health providers, and substance abuse treatment providers
clarified the process and context of service provision to parents of children in foster
care. In general, foster care providers seek a balance between encouraging parents
to take the initiative in fulfilling their needs and helping them overcome barriers to
accessing services (i.e. providing transportation, completing paperwork). More
specifically, several themes emerged around mental health and substance abuse
services.

Mental Health

Following are general themes in interviews with foster care providers.

- Stakeholders reported that mental health services were available to parents
  through the CMHCs, private providers, or through the foster care contractors'
  own therapists. One respondent said that if parents are motivated to get
  services, they can get them. However, many parents are resistant.

- In general, foster care providers have case managers that help parents make
  appointments. However, follow-through is very individual. Some

caseworkers/case managers are more proactive in helping parents and some use this as a test of parental motivation.

- For the most part, sliding fee scales at CMHCs help parents to afford care. Some parents, however, are not able to afford even a $20 co-pay. Parents with the means can also opt to see another provider at their expense.

- Most contractors have, over time, hired therapists to work with families. These services might be offered in the case of parents who have a conflict with the local CMHC or to families with transportation challenges or specific needs that can be met by subcontracted providers more expediently than if the parent sought services at the CMHC.

- At least one foster care provider reported that adult SPMI does not categorically rule out reunification. In this case, the parent's case manager would be included in case planning.

- Foster care providers reported that the timeliness, intensity, and focus of services are barriers.
  - Seven days is the minimum wait for a parent to get help for mental health issues unless they are threatening to hurt themselves or others.
  - In many CMHCs, "emergency" cases are seen within a month. "Intensive" therapy can mean twice a month.
  - One interviewee reported that there are only two therapists in the West Region who speak Spanish.
  - Foster care providers also mentioned their frustration that while parents may be attending mental health appointments as required, MH

providers aren't necessarily addressing issues that brought their child into care.

- All foster care providers reported meeting on a regular basis with CMHCs to discuss particular cases and to talk more generally about service provision.

- Foster care providers noted that CMHCs are good about sending therapists into remote communities for one day/week.

- New contracts will make providers more responsible for paying for services to families.

Representatives of the CMHCs identified several problems in working to coordinate care for parents of children in foster care.

- Services to parents have always been a problem due to the lack of a dedicated funding source. Furthermore, these difficulties have been exacerbated since the state privatized foster care. Foster care contracts were not written with this issue in mind, and it is given short shrift.

- Mental health representatives acknowledged that some foster care providers had understandably sought to provide in-house services because they had underperforming community partners. Admittedly, some CMHCs are very weak; CMHCs in rural areas can be weak because the most highly trained and skilled therapists work in urban areas. Interviewees expressed some reservations about the changes in the Medicaid state plan which will allow foster care providers to "associate" with CMHCs and provide mental health services. While one interviewee felt that one foster care provider was particularly committed to serving parents with mental health needs (and would

likely do so without reimbursement), this interviewee worried that most providers were seeking Medicaid reimbursements.

- A big problem is out-of-catchment area foster care placements. When children are placed in counties far away from parents, parents are unable to participate meaningfully in family therapy activities.

- Also, CMHCs experience difficulties with child-welfare involved parents because 1) they can often not afford services; 2) they have transportation and other access issues; 3) they are court-ordered, and negative incentives are not necessarily conducive to treatment progress.

- Mental health representatives encouraged foster care providers to work harder on engaging parents in treatment and felt that in some cases, inappropriate services (e.g. family therapy) were being conducted with resource families when they would more appropriately be conducted with birth or bio families.

Substance Abuse

RADAC serves as single point of entry for most of the state. RADAC administers a standardized assessment of client AOD problems: The Kansas Client Placement Criteria (KCPC). This instrument is utilized to determine client needs and to determine the appropriate level of care, if any, for treatment. The assessment documentation must include source and reason for referral, history, treatment plan and evaluation, including recommendations. Medicaid policy limits the hours per year of various levels of treatment.

According to stakeholders, both mental health and foster care providers, RADAC works with parents to examine financial resources and options for treatment. In some parts of the state, parents can wait up to month for substance abuse services. Foster care providers feel there is not much in the way of stop-gap measures while parents are awaiting treatment. Case management is targeted toward individuals with repeated admissions, co-occurring disorders, IV drug use, women and those experiencing homelessness. RADAC offers a care coordinator/counselor to work with women who are waiting for a bed. Some programs accept all mothers with children if they do not have behavior problems. Language barriers, especially, bilingual substance abuse providers are lacking. In general, workers feel parent motivation is biggest factor in getting substance abuse treatment.

Role of the Court

According to stakeholders, some judges issue standing orders for AOD assessment or for parents to sign releases for information sharing. Some courts believe that every family needs the full array of treatment so the judge orders everything. Some foster care providers feel that they have a greater opportunity to conduct an assessment when the family has more ownership and less negative coercion by the court. The volume of court orders can be daunting to parents. Some judges restrict parental visitation if not clean. In at least one county, there is a culture of excessive court orders and pride in getting relinquishments.

Examination of Administrative Databases

Researchers investigated several potential administrative databases to assess which might provide viable source data for the study of parent mental health and substance abuse service utilization. Databases examined included FACTS, Medicaid database (MMIS), Automated Information Management (AIMS) database, and Kansas Client Placement Criteria (KCPC) database.

Researchers explored barriers to obtaining a valid sample. Barriers include: 1) aggregation of parent and child case plan goals on Form 2030E in FACTS; 2) difficulty matching one unique parent with one unique child in FACTS since primary providers may shift as permanency plan goals change; 3) and potential difficulties gaining IRB approval for parent rather than child data, particularly substance abuse data through the Kansas Client Placement Criteria (KCPC) system.

Researchers discussed these problems with database consultants and concluded that most barriers can be overcome by selecting a sample in FACTS and then removing microidentifiers to match the sample to in the Medicaid database (MMIS), Automated Information Management (AIMS) database, and Kansas Client Placement Criteria (KCPC) database. Data sources will be discussed in greater detail in the research design section of this report.

Data from Case Reviews/Case Stakeholder Interviews

In depth case reviews will be conducted in FY 2007 on 30 CINC NAN cases. These case reviews will provide an opportunity to learn what information is available on parents, particularly services to parents. Stakeholder interviews (with therapists,

foster/resource parents, caseworkers, and supervisors) will clarify information and provide different key actor perspectives on services to parents and their effect on case outcomes. This portion of the study will examine the following domains:

1. Level of need for mental health and substance abuse services

Researchers will read the case file to glean the mental health and substance abuse needs of parents which were recognized by child welfare personnel, as well as recommendations made to address these needs. Researchers will gather this information from completed mental health and substance abuse assessments, such as psychological evaluations. Adequacy and timeliness of assessments will be considered. For needs mentioned in assessments or case plans, we will look for goals that address identified needs. Researchers will also seek to identify underlying needs which do not appear in case documentation, as well as discernable disagreements among parties to the case.

2. Services provided to parents of children in foster care

For this domain, researchers will assess whether the services provided matched parental needs—in terms of appropriateness, timeliness, and quality. Questions include: Are services individualized? What was the court role in service provision?

3. Main barriers to obtaining services

Researchers will seek to determine whether there were barriers to parents accessing services. These might include parent motivation; availability of local resources; financial barriers; and logistical issues such as transportation, child care,

and lack of linguistically competent providers. The impact of placement changes on service provision will also be assessed.

4. Systems collaboration

This area of investigation will include whether bio/birth family members were involved in case planning, and whether there was regular communication between foster care personnel, mental health providers, substance abuse providers, CASAs, foster parents, birth parents, and anyone else germane to the case.

5. Effect of services to parents on child welfare outcomes

In reading cases, researchers will attempt to discern what impact services had or did not have on timely permanency. Questions to be asked include: Did services promote timely permanency? What providers or persons promoted a successful outcome? What are the most effective services for specific problems? Could additional or different services have prevented or delayed placement?

Information from these in-depth case reviews will be collected throughout January and February, 2007. The parent section of the case reviews will be analyzed pending approval of the parent study task order.

CONCLUSION

In many ways, though not always readily acknowledged, the child welfare and foster care systems are not oriented toward assisting biological parents to make necessary changes to reunify with their children. Foster care contracts specify no contractual obligations toward birth parents with regard to mental health and substance abuse services. In addition to their other tasks, workers may lack the

incentive to work with parents who are often difficult to engage. Lack of training and experience may limit workers' abilities to identify mental health or substance abuse issues among parents. Moreover, workers may believe that parents must access services for themselves in order to prove their motivation to earn their children's return.

While foster care, mental health, and substance abuse providers all recognize that the lack of services to parents of children in foster care is a problem, no one system appears to accept responsibility for this population. The absence of state and federal standards, a general lack of accountability measures, and the lack of dedicated funding streams make service provision a hit or miss proposition. Not surprisingly, while many can recognize this as a problem, only a handful of all agencies are currently working to solve the problem. While parents are not the focus of foster care intervention, they are critical to child well-being regardless of the outcome of the case—whether reunification or another permanency arrangement.

The study proposed in the next and final section of this report will optimally shed light on the most effective and targeted approaches to service delivery for this important but underserved population.

RESULTS - PROPOSED PARENT STUDY DESIGN

Findings from this year's study indicate that services to parents are rarely a primary focus of foster care. Yet biological parents play a critical part in what ensues over the course of a family's involvement with the child welfare system. Since service provision is a multi-faceted issue within the complex arena of child welfare, it is important to gather information from multiple sources in order to glean a full understanding of the issue. As a result, we propose the following design for the Parent Study.

PURPOSE

The purpose of studying services to parents of children in foster care is threefold: 1) to describe referral and service utilization patterns of parents referred for mental health or substance abuse services; 2) to describe parent experiences seeking services and to better understand what services lead to successful reunification outcomes; and 3) to document provider experiences and understand the challenges they face in providing effective services to this population.

At the present time, research on this topic is lacking. To ensure that services to parents of children in foster care are provided in a manner that maximizes positive child welfare outcomes, much more remains to be known. This study will contribute to our knowledge base in an important and understudied area of child welfare practice. Ultimately, in collaboration with SRS, providers, and key stakeholders, data from this study should suggest ways to optimize mental health and substance abuse treatment to parents of children in foster care.

RESEARCH QUESTIONS

1. What are effective program models for serving parents who need mental health and substance abuse services?

2. What is the level of need for mental health and substance abuse services among parents of children in foster care?

3. What services are provided to parents of children in foster care?

4. How do services affect child welfare outcomes, particularly permanency outcomes?

5. What challenges do foster care providers encounter facilitating receipt of services?

6. How are child welfare, mental health and substance abuse systems collaborating around services to parents?

7. What barriers do parents experience when trying to obtain services?

8. What worked for parents? What services or supports facilitated stable reunification?

METHODOLOGY

A mixed-method, multi-pronged approach will include the following data sources:

1. *Literature review*

An expanded literature review will build on information gathered in the current year to gauge the state of knowledge regarding empirically-based intervention and effective service delivery to this population. Promising practices such as shared

treatment plans and co-location of therapists will be explored, as well as innovative program models such as shared parenting.

2. *Demographic and service statistics*

Researchers will request an extract of KIDS data, from FY2004-FY2006. Primary caregivers will be identified for each case. Current or most recent caregivers will be selected. Parents will be selected who have the following indicators of need for mental health or substance abuse treatment from the Adult Risk Assessment fields:

- Has current alcohol abuse problem

- Has current drug abuse (other than alcohol) problem

- Current substance abuse, but willing to participate in treatment

- Has a history of substance abuse

- Apathetic or hopeless

- Has a significant history of depression

- If so, has ever attempted suicide

Unique identifiers will be used to match the sample of caregivers to a sample in the Medicaid database, MMIS, the Community Mental Health Center database, AIMS, and the Kansas substance abuse database, KCPC. Initially, researchers will examine frequencies for all case dispositions other than adoption (case closed, foster care, family services, and family preservation). Parents of children in foster care will be the focus of remaining analyses.

Frequencies and descriptive analyses of parent receipt of services will first be completed. These initial analyses will determine the appropriate statistical method

for comparing subgroups of parents—for example, parents who received mental health services, parents who received substance abuse services, parents who received both MH and AOD services, and parents who did not receive services. It will be difficult to determine whether the non-service group received no services or received unreported services; however, some attempt will be made to compare parents with an identified need who received some services with parents who did not.

For parents who received treatment, service utilization data for substance abuse and mental health services will be analyzed to determine 1) average type, duration, and intensity of services; 2) the relationship between types, duration, and intensity of services and permanency outcomes. In addition, the AIMS database will provide data about mental health services which may or may not have been Medicaid reimbursable. This is true of the KCPC database as well, as it includes some private pay information for AOD services. Additionally, the AIMS database includes diagnoses and Global Assessment of Functioning (GAF) scores for clients and will allow researchers to conduct an analysis of most common diagnoses and GAF scores among parents of children in foster care. KCPC will allow researchers to conduct a similar analysis on factors such as substance of choice, length of treatment, and SASSI scale scores.

3. *Case reviews/case interviews*

As part of year two's continuing CINC NAN study, 30 in-depth case reviews of cases with child or parental substance abuse or mental health needs will be conducted between January and June, 2007. Both child and parent data will be

gathered from these case reviews. The parent portion of the case reviews will be analyzed for this study, and will include such information as: reviewer assessment of need for services, appropriateness of services delivered, emphasis on services in case plans, and emphasis on services among foster care caseworkers.

In-depth case reviews will permit researchers to gather more detailed information than is possible with large administrative databases. In addition to case reviews, researchers will conduct interviews with all pertinent providers, including therapists, substance abuse providers, and foster care caseworkers. These personnel will provide case details such as parent motivation, availability of services, barriers to services, etc. Case reviews will allow researchers to understand, in depth, the process by which need is assessed, services are delivered, and outcomes are affected.

4. *Questionnaires administered to foster care supervisors*

Researchers will design and administer an online survey of foster care supervisors. The purpose of the survey is to gather data on common problems and successes faced by workers and supervisors in: 1) assessing parents' needs for substance abuse or mental health service; 2) facilitating access to services; and 3) working with collateral service providers toward treatment goals. The survey will document systems integration and funding stream challenges, as well as those things which appear to facilitate the receipt of timely, appropriate services.

5. *Focus group with parents of children in foster care*

Researchers will recruit from foster care providers (after care programs) a sample of parents whose children reunified and remained reunified for at least one year.

Researchers will conduct focus groups or interviews with parents to determine the

most salient factors in promoting successful and stable reunification. In addition,

focus groups will document parent experiences with substance abuse or mental

health services. Focus groups will contribute novel findings to the research literature,

which remains largely without such study, despite the importance of parent

perspectives. Table 1 provides an overview of the proposed study design.

Table 1: Study Design Matrix

Study Question	Elements/Sub-Questions	Data Sources
1. What are effective program models for serving parents who need mental health and substance abuse services?	What do the literature and a national best practice search reveal? What specific service/approaches were helpful to achieving successful outcomes?	Literature review Provider survey Focus group
2. What is the level of need for mental health and substance abuse services among parents of children in foster care?	What MH or AOD assessments were completed? What needs were identified in case plans?	KIDS Case review
3. What services are provided to parents of children in foster care?	What types of services were provided? How often? Over what period of time?	MMIS, KCPC, AIMS
4. How do services affect child welfare outcomes, particularly permanency outcomes?	Among the sample of parents who received services, were permanency outcomes different compared to a group of parents who did not receive services?	KIDS MMIS AIMS KCPC
5. What challenges do foster care providers encounter facilitating receipt of services?	Did funding play a part? Waiting lists? Geographic access? Sufficient providers? Bureaucracy?	Case review Provider survey
6. How are child welfare, mental health and substance abuse systems collaborating around services to parents?	What are the main facilitating or impeding factors?	Provider survey Case review Parent focus groups
7. What barriers do parents experience when trying to obtain services?	What problems did parents face when trying to obtain services?	Parent focus groups
8. What worked for parents? What services or supports facilitated stable reunification?	What factors contributed to successful, stable reunification?	Parent focus groups

Human Subjects Approval

Rigorous measures will be taken to insure confidentiality of all private information. Researchers will seek human subjects' approval as required by the University of Kansas. Research participants will sign informed consent statements, and participation in the study will be entirely voluntary.

BIBLIOGRAPHY

Ackerson, B.J. (2003). Coping with the dual demands of severe mental illness and parenting: The parents' perspective. *Families in Society, 84*(1), 109-118.

Ackerson, B.J. & Venkataraman, M. (2003). Issues in parenting by clients with severe and persistent mental illness: A survey of experts. Journal of Family Social Work, 7(1), 35-52.

Akin, B.A. & Gregoire, T.K. (1997). Parents' views on child welfare's response to addiction. *Families in Society, 78*(4), 393-404.

Alpert, L.T. (2005). Research review: Parents' service experience – a missing element in research on foster care case outcomes. *Child and Family Social Work, 10*, 361-366.

Barth, R. (1994). Effects of age and race on the odds of adoption versus remaining in long-term out-of-home care." *Child Welfare*, 76: 285-308.

Becker, M.A., Larsen, R., and Jordan, N. (2002). *Predictors of Parent-Child Reunification and Behavioral Health Services Use and Cost for Children in Foster Care.* Tampa: University of South Florida, Louis de la Parte Florida Mental Health Institute.

Berson, I.R. & Armstrong, M.I. (2000). *Mental health care for child welfare clients: Historical data analysis.* Tampa: University of South Florida, Louis de la Parte Florida Mental Health Institute.

Berson, I.R., Roggenbaum, S., & Vargo, A.C. (2001). *Mental health care for child welfare clients.* Tampa: University of South Florida, Louis de la Parte Florida Mental Health Institute.

Budd, K.S., Poindexter, L.M., Felix, E.D., & Naik-Polan, A.T. (2001). Clinical assessment of parents in child protection cases: An empirical analysis. Law and Human Behavior, 25 (1): 93-108.

Child Welfare League of America (1998). *Alcohol and Other Drug Survey of State Child Welfare Agencies.* Washington D.C.: CWLA.

Chipungu, S. & Bent-Goodley, T. (2004). Meeting the challenges of contemporary foster care. *The Future of Children: Children, Families and Foster Care, 14*(1), 75-93.

Christian, S. (2006) *The Changing Landscape of Federal Child Welfare Financing: A Primer for Policymakers.* National Conference of State Legislatures.

Cook, J.A. & Steigman, P. (2007). Parents with mental illness: Their experiences and service needs. Online, accessed February 12, 2007.

Courtney, M. (1994). Factors associated with the reunification of foster children with their families." *Social Service Review*, March 1994: 81-108.

Faller, K. & Bellamy, C. (2000). Mental health problems and child maltreatment. University of Michigan Interdisciplinary Child Welfare Training Program. Retrieved from http://www.ssw.umich.edu/icwtp/mentalHealth/d-mhpar.pdf

Gelles, R. (2003). Interview with Richard Gelles. Accessed online at http:www.pbs.org/wgbh/pages/frontline/shows/fostercare/inside/gelles.html.

General Accounting Office (GAO) (2006). *Child Welfare: Improving Social Service Programs, Training and Technical Assistance Would Help Address Long-Standing Service Level Workforce Challenges* (GAO-07-75). Washington, DC: Author.

General Accounting Office (GAO) (2003). *Foster care: States focusing on finding permanent homes for children, but long-standing barriers remain* (GAO-03-626T). Washington, DC: Author.

Green, B.L., Rockhill, A. & Furrer, C. (2006). Understanding patterns of substance abuse treatment for women involved with child welfare: The influence of the ASFA. *The American Journal of Drug and Alcohol Abuse. 32*: 149-176.

Gregoire, K.A. and Schultz, D.I. (2001). Substance-abusing child welfare parents: Treatment and child placement outcomes. *Child Welfare*, 80, 433-452.

Grella, G.E., Hser, Y., & Huang, Y. (2005). Mothers in substance abuse treatment: Differences in characteristics based on involvement with child welfare services. *Child Abuse and Neglect*, 30: 55-73.

Hohman, M.M. & Butt, R.L. (2001). How soon is too soon: Addition recovery and family reunification. *Child Welfare, 80*(1): 53-67.

Hunter, T.N. (2003). Child welfare and alcohol and other drug treatment (AOD): Bridging the gap to comprehensive services. *Journal of Family Social Work, 7,* 63-73.

Jacobsen, T., Miller, L.J., Kirkwood, K.P. (1997). Assessing parental competency in individuals with severe mental illness: A comprehensive service. *Journal of Mental Health Administration*, 24(2): 189-199.

Jivanjee, P., Sieverin-Held, D. & Siepmann, J. (Eds.) (1999*). Family Participation in Therapeutic Foster Care: Multiple Perspectives. A Final Report on a Study of Families and Therapeutic Foster Parents as Partners.* Portland, OR: Research and Training Center on Family Support and Children's Mental Health, Portland State University.

Joseph, J.G., Joshi, S., Lewin, A.B. & Abrams, M. (1999). Characteristics and perceived needs of mothers with serious mental illness. *Psychiatric Services*, 50(10), 1357-1359.

Karoll, B.R. & Poertner, J.(2002). Judges', caseworkers' and substance abuse counselors' indicators of family reunification with substance-affected parents. *Child Welfare, 81*(2), 249-267.

Kenny, E.P. (2004). Caseworkers' attitudes regarding service needs and client success: Reunifying parents with a drug addiction and their children. Unpublished master's thesis, Miami University, Oxford, Ohio.

Magura, S., & Laudet, A.B. (1996). Parental substance abuse and child maltreatment: Review and implications for intervention. *Children and Youth Services Review, 18*(3), 193-220.

Marsh, J.C., D'Aunno, T.A., and Smith, B. (2000). Increasing access and providing social services in drug abuse treatment for women with children. *Addiction, 95*, 1247-1287.

Marsh, J.C., Ryan, J.P., Choi, S., & Testa, M.F. (2006). Integrated services for families with multiple problems: Obstacles to family reunification. *Children and Youth Services Review, 28*(9), 1074-1087.

McCarthy, J., Marshall, A., Irvine, M. & Jay, B. (2004). *An Analysis of Mental Health Issues in States' Child and Family Service Reviews and Program Improvement Plans.* National Technical Assistance Center for Children's Mental Health Georgetown University Center for Child and Human Development.

Miller, K.A., Fisher, P.A., Fetrow, B., & Jordan, K. (2006). Trouble on the journey home: Reunification failures in foster care. Children and Youth Services Review, 28(3), 260-274.

Milner, J., Mitchell, L., and Hornsby, W. (2005). Child and family services reviews. In Mallon, G.P. & Hess, P.M. (Eds.) *Child welfare for the twenty-first century: A handbook of practices, policies, and programs*. New York: Columbia University Press.

Morton, T. (1999). The increasing colorization of America's child welfare system: The overrepresentation of African-American children. *Policy and Practice*, 12/99*.*

National Center on Addiction and Substance Abuse (1999). *No Safe Haven: Children of Substance Abusing Parents.* New York: Columbia University, Author.

National Child Welfare Resource Center for Family-Centered Practice (2004). Best practice, next practice: Family-centered child welfare. Winter, 2004, p. 18.

Nicholson, J., Biebel, K., Hinden, B., Henry, A., & Stier, L. (2001). *Critical Issues for Parents with Mental Illness and Their Families.* Worcester, MA: University of Massachusetts Medical School, Center for Mental Health Services Research.

Nicholson, J., Sweeney, E.M., & Geller, J.L. (1998). Focus on women: Mothers with mental illness. The competing demands of parenting and living with mental illness. *Psychiatric Services, 49*, 635-642.

Oyserman, D., Mowbray, C.T., Meares, P.A., & Firminger, K.B. (2000). Parenting among mothers with serious mental illness. *American Journal of Orthopsychiatry, 70*(3), 296-315.

Portland State University (1998, January). Cohort III: A study of families with children entering foster care in Oregon between mid-1992 and 1995. Portland, OR: Author.

Raghavan, R., Inkelas, M., Franke, T., & Halfon, N. (2007). Administrative barriers to the adoption of high-quality mental health services for children in foster care: A national study. *Administration & Policy in Mental Health and Mental Health Services Research*.

Risley-Curtiss, C., Stromwall, L., Hunt, D. & Teska, J. (2004). Identifying and reducing barriers to reunification for seriously mentally ill parents involved in child welfare cases. *Families in Society: The Journal of Contemporary Social Services, 85(*1), 107-118.

Roberts, D. (2002). *Shattered bonds: The color of child welfare.* New York: Basic Books.

Ryan, J.P. (2006). *Illinois Alcohol and Other Drug Abuse (AODA) Waiver Demonstration: Final Evaluation Report.* Urbana-Champaign: University of Illinois, Children and Family Research Center.

Sands, R. G. (1995). The parenting experience of low-income single women with serious mental disorders. *Families in Society, 76*(2), 86-96.

Shireman, J. (2003). *Critical Issues in Child Welfare*. New York, NT: Columbia University Press.

Smith, B.D. (2003). How parental drug use and drug treatment compliance relate to family reunification. *Child Welfare, 82*(3), 335-365.

Smith, B.D., & Donovan, S.E.F. (2003). Child welfare practice in organizational and institutional context. *Social Service Review*, 77, 541-563.

Smith, B.D. & Marsh, J.C. (2002). Client service matching in substance abuse treatment for women with children. *Journal of Substance Abuse Treatment*, 22(30), 161-168.

Sturm, R. & Sherbourne, C.D. (2001). Are barriers to mental health and substance abuse care still rising? *Journal of Behavioral Health Services & Research, 28*(1), 81-88.

Sun, A. (2000). Helping substance abusing mothers in the child welfare system: Turning crisis into opportunity. *Families in Society*, 81 (2): 142-151.

Tracy, E. M. (1994). Maternal substance abuse: Protecting the child, preserving the family. *Social Work, 39*(5), 534-540.

Tracy, E. M. & Farkas, K.J. (1994). Preparing practitioners for child welfare practice with substance-abusing families. *Child Welfare, 73*(1), 57-67.

U.S. Department of Health and Human Services. (1999). *Blending Perspectives and Building Common Ground. A Report to Congress on Substance Abuse and Child Protection.* Washington, D.C.: U.S. Government Printing Office, 1999

U.S. Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: Substance and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

U.S. Department of Health and Human Services. (2000). Rethinking child welfare practice under the Adoption and Safe Families Act of 1997: A resource guide. Washington, D.C.: U.S. Government Printing Office.

U.S. Department of Health and Human Services. (2001). Assessing the context of permanency and reunification in the foster care system. Accessed online at: http://aspe.hhs.gov/hsp/fostercare-reuif01/chapter5.htm.

Webb, M.B. & Harden, B.J. (2003). Beyond child protection: Promoting mental health for children and families in the child welfare system. Journal *of Emotional and Behavioral Disorders*, 11 (1): 49-58.

Wells, K. & Guo, S. (2004). Reunification of foster children before and after welfare reform. *Social Services Review, 78*(1), 74-95.

Woodhouse, B.B. (2002). Making poor mothers fungible: The privatization of foster care. In *Child Care and Inequality: Rethinking Carework for Children and Youth*, Cancian, Kurz, London, Reviere, Tuominen (Eds.). New York: Routledge.

Wulczyn, F. & Orlebeke, B. (2006). Getting what we pay for: Do expenditures align with outcomes in the child welfare system? Chapin Hall Center for Children, *Issue Brief 106*.

Wulczyn, F. (2004). Family reunification. *The Future of Children, 14*(1), 95-113.
Wulczyn, F. (2002). Reunification from foster care. Unpublished manuscript.

Young, N. K., Gardner, S. L., Whitaker, B., & Yeh, S. (2005). *A review of alcohol and other drug issues in the states' child and family services reviews and program improvement plans*. Irvine, CA: National Center on Substance Abuse and Child Welfare.

Young, N.K., Gardner, S.L., & Dennis, K. (1998*). Responding to alcohol and other drug problems in child welfare: Weaving together practice and policy*. Washington, DC: CWLA.

APPENDICIES

APPENDIX A: ADMINISTRATOR/KEY INFORMANT INTERVIEW GUIDE

CINC NAN Year Two:
Mental Health and Substance Abuse Services to Children and Youth in Foster Care and their Parents

1. Do you provide direct mental health or substance abuse services to children in foster care? To birth/bio parents of children in foster care?
2. If so, what kinds of services?
3. What is your contractual obligation to provide MH and AOD services to children? To parents?
4. How does the referral/intake process work with the CMHC in your area? For children? For parents?
5. Are intakes/treatment expedited for children? For parents? Is there a specific protocol for these cases? What is the average turnaround for treatment?
6. How do parents finance services? Do most parents initially have Medical cards?
7. Do all AOD referrals go through RADAC, or are some services provided by the CMHCs or other providers?
8. How would you characterize the relationship between the courts, SRS, you as the provider, and the CMHCs?
9. What are the biggest barriers to MH and AOD services for children and parents?
10. What could be done to improve coordination of services?
11. What would you like to know about services to parents? How might it be studied in the best way?
12. What impact, if any, have changes to the State Plan had on services your agency delivers?
13. What is your involvement in the development of the Partnership Plan or Shared Outcomes initiatives currently underway?

APPENDIX B – CASE REVIEW DATA COLLECTION TOOL

CINC-NAN 2007 CASE STUDY

FACE SHEET

Case Reviewer:	Date of Review:		
Identifying Information			
Child's Name:	Client Id:		Case Id:
DOB:	Home County:		
Head of House:	SSN:		Relationship:
Other Parent:	SSN:		Relationship:
Other info about household:			
Case Contact Information (add rows as needed to record different workers)			
Provider case manager(s):	Phone:		Email:
Provider supervisor:	Phone:		Email:
	Phone:		Email:

Significant Stakeholders (add rows as needed)			*Date of Interview*
Name:	Phone:	Relationship:	
Name:	Phone:	Relationship:	
Name:	Phone:	Relationship:	
Name:	Phone:	Relationship:	
Name:	Phone:	Relationship:	
Name:	Phone:	Relationship:	
Name:	Phone:	Relationship:	

Key Dates (Record dates from database file prior to site visit.)			
Removal date:	Trial home visit date:		Discharge date:

Other History (e.g., reported for abuse/neglect or placed out of home in another state, mental health or AOD services)

INFORMATION TO BE COLLECTED ON CHILD

Item 1. Level of Need – Child Mental Health

Consider all assessments, Permanency Plan(s), reports to the Court, Court Orders, case logs, letters, CAFAS, CBCL, etc.

Core Questions

1) **What MH assessments were documented in the case file?**
    Note dates of assessment, when relevant.

	Yes	No	NA / Unknown
SED Screen - If yes, indicate determination below _____ Not SED _____ SED with CBS _____ SED no CBS			
Provider Assessment			
Child Welfare MH Referral Guide			
CMHC or Private MH provider assessment			
Psych evaluation			
Other assessments (List below. For example: CAFAS, CBCL, etc.)			

   1a) Comments on Assessments:

2) **What mental health needs were identified and what recommendations were made to address these needs? List all MH needs, including major symptoms, behavioral indicators, etc. Record type of services recommended, frequency planned and treatment goals.**

3) **List available DSM diagnoses.**
Axis I:
Axis II:
Axis III:
Axis IV:
Axis V (GAF score):

4) **What were underlying needs that were not identified and/or addressed, if any?**

5) **Among parties, were there discernible disagreements about the mental health needs of the youth?**

6) How adequate were assessments in covering all relevant areas/family members and in identifying needs?

7) How would you describe the timeliness of MH assessments? Record reasons for lack of timeliness, if possible.

Item 2. Service Provision – Child Mental Health

Core Questions

1) What mental health services does the case file indicate the youth received?

2) How well did mental health services provided match the youth needs? Consider frequency of services, type of service/treatment, and goals of services/treatment. Also consider whether the treatment plan was followed.

3) How would you describe the timeliness of MH service initiation? Include discussion of MH response to emergencies and crises.

4) How would you characterize the role/involvement of the Court related to MH Services?

Item 3. Level of Need – Child AOD

Core Questions

	Yes	No	NA / Unknown
5) Was a RADAC assessment documented in the case file? *Include dates referred or completed and note if date was not clear.* *Also indicate findings of RADAC screen below:* _____ No treatment _____ Education _____ Outpatient _____ Inpatient			

6) What AOD needs were identified and what recommendations were made to address these needs? List major types of AOD use/abuse. Record type of services recommended, frequency planned and treatment goals.

7) How well were AOD needs assessed? Consider timeliness of assessment.

8) **Among parties, were there discernible disagreements about the AOD needs of the youth?**

9) **Provide any other comments on youth AOD needs.**

Item 4. Service Provision – Child AOD

Core Questions

10) **What AOD services does the case file indicate the youth received?**

11) **How well did AOD services provided match the youth needs? Consider frequency of services, type of service/treatment, and goals of services/treatment. Also consider whether the treatment plan was followed.**

12) **How would you describe the timeliness of AOD services received by the youth?**

13) **How would you characterize the role/involvement of the Court related to AOD Services?**

Item 5. Level of Need – Adult Mental Health & Other Needs

Note: Complete for all adult caregivers responsible for the child for whom information is available.

Core Questions

14) **What MH & other assessments were documented in the case file?**
   Include dates completed and note if date was not clear. Include one or more caregivers.

	Yes	No	NA / Unknown
Provider Assessment			
CMHC or Private MH provider assessment			
Psych evaluation			
Other assessments (List below.)			

   14a)   **Comments on Assessments:**

15) **What mental health and other needs were identified and what recommendations were made to address these needs?**

List all identified MH needs of caregivers, including major symptoms, behavioral indicators, etc. Record type of services recommended, frequency planned and treatment goals.

16) Was or were the parent(s) considered SPMI? (Seriously and Persistently Mentally Ill)

17) List available DSM diagnoses.
Axis I:
Axis II:
Axis III:
Axis IV:
Axis V (GAF score):

18) What were underlying needs that were not identified and/or addressed, if any?

19) Among parties, were there discernible disagreements about the mental health needs of the adult(s)?

20) How adequate were assessments in covering all relevant areas/family members and in identifying needs?

21) How would you describe the timeliness of MH assessments?

Item 6. Service Provision – Adult Mental Health & Other Social Services

Core Questions

22) What mental health and other social services, if any, does the case file indicate the adult(s) received?

23) How well did mental health and social services provided match the adult(s)' needs? Consider frequency of services, type of service/treatment, and goals of services/treatment. Also consider whether the treatment plan was followed.

24) How would you describe the timeliness of MH service initiation? Include discussion of MH response to emergencies and crises.

25) How would you characterize the role/involvement of the Court related to MH Services?

Item 7. Level of Need – Adult AOD

Core Questions

	Yes	No	NA / Unknown
26) Was a RADAC assessment documented in the case file?			

Include dates referred or completed and note if date was not clear. *Also indicate findings of RADAC screen below:* _____ No treatment _____ Education _____ Outpatient _____ Inpatient			

27) What AOD needs were identified and what recommendations were made to address these needs? List major types of AOD use/abuse. Record type of services recommended, frequency planned and treatment goals.

28) How well were AOD needs assessed? Consider timeliness of assessment.

29) Among parties, were there discernible disagreements about the AOD needs of the adult?

30) Provide any other comments on AOD needs of adult.

Item 8. Service Provision – Adult AOD

Core Questions

31) What AOD services does the case file indicate the adult received?

32) How well did AOD services provided match the adult's needs? Consider frequency of services, type of service/treatment, and goals of services/treatment. Also consider whether the treatment plan was followed.

33) How would you describe the timeliness of AOD services received by the adult?

34) How would you characterize the role/involvement of the Court related to AOD Services?

Item 9. Case Planning (entire case)

Core Questions

35) Provide comments on the individualization of case planning and the Permanency Plan(s). Record if/when PP goal changed. Consider Notes for Case Reviewers listed below.

Notes for Case Reviewers

- Consider whether Permanency Plans were reviewed in a timely manner. PPs are required by law to be

reviewed at least every 6 months.
- How individualized were the PP's?
- Were there any disagreements regarding the permanency goal?
- Do the PP's include MH needs as identified by assessments?
- Do the PP's include AOD needs as identified by assessments?
- Does it appear that the youth participated in developing the plan(s)?
- Does it appear that the biological parents participated in developing the plan(s)?
- Do the PP's include tasks for both youth and parents?
- Were the PP's appropriately adapted and updated as new needs were identified?
- Did the MH provider attend case planning meetings?
- Did the AOD provider attend case planning meetings?

Item 10. Prevention & Permanency (entire case)

Core Questions

36) **What could have been done to prevent placement of this youth? What services or activities would have been helpful?**

37) **What service barriers, if any, were encountered by the youth and family? How do you see these barriers impacting the youth achieving timely permanency? Consider items listed in the Notes for Case Reviewers below.**

38) **What events, services or people were important in <u>supporting</u> timely permanency? Consider the role of MH or AOD professionals (e.g., helping maintain placement by responding to a crisis or supporting a resource parent).**

Notes for Case Reviewers

39) **In considering prevention, barriers, and supports, review the following:**
- Assessments
  - ° Were assessments timely?
  - ° Were assessments comprehensive? Were assessments inclusive of all relevant family members?
  - ° Were there underlying needs that were not addressed?
  - ° Were youth and family strengths identified?
  - ° Were assessments culturally relevant/competent?
- Services
  - ° Were services appropriate for adequately addressing the needs of the youth? For the caregivers?
  - ° Were services provided in a timely manner?
  - ° Were services individualized for this youth? For this family?

- ° Were services culturally relevant/competent?
- Individualization of case planning
  - ° Did the youth participate or have input in the case planning process?
  - ° Did the birth family participate or have input in the case planning process?
- Major service barriers
  - ° Was availability of local resources a service barrier (e.g., distance, waiting lists, etc.)?
  - ° Were there any other access issues to services (e.g., transportation, child care, language)
  - ° Was caretaker participation a service barrier?
  - ° Were dual diagnosis system challenges a service barrier?
- Family focus
  - ° Did assessments consider all relevant family members?
  - ° Did services involve all relevant family members?
  - ° Were relative placements considered?
- Placement proximity
  - ° Did placement proximity affect any family members' ability to attend family therapy or participate in other case plan goals?
- Placement stability
  - ° Consider the impact of placement changes on permanency (helping or hurting).
  - ° Did placement moves interrupt MH or AOD service continuity?
- Role of Mental Health services
  - ° Was the lack of mental health services a major contributor to this youth entering placement? Could mental health services have prevented this placement?
  - ° Was mental health timely in responding to crises so as to prevent placement disruption?

Item 11. Summary & Questions

Summary

Include key events.

Questions to ask Interviewees

Record questions raised by the case review.

Item 12. Interview Questions

40) Were MH and/or AOD needs adequately assessed? Timely?

41) Were services timely?

42) Did services match the needs of this youth and family in terms of appropriateness, frequency, timeliness and intensity?

43) What could have been done to prevent placement of this youth? What services or activities would have been helpful?

44) What service barriers, if any, were encountered by the youth and family? How do you see these barriers impacting the youth achieving timely permanency?

45) What events, services or people were important in <u>supporting</u> timely permanency? Consider the role of MH or AOD professionals (e.g., helping maintain placement by responding to a crisis or supporting a resource parent).

46) System coordination: What were the best parts of service coordination/collaboration for this case? What were the challenges to service coordination/collaboration for this case?

Item 12. Expert Impressions and Summary Themes

Expert Impressions

Consider adequacy of assessment, timeliness of assessment and services, appropriateness of services, etc. Summarize the case overall, including information gained from interviews. Key headings are provided below.

Assessment (timeliness & comprehensiveness)

Service – (timeliness & appropriateness)

Individualization of Case Planning & Services

Major Supports (key people, events, services)

Family Focus

Service Barriers

Placement Proximity (impact on services and outcome)

Placement Stability (if problem what efforts made to maintain placements)

Mental Health / AOD Role
- Preventing Placement
- Responding to Crises

Stability of caseworkers and therapist

Systems coordination

APPENDIX C: CSFR DATA INDICATORS

TABLE OF DATA INDICATORS FOR THE
CHILD AND FAMILY SERVICES REVIEW

Ranges, Medians, and National Standards for the Child and Family Services Review Data Indicators - Fiscal Year (FY) 2004*

DATA INDICATORS	Range	Median	National Standard
Data indicators associated with CFSR safety outcome 1 – Children are, first and foremost, protected from abuse and neglect.			
Of all children who were victims of a substantiated or indicated maltreatment allegation during the first 6 months of FY 2004, what percent were not victims of another substantiated or indicated maltreatment allegation during a 6-month period?	86.0 – 98.0	93.3	**94.4 or higher**
Of all children served in foster care in FY 2004, what percent were not victims of a substantiated or indicated maltreatment by a foster parent or facility staff member?	98.59 – 99.90	99.58	**99.67 or higher**
Data indicators associated with CFSR permanency outcome 1 – Children have permanency and stability in their living situations			
Permanency Composite 1: Timeliness and Permanency of Reunification	50 – 150	101.6	**110.2 or higher**
Component A: Timeliness of reunification			
Of all children discharged from foster care to reunification in FY 2004 who had been in foster care for 8 days or longer, what percent were reunified in less than 12 months from the date of the most recent entry into foster care? (This includes the "trial home visit adjustment.")	44.3 – 92.5	69.9	No Standard
Of all children discharged from foster care to reunification in FY 2004 who had been in foster care for 8 days or longer, what was the median length of stay (in months) from the date of the most recent entry into foster care until the date of reunification? (This includes the "trial home visit adjustment.")	1.1 – 13. 7	6.5	No Standard
Of all children entering foster care for the first time in the second 6 months of FY 2003 who remained in foster care for 8 days or longer, what percent were discharged from foster care to reunification in less than 12 months from the date of the first entry into foster care? (This includes the "trial home visit adjustment.")	17.7 – 68.8	39.3	No Standard
Component B: Permanency of reunification			
Of all children discharged from foster care to	1.4 –	15.0	No

reunification in FY 2003, what percent re-entered foster care in less than 12 months from the date of discharge?	31.2		Standard

*The years cited in the measures reflect the data reporting periods used to establish the national standards. When the data indicators are established for individual States undergoing a CFSR review, the measures will reflect the data reporting periods relevant to each State's review.

DATA INDICATORS	Range	Median	National Standard
Permanency Composite 2: Timeliness of Adoptions	50 – 150	94.4	**103.0 or higher**
Component A: Timeliness of adoptions of children discharged from foster care			
Of all children who were discharged from foster care to a finalized adoption in FY 2004, what percent were discharged in less than 24 months from the date of the most recent entry into foster care?	6.2 – 73.0	24.6	No Standard
Of all children who were discharged from foster care to a finalized adoption in FY 2004, what was the median length of stay in foster care (in months) from the date of the most recent entry into foster care to the date of discharge?	16.9 – 55.7	32.5	No Standard
Component B: Progress toward adoption for children who meet ASFA time-in-care requirements			
Of all children in foster care on the first day of FY 2004 who were in foster care for 17 continuous months or longer, what percent were discharged from foster care to a finalized adoption before the end of the fiscal year?	2.2 – 22.8	17.7	No Standard
Of all children in foster care on the first day of FY 2004 who were in foster care for 17 continuous months or longer, what percent became legally free for adoption (i.e., a termination of parental rights was granted for each living parent) in less than 6 months from the beginning of the fiscal year?	0 – 17.2	7.4	No Standard
Component C: Progress toward adoption of children who are legally free for adoption			
Of all children who became legally free for adoption (i.e., a termination of parental rights was granted for each living parent) during FY 2003, what percent were discharged from foster care to a finalized adoption in less than 12 months of becoming legally free?	0 – 100	43.7	No Standard
Permanency Composite 3: Achieving permanency for children in foster care for long periods of time	50 – 150	103.8	**111.7 or higher**
Component A: Achieving permanency for children in foster care for long periods of time			
Of all children who were discharged from foster care in FY 2004 and were legally free for adoption (i.e., there	84.8 –	97.0	No Standard

was a termination of parental rights for each living parent), what percent were discharged to a permanent home prior to their 18th birthday? A permanent home is defined as having a discharge reason of adoption, guardianship, or reunification (including living with relative).	100		
Of all children in foster care for 24 months or longer on the first day of FY 2004, what percent were discharged to a permanent home prior to their 18th birthday and by the end of the fiscal year? A permanent home is defined as having a discharge reason of adoption, guardianship, or reunification (including living with relative).	8.1 – 35.3	24.5	No Standard
Component B: Children growing up in foster care			
Of all children who exited foster care with a discharge reason of emancipation prior to their 18th birthday or who reached their 18th birthday while in foster care, what percent were in foster care for 3 years or longer?	17.9 – 80.4	50.7	No Standard

DATA INDICATORS	Range	Median	National Standard
Permanency Composite 4: Placement Stability	50 – 150	99.2	**108.5 or higher**
Of all children in foster care in FY 2004 who were in foster care for (a) 8 days or longer and (b) less than 12 months, what percent had two or fewer placement settings?	55.0 – 99.6	83.3	No Standard
Of all children in foster care in FY 2004 who were in foster care for at least 12 months but less than 24 months, what percent had two or fewer placement settings?	27.0 – 99.8	59.9	No Standard
Of all children in foster care in FY 2004 who were in foster care for at least 24 months, what percent had two or fewer placement settings?	13.7 – 98.9	33.9	No Standard

*The years cited in the measures reflect the data reporting periods used to establish the national standards. When the data indicators are established for individual States undergoing a CFSR review, the measures will reflect the data reporting periods relevant to each State's review.

Common Terminology

Data indicator: Refers to the two safety measures and the four permanency composites for which national standards have been developed. That is, anything that has a national standard is referred to as a data indicator.

Composite: Refers to a data indicator that incorporates State performance on multiple permanency-related individual measures.

Composite score: This term is the number that reflects a State's performance on a particular composite. Composite scores range from 50 to 150, with higher scores reflecting higher performance.

Individual measures: Refers to the specific measures that are included in each composite. Although it would be technically correct also to use that term to refer to the two safety measures, it may be clearer to refer to the two safety measures as safety "data indicators" since they have national standards associated with them. That way we will be able to differentiate them from the individual measures in the composites.

Components: Refers to the primary parts of a composite. Components may incorporate only one measure or may have two or more measures that are closely related to one another. (The table identifies the components for each composite.)