



**Mental Health and Substance Abuse
Services to Children in Need of Care
Non Abuse and Neglect (CINC-NAN)**
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Executive Summary

Chapter 1: Introduction and Literature Review

This report represents the second year of a major research project focused on the Child in Need of Care (CINC) Non-Abuse/Neglect (NAN) population in Kansas. This year's study narrowed its purview to one of five CINC NAN typologies derived from a cluster analysis conducted in the first year of this research initiative, adolescents without abuse and neglect histories who entered care in FY 2005. This year's study chose to concentrate on this subset of CINC-NAN adolescents because researchers hypothesized that these adolescents, who presented with no prior abuse or neglect histories and minimal indications of parent problems, might especially benefit from services intended to prevent placement and expedite reunification. To gain a sense of the use and impact of mental health and substance abuse services among this population, an in-depth qualitative analysis was conducted on 30 cases (p.12)¹.

The study sought to: 1) understand and describe the mental health needs of this adolescent CINC-NAN population; 2) gauge access to and impact of mental health and substance abuse services on the foster care experiences of CINC-NANs, including permanency outcomes; 3) inform the development of evidence-based service strategies to prevent unnecessary out-of-home placements; and 4) help mitigate barriers to timely permanency in those situations in which placement cannot be avoided.

A review of the literature showed that little research has been conducted which specifically addresses the NAN population in foster care. Therefore, the general foster care literature related to the provision of mental health and substance abuse services was reviewed, including critical components of service provision for youth and their families (p. 6).

Children in foster care exhibit a high level of need for mental health and substance abuse treatment services, and in general, use of mental health and substance abuse services is high in this population. However, existing literature suggests that not all foster children receive the mental health and substance abuse services they need (p.7-8).

The literature review included in this chapter summarizes core components of service provision that are relevant to this study's focus on mental health and substance abuse services, including assessment and case planning (p.8-9). Other issues discussed include system barriers, family focus, and systems collaboration (p.11-13).

Chapter 2: Methods

This was a qualitative study that employed case file review and individual interviews. A limited quantitative analysis of data from the Kansas Addiction and Prevention Services (AAPS) database was also performed. Based on pre-specified criteria, a purposive sample of 30 cases was drawn from a pool of 255 cases originally randomly selected from a statewide database in

¹ Page numbers are inserted to assist the reader in locating more detailed information in the body of the report.

FY 2006. (p.19). The sample consisted of 30 youth ranging in age from 12 to 17 years old. Sixty percent of the youth were teen girls and 40 percent were teen boys. Fifty-seven percent of the youth were white and 40 percent were children of color (p.19).

The following research questions guided this study:

1. What are the identified mental health and substance abuse (MH/SA) needs of children identified as CINC-NANs? Based on evidence available in case files, were these needs adequately assessed?
2. What MH/SA services were recommended?
3. Were needed services available, accessible, and provided in a timely manner?
4. What factors were identified as barriers and supports to MH/SA services?
5. What impact do MH/SA services have on achieving child welfare outcomes?

Data collection included review of foster care provider case files and 54 individual interviews with foster care case managers and supervisors, therapists, and other parties to the case. A semi-structured data collection tool guided collection of data and interviews (p.20). Data were imported into a qualitative software program for coding and analysis. Inter-rater reliability and validity were addressed through methodological triangulation, investigator triangulation, and skeptical peer review (p.23).

Like all research, this study has its limitations. First, it predominantly relied on foster care agency case files, which include only certain information about mental health and substance abuse services. This limitation was tempered by interviews with involved parties, including mental health professionals, and by the supplementary quantitative analysis of AAPS data. Secondly, this was an in-depth case study of a small number of cases. While case study was most appropriate to capture a thick description of youth experiences with foster care and MH/AOD treatment, the small number of cases limits the study's generalizability. Third, in order to allow time for services to be delivered and permanency to be achieved, cases comprised a cohort which entered foster care in FY 2005. Changes in child welfare contracts that occurred in July 2005 occurred after the children in our sample were in care. These changes may moderate some of the study's findings.

Chapter 3: Mental Health

This chapter examines mental health assessment and treatment of foster care youth in our sample. Service adequacy, timeliness, and congruence with needs were examined. Following is a summary of key findings related to mental health assessments, services, barriers, and supports.

Assessment of Youth (p.28)

- Youth in the sample presented with a significant level of acuity. Nineteen of 30 youth were considered to have a serious emotional disturbance. The most common diagnoses among them were behavior and attention diagnoses, followed by mood disorder diagnoses. Unreported maltreatment (or other trauma) was the norm across cases. The significant acuity of presenting problems among youth likely reflects unmet needs for services earlier in the lives of cases.

- Nearly 80% of youth with identified mental health needs received timely mental health assessments.
- While some assessments were particularly comprehensive for the youth *as individuals*, assessments showed a chronic lack of attention to family of origin issues and members—historically and currently. Few assessments included information relevant to the child’s immediate family environment.

Mental Health Treatment of Youth (p.46)

- Service initiation was considered good to adequate in about half the cases reviewed. In a quarter of remaining cases reviewed, slow initiation was attributable to non-mental health provider variables (e.g. failure to keep appointments, failure to complete required paperwork). Service initiation appeared to be problematic in the final quarter of cases, but case documentation does not permit researchers to characterize factors which led to the lack of timely service initiation.
- Treatment adequacy ranged from excellent to fair. Successful treatment was distinguished by effective engagement of family members, specialized services (e.g. youth-targeted programs), and case-specific treatment goals rather than cookie cutter treatment goals. Service gaps included: lack of family therapy and lack of attention to sexual abuse. Systemic issues included: lack of compliance among youth and parents, insufficient attendance at therapy to develop a therapeutic alliance, and vague treatment goals.

Assessment and Treatment of Parents (p.58)

- While there were some exceptions, the norm across cases was little participation from family members, in family therapy or in parents’ own individual treatment.

Barriers and Supports (p. 56)

- Major barriers to services included: service disruption due to placement changes; inconsistently delivered or attended services; lack of family focus; parent or youth non-compliance; geographic barriers; and lack of a dedicated funding source for parent treatment.
- Major supports included: resource families, wraparound services, and family therapy.

Chapter 4: Alcohol and Other Drug Abuse

In addition to mental health needs and treatment, this study sought to understand the need for assessment and treatment of substance abuse among youth and parents. Researchers attempted to discern how AOD needs were addressed by respective service systems and how service delivery impacted the foster care experiences of youth and their families. Following is a summary of the key findings related to AOD assessments, services, and barriers.

Youth Assessment (p. 63)

- There was a very high level of need for AOD assessment and treatment among youth in this study. Eighteen of the 30 youth were referred for an AOD assessment.

- Findings on timeliness of assessments were mixed. Child welfare referrals for assessment were not always timely; however, AOD assessments were conducted in a timely manner.
- The level of need for AOD treatment was best gauged by assessing need at multiple points in time instead of at one point in the life of a case. Continual assessment and monitoring of AOD abuse is needed.
- Documentation surrounding AOD assessment, recommendations, urine screenings, and treatment activities was repeatedly found to be incomplete or missing.
- The AOD needs of youth were complex, both in severity and in the co-occurrence of AOD use and abuse and associated problems (e.g., trauma, criminal involvement, runaway and other out-of-control behaviors)

Youth Treatment (p. 66)

- Twelve youth received treatment. Two youth received inpatient treatment; ten received outpatient treatment.
- Most treatment was accessed in a timely manner. Youth also appeared to change levels of treatment in a timely way.
- Cases were marked by a lack of specialized discharge planning. Discharge planning for youth in custody is a specialized task which may differ from discharge planning for youth who are not in custody.

Adult Assessment and Treatment (p. 68)

- Despite evidence of significant parental substance abuse issues, referrals for parent substance abuse assessment were rare. Even more rare were parents who received AOD treatment.

Barriers (p. 69)

- The lack of family involvement in treatment was found to be a major barrier among these cases.
- A second major barrier was an absence of court authority as it related to parental needs and mandate for treatment.

Chapter 5: Child Welfare

Chapter 5 focuses on the child welfare system's role in foster care, especially as it relates to youth and parent mental health and AOD needs. This chapter is organized around the primary role that child welfare case managers play in facilitating the provision of treatment and supportive services to families involved in the foster care system.

The following are key findings to child welfare responsibilities for assessment, case planning, service implementation, and child welfare case outcomes.

Assessment (p.72)

- Youth's assessments demonstrated timely referral for mental health and substance abuse services.
- Assessments largely focused on the youth without sufficient attention to parents and the family system.
- Assessments did not routinely address youth/family strengths and culture.
- Systematic reassessment rarely appeared to guide case decisions.

Case Planning (p.77)

- Case managers were very consistent in meeting timeliness requirements for permanency planning conferences.
- Case plans yielded some evidence of individualized and strengths-based goals; however, they lacked individualized and strengths-based goals and they were seldom family-centered.
- Youth and family participation in plan development was more the exception than the rule.

Service Implementation (p.83)

- Mental health and substance abuse treatment services were frequently provided to youth. Service provision to parents was rare.
- Missing service areas suggest lack of attention to underlying needs (e.g., sexual abuse, trauma, abandonment, grief).
- Greater efforts to engage birth parents and other relevant family members are needed.
- Monitoring service implementation and case plan goals appeared limited. Progress on case plan goals needs to be more specific and measurable. This would help families and case managers alike to measure progress. Clearer case plan goals would also make clearer the basis on which permanency decisions are made.
- Agencies did not seem to have a systematic approach for determining reunification readiness.

Other Factors Related to Service Provision (p. 91)

- Placement proximity and placement stability negatively impacted case outcomes for several youth.
- Placement stability ranged from excellent to problematic. About a quarter of cases appeared to have preventable stability issues.
- Gaps in case documentation included incomplete and conflicting information. These problems were compounded by worker turnover, which is when complete documentation is especially necessary.

Child Welfare Case Outcomes (p.90)

- While sixteen of the 30 youth in the sample achieved reunification, only eight achieved reunification within 12 months of entering care. One third of the 30 youth experienced at least one foster care re-entry subsequent to the review period. Only eight youth experienced timely permanency with no re-entry.
- Eleven of the thirty youth aged out of care, few with adequate preparation for adult life.
- More than one third of youth were in care for 12 months or longer.
- The most urgent findings from the case review are poor case outcomes and an absence of parent participation in assessment and services. The absence of strong engagement strategies and comprehensive family assessments impacts case planning and service provision and likely contributes to poor case outcomes for these youth.

Chapter 6: Cross-Systems

Chapter 6 addresses cross-system issues with a focus on collaboration between systems, as this is fundamental to successful service delivery with families involved in foster care. Collaboration is addressed by covering each of the following topics: service initiation, ongoing information sharing, and interagency coordination. While prominence is given to mental health and substance abuse service systems, two other important systems are also addressed in this chapter: the judicial and educational systems.

The following are key findings related to the basic elements of collaboration between all systems.

Service Initiation (p. 101)

- The time-consuming mental health intake process results in delays in service initiation. The necessity to repeat the process in cases of placement instability becomes particularly problematic.
- AOD assessment and treatment initiation appear to be relatively unproblematic, although some workers question the validity of the RADAC assessment due to its basis in self-report.

Information Sharing (p. 103)

- Information sharing between systems typically occurs through periodic phone calls or e-mail. Regular, well-documented exchange of information is wanting, particularly with AOD providers.

Interagency Collaboration (p. 106)

- Three successful models of collaboration emerged: multidisciplinary teams, wrap around and family meetings. Case planning meetings are too poorly attended by other professionals to serve as an effective mechanism for ongoing interagency collaboration.

Other Major Systems – Courts & Schools (p. 108)

- The court role varied widely by jurisdiction. Court orders facilitated compliance with services by youth and their parents.

- A majority of cases involved educational issues. Schools are an overlooked potential resource for youth in care.

Chapter 7: Major Supports and Barriers

Chapter 7 summarizes the major supports and barriers that were identified across the 30 cases reviewed in this study. Researchers considered both case documentation and interviews to identify supports and barriers.

The following is a summary of the key findings related to major supports and barriers.

Major Supports (*p. 115*)

- Helping professionals who built trusting, caring, and respectful relationships
- Resource parents who provided structure and assistance (e.g. job training and preparation) that led to other improvements among youth in their care
- Various services, including individual and family therapy, Level VI placements, substance abuse services, educational services, and aftercare services
- Exceptional efforts and best practices that demonstrated high commitment, effort, and innovation

Barriers and Service Gaps (*p. 121*)

- Shortfalls in practice demonstrated the need for:
 - More comprehensive family assessments and services that address underlying needs
 - Practice strategies for engaging noncompliant and resistant parents and youth
 - More family-centered practice, including engagement of all family members and informal supports in assessment and services
- Gaps in services pointed to the need for:
 - A more complete continuum of care, including placement prevention interventions, easily accessible parent-child mediation services, crisis response from mental health, and aftercare services
 - More high quality, youth-specific services at the local level
 - More same-language and culturally relevant services to address the needs of Spanish-speaking families, youth of color, and sexual minority youth

Chapter 8: Conclusions and Recommendations

This chapter summarizes seven major findings from this year's in-depth case review of 30 CINC-NAN cases. Findings cut across cases and service categories. Policy and practice implications of these findings are also discussed. Further description of each finding and recommendation can be found in Chapter 8.

Seven Major Findings

- Finding #1: Cases were marked by multiple and complex needs, and commonly included youth with histories of abuse and neglect or other trauma. (*p. 133*)

- Finding # 2: Across systems, cases overwhelmingly focused on individual youth when a family focus would have been more appropriate and helpful. (p. 135)
- Finding #3: The majority of youth received mental health and substance abuse assessments and services as needed. For the most part, services stabilized youth and promoted well-being, although some service gaps exist. (p. 138)
- Finding #4: Lack of attention to youth and family underlying needs impeded effective assessment, service planning, and provision. (p. 139)
- Finding #5: Interagency collaboration facilitated service delivery, but this area needs more development and widespread implementation. (p. 140)
- Finding # 6: Cases were marked by missed opportunities for prevention, crisis, and ongoing support. (p. 142)
- Finding #7: Collectively, poor outcomes were achieved with these youth. (p. 143)

Policy Implications and Recommendations

Policy implications and recommendations are grouped into five topics and listed below.

NAN Assessment at Intake (p. 145)

- Revise NAN assessment protocol at the point of intake to more adequately address past abuse and neglect or other trauma.

Comprehensive Family Assessment and Engagement Strategies (p. 146)

- Conduct comprehensive family assessments.
- Improve parent and youth engagement in the case management process.
- Provide culturally relevant, competent services.

Mental Health and AOD Service Enhancements (p. 148)

- Provide family therapy.
- Improve service response for youth with trauma histories, particularly sexual abuse.
- Provide specialized mental health and AOD services for youth.
- Provide mental health and AOD services to parents of youth in foster care.

Foster Care/Placement Enhancements (p. 150)

- Monitor cases which have more than three placement moves within a specified period of time.

- In the absence of therapeutic foster care or sufficiently stabilizing outpatient treatment, longer stays in PRTFs or similar highly structured settings may be necessary for some youth.
- Provide more training and mental health support for resource parents.
- Improve adult preparation of foster youth by maintaining family connections.
- Use mental health services or respite to maintain placements.
- Provide aftercare.

Cross-Systems Collaboration (p. 152)

- Develop placement prevention alternatives for cases characterized by parent or child refusal to return home.
- Increase the use of wraparound services.
- Implement multidisciplinary group supervision.
- Courts and child welfare could partner more effectively to improve child welfare outcomes and to hold parents accountable for the care of their youth.
- Improve information sharing between child welfare and AOD providers.
- Hold joint trainings and create ongoing professional development and networking opportunities across the mental health, substance abuse, and child welfare systems.
- Consider integrated models of care such as co-location of mental health and substance abuse staff in child welfare agencies or multi-service centers.

Chapter 1. Introduction and Literature Review

This report represents the second year of a major research project focused on the Child in Need of Care (CINC) Non-Abuse/Neglect (NAN) population in Kansas. CINC-NANs have long been of concern to child welfare administrators. Over the years, various groups have attempted to change Kansas laws to more specifically address the needs of this group of children and their families. The most recent attempt was the introduction of SB 171 which narrowed the definition of a Child in Need of Care and excluded cases formerly identified as NAN cases. In response to this bill, SRS convened a diverse group of stakeholders. In these meetings, stakeholders determined that the state of Kansas would benefit from additional research into the composition and needs of this diverse population. No comprehensive study of this population in Kansas had been conducted previously.

In FY 2006, researchers from the University of Kansas School of Social Welfare (KU SSW) undertook a mixed methods study of children in need of care for reasons other than abuse and neglect. The goals of last year's study were to: 1) to examine predominant report sources, removal reasons, and practice variations among judges and caseworkers; 2) to discern whether children with CINC-NAN status encountered abuse and neglect; 3) to develop clinical typologies for this group of children and families; and 4) to determine whether CINC-NAN placements could have been prevented.

The study comprised a number of separate analyses, including 1) an investigation of NAN removal rates from July 2000 to October 2005; 2) an examination of time to permanency for NANs placed in care between July 2000 and October 2005; 3) a cluster analysis of 9110 children who were assigned CINC-NAN cases in calendar years 2004 and 2005; 4) an in-depth case review of 255 randomly selected CINC-NANs who entered out of home care in FY 2005;

and finally 5) an analysis of the mental health involvement of children in care which relied on databases maintained by SRS Children and Family Services, Medicaid, Kansas' 26 Community Mental Health Centers, and the Mental Health Consortium.

Last year's study produced three major findings which drove the current study: 1) the presence of significant substance abuse problems among children and youth with CINC-NAN designations; 2) a high degree of mental health need among CINC-NANs; and 3) a subpopulation of NAN adolescents who appeared to present with fewer parent concerns and less prior contact with the child welfare system than their higher risk cohorts. Findings germane to the development of the present study are discussed below.

Substance Abuse in the CINC-NAN Population-Results from FY 2006

In the in-depth case review of 255 randomly selected NANs, substance abuse was indicated in 21.6% of cases reviewed; that is, approximately 55 of 255 children or youth appeared to have a substance abuse problem. Almost half (48%) of the teens in the sample aged 16-17 had indicated substance abuse issues. Perhaps most surprising, researchers also found high levels of substance use among *younger* children in the sample. One third of children aged 13-15 and at least 4% of children aged 10-12 had indications of substance abuse. These data suggest that substance use in the CINC-NAN population is common and that alcohol and drug use may begin quite early. Also noteworthy was the fact that most children and youth in the sample were using drugs other than alcohol. Ten percent of CINC-NANs with substance abuse indications were primarily using "other drugs."

Implications of these findings, and of prior research which demonstrates that substance abuse contributes to poor outcomes at many different junctures in the child welfare experience (Moore, et al., Chapter 8, p. 8.8) suggests the need to better understand the circumstances under

which Kansas CINC-NANs are assessed for and receive substance abuse treatment. Some questions raised by last year's study which informed the present study are: How are NANs currently assessed for AOD needs? What AOD services do NANs and their families receive? What barriers do NANs and their families encounter when seeking AOD services? What is the impact of services on child welfare outcomes? These questions, and their operationalization for the study, will be discussed in greater detail in Chapter 2: Methodology.

Mental Health Needs and SED Status among CINC-NANs

Another finding from the FY 2006 study which is pertinent to this year's project is the significant need for and receipt of mental health services among CINC-NANs. Quantitative analyses of four linked databases (Moore et al., Chapter 6) revealed that the likelihood of receiving mental health services increased the longer a child was in placement. Details of mental health use were documented by an in-depth case review (Moore, et al., Chapter 5). Because the case review examined only one removal episode per child, case review data could neither confirm nor disconfirm this finding. However, a significant percentage of the children in the case review sample, 18.8%, had a mental health diagnosis at the time of intake. Furthermore, of the 255 children in the sample, 9% met criteria for severe emotional disturbance at the time of the first case plan.² Eight percent of children in the sample had threatened or attempted suicide, and 7% of the children were self-injurious. All but one child with an SED designation received Home and Community Based Services (HCBS).

Nearly two thirds of the CINC-NAN population in care received some type of mental health services during the review period. While last year's study did not seek to identify the

² The term severe emotional disturbance (SED) refers to a diagnosed mental health condition that substantially disrupts a youth's ability to function socially, academically, and emotionally.

potential of mental health services to prevent placement, findings did corroborate existing studies which indicate that many children in need of specialized mental health services do not receive services until they enter out of home care (GAO, 2003). This finding, in turn, raises several questions which formed the basis of the current study: To what extent can mental health services reduce the demand for out of home placement? What barriers do children and families encounter in accessing mental health services prior to placement? What types of mental health services are provided to children and families? Do children (and parents) routinely receive the services to which they are referred? What is the impact of services on permanency outcomes?

Before reviewing the research literature which also informed the current study, one remaining finding from last year's CINC-NAN study will be discussed.

NAN Typology Findings

The third important finding from the FY 2006 CINC-NAN study derived from a cluster analysis of NAN typologies which initially analyzed 9110 unique cases. Researchers found that cases *at intake* could be meaningfully grouped into three general groups: Cluster 1: Truant Youngsters, Cluster 2: Acting Out Adolescents, and Cluster 3: Children of Parents with Diminished Parenting Capacity. A subsequent cluster analysis of children *in care* taken from the case review sample of 255 children identified two main groups of adolescents. The primary and dramatic differentiating factor between the two groups was prior abuse or neglect reports or substantiations. Thus, the two groups of adolescent NANs were classified as: Cluster A: Adolescents with Past Abuse or Neglect Histories and Cluster B: Adolescents without Abuse and Neglect Histories.

This year's study chose to focus on this second group, Cluster B. Compared with their cohorts in Cluster A, Cluster B adolescents were 1) significantly less likely to have past

abuse/neglect allegations or substantiations; 2) somewhat less likely to have open NAN cases; 3) more likely to have a history of running away, suicidal or self injurious behavior, and educational problems; 4) parents who were considered by SRS staff “unable to cope” but who exhibited few other risk factors; 5) new to child welfare but known to juvenile justice, in-home services, and the police; and 6) in care because youth, parents, or both refused the child’s return to the home.

The rationale for focusing on Cluster B adolescents in this year’s study is as follows: The cluster analysis performed in FY 2006 suggests that there exists a subgroup of NAN adolescents typified by parents with fewer presenting problems than their Cluster A cohorts. For example, parents of Cluster A adolescents were more likely to have histories of incarceration, prior abuse and neglect allegations and substantiations, and significant mental health and substance abuse needs. Additionally, the cases of Cluster B adolescents were marked by a significant degree of potentially remediable parent-child conflict, such as the refusal of the child’s return home by the child, the parent, or both child and parent. Finally, compared to their Cluster A counterparts, cluster B adolescents were more likely to have histories of running away and suicidal or self-injurious behavior, but less likely to have SED designations or mental health diagnoses.

Given the high degree of potentially remediable parent-child conflict, the pattern of running away from home, and the lack of documented prior mental health or substance abuse treatment despite some indication of need, this subgroup would appear to be a prime population for alternative service strategies to prevent out of home placement. Parent-child mediation and mental health and substance abuse services are three such possible service responses. Ultimately, the current study narrowed its scope to the mental health and substance abuse needs of children in care and their families. Specifics of the sampling plan, goals, research questions and

procedures are detailed in Chapter 2, Methodology. The remainder of this chapter briefly reviews the research literature relevant to this study of mental health and substance abuse services to children in care.

Literature Review

Services to children and families are a universal component of the child welfare system's approach for achieving safety, permanency and well-being. Surprisingly, relatively little is known about treatment and supportive services to families and how these services relate to child welfare outcomes (Cash & Berry, 2002; James, Landsverk, Slymen & Leslie, 2004). This review briefly summarizes what is known about mental health and substance abuse service needs and service use among youth in foster care, including critical components in the provision of services to these youth and their families. As pointed out in last year's study, literature specifically addressing the non-abuse/neglect population in foster care is sparse. Therefore, this review highlights general foster care literature related to the provision of mental health and substance abuse services.

Mental Health and Substance Abuse Service Needs

Children in foster care exhibit a high level of need for mental health services. Recent estimates reveal that from 50 to 75 percent of children in care have significant mental health problems (Landsverk, Burns, Stambaugh & Reutz, 2006). The prevalence of need reflects histories of past trauma, family violence, abandonment or rejection, and parental issues with mental health and substance abuse. In foster care, separation from family, adjustments to placement and numerous other life changes contribute to emotional and behavioral needs. Frequently seen mental health problems for children in care include PTSD and abuse-related trauma, disruptive behavior disorders, depression and substance abuse (Landsverk, et al., 2006).

Substance abuse, particularly drug use, is a common area of need for youth in foster care. Compared to youth who have never been in foster care, youth in care, aged 12-17, were slightly more likely to use alcohol, two times more likely to use illicit drugs, and five times more likely to be drug-dependent (Pilowsky & Wu, 2006). In one study, 56 percent of adolescents reported using street drugs while in foster care (Barth, 1990). Substance abuse issues are particularly prevalent among youth living in group care as opposed to other out-of-home living situations (U.S. Department of Health and Human Services Administration for Children and Families, 2005).

Use of Mental Health and Substance Abuse Services

Mental health treatment for foster youth typically consists of standard outpatient services as well as institutional care (Landsverk et al., 2006). The National Survey of Child and Adolescent Well-Being (USDHHS, 2005) revealed that just 31 percent of children in out of home care receive any type of outpatient mental health service. In a study of services among older youth in foster care, Missouri researchers found that 25 percent were utilizing mental health treatment upon entry into foster care (McMillen, et al., 2004). For those without prior service use, 80 percent of these older youths received a mental health service within a year of entering the system. While in care, children and youth utilize a significant proportion of mental health resources. Foster children in California comprise 4 percent of all children enrolled in Medicaid yet they represent 55 percent of all visits to psychologists and 45 percent of all psychiatrist visits (Simms, Dubowitz & Szilagyi, 2000).

Correlates of mental health service use include race/ethnicity, geographic locale, placement type and reason for entry into care. Numerous studies identify racial disparities (Burns et al., 2004; Garland et al., 2000; Leslie et al, 2000; McMillen, et al., 2004) with Caucasian children more likely to receive services than African American or Latino children. McMillen and

colleagues (2004) identified geographic variations in service use. Youth in kinship care receive fewer services than youth in other placement types (Leslie, et al., 2000). Children in foster care for neglect or abandonment may be less likely to receive mental health services than children in care for reasons of sexually or physical abuse (Leslie et al., 2000, Marsenich, 2002).

In 1998, the Child Welfare League of America (CWLA) reported that child welfare agencies obtain substance abuse treatment for only about a third of youth who need it. A more recent study conducted by the Washington State Department of Social & Health Services (2002), found that around half the adolescents in foster care in Washington who need substance abuse treatment receive it. The State of Washington study also discovered that more adolescents in foster care receive treatment for alcohol or other drugs than youth living with parents.

Critical Components of Service Provision

The successful provision of services to youth and families involved with foster care involves a number of critical components. Presented below is the current state of knowledge regarding the aspects of service provision examined by this study.

Assessment

Effective service provision begins with accurate, timely and comprehensive assessment of need. Few child welfare agencies universally screen families for mental health or substance abuse problems as children enter care (Halfon, Zapeda & Inkelas, 2002). Most, if not all agencies, utilize an assessment process to evaluate risk, safety and immediate service needs.

Federal Child and Family Service Reviews (CFSRs) have found that child welfare assessments frequently focused too narrowly on a targeted individual in the family rather than on all family members (Milner, Mitchell & Hornsby, 2001). Other barriers to effective assessment include:

- Specific information for adequate decision-making is not gathered;

- Judgments are based on too little information about the family;
- Current information garners more attention than past information;
- Professionals tend to be skeptical about new information that contradicts previously made decisions; and
- Errors in communication contribute to inappropriate decision-making.
(Children and Family Research Center, n.d.).

A comprehensive family assessment is usually the best means to obtain information to guide service planning and provision. Comprehensive family assessment focuses on broadly understanding a family's situation rather than focusing narrowly on the incident that brought the child into care (Schene, 2005). Guided by principles of family-centered, cultural competent practice, this approach recognizes underlying needs contributing to the presenting problem such as domestic violence, substance abuse, mental health, chronic health issues, and poverty.

Despite the number of youth and families challenged by mental health and substance abuse issues, workers often have limited knowledge, training and skills in understanding and responding to addiction, relapse, and the effects of trauma (Faller & Bellamy, 2000; Kerker & Dore, 2006; CWLA, 1998). The child welfare system and collateral systems also often overlook the need for repeated or continuous assessment over the course of the case.

Case Planning

The child welfare system has primary responsibility for planning and coordinating services to ensure the safety, permanency and well-being of children in care. In this role caseworkers must select and facilitate the provision of services, collaborate with service providers, determine progress toward achievement of goals, and maintain records to document this progress (DePanfilis & Salus, 2003). The case plan is road map to service provision and successful outcomes. Brittain and Hunt (2004) share common pitfalls in case plans:

- Objectives that do not accurately reflect the desired change in behavior;
- “Cookie-cutter” plans that do not consider individualized needs;
- Attempting to address too many risk factors overwhelms the family with tasks.

In contrast, quality case planning and service provision is based on the following foundation:

- Importance of engagement and relationship-building for gathering meaningful information on family, children, and youth;
- Essential involvement of families and youth in identifying their own needs and strengths;
- Acknowledgement of the cultural, ethnic, linguistic, and other individual factors influencing family and youth needs;
- Recognition of youth and family readiness to change; and
- Inclusion of extended family and other family support resources as well as other service providers (Schene, 2005).

Another significant factor in quality case management and positive child welfare outcomes is consistency of caseworkers (Flower, McDonald & Sumski, 2005). Researchers link a lack of continuity in child welfare caseworkers to the decreased likelihood of achieving permanency (Flower, et al., 2005; Ryan, Garner, Zyphur & Zhai, 2006). The National Council on Crime and Delinquency (NCCD, 2006) determined that staff turnover disrupts case planning but also found permanency cases to be closed more quickly in a cluster of agencies with highest turnover. The NCCD hypothesized that this reflects workers' attempts to close cases quickly in order to lighten their load.

Effective case management impacts the pathways that children take through foster care. These pathways can exacerbate the need for services, as in the case of multiple placements. Mental health agencies commonly report the frequency of placement change as a major barrier to effective delivery of mental health services (Halfon, et al., 2002). Lack of stability in foster placements complicates the delivery of services to youth through a discontinuity of services. Kerker and Dore (2006) suggest that not enough is done to ensure the stability of foster placements. Pathways through foster care can also mediate conditions and service needs as in the

case of a consistent, supportive service provider or resource parent. Resource parents, in particular, can be a major support for children in care. Garland and colleagues (2000), however, caution that foster parents do not always follow through on services for children in their care. Kerker and Dore (2006) call for training foster parents as “therapeutic agents” rather than utilizing them as simply “surrogate caretakers.”

Service System Barriers

Youth and families need immediate access to quality services in order to resolve issues within shortened time frames for permanency. Researchers have found that professionals tend to identify barriers to services in child welfare as family-related (i.e. “family not engaged” or “parent fails to follow-through”) rather than systemic (Trupin, et al., 1993). Yet, services are provided in the context of policies, financing and organizational factors that can create roadblocks for families. Barriers to the provision of services for youth and families involved with foster care include issues around availability, accessibility, timeliness, appropriateness, quality and effectiveness.

- **Availability** of mental health and substance abuse services is a common challenge particularly in rural areas. A lack of substance abuse treatment resources is identified as an issue in 80 percent of states (GAO, 2002). Half of all states report that a lack of mental health services impedes progress toward meeting federal child welfare outcomes (Administration for Children and Families, 2002). A shortage of trained mental health professionals, especially child and adolescent psychiatrists, contributes to service availability problems (Burns et al., 2004).
- **Accessibility** of services, or ease of use, is impacted by factors such as transportation, language and cost. Transition to managed care financing of mental health services results in reduction in services for children and adolescents with emotional disorders (Stroul, Pires, Armstrong & Meyers, 1998). Organization of systems, particularly mental health, requires children to change providers each time they are placed in a new setting (Kerker & Dore, 2006). Webb and Harden (2003) draw attention to transitions in and out of care when access to benefits and care can be disrupted.
- **Timeliness** of service provision is critical. Fuller and Wells (1998) found that lack of services during the first 60 days of a case predicts subsequent maltreatment reports.

- **Appropriateness** implies how the service fits or addresses the presenting or underlying needs. Chipungu and Bent-Goodley (2004) cite the ubiquitous goal of “parenting class” as an example of a common mismatch between services extended to families and what might truly help them. Kamerman and Kahn (1990) note that short-term help is typically what is available and offered to families though many have long-term needs. Services for minority families, particularly in mental health, must address unique cultural needs (Webb & Harden, 2003).
- **Quality** relates to the effectiveness of service provision. Researchers suggest that there is little evidence that “usual” mental health care in public mental health centers will lead to measurable benefit for children and youth in foster care (Landsverk, et al., 2006). Empirically supported interventions for children in foster care include wraparound, family-based treatment (Multisystemic family therapy and functional family therapy) and treatment foster care (Kerker & Dore, 2006). Yet it is unclear to what extent mental health and substance abuse treatment professionals are prepared and supported to offer evidence-based interventions to families in foster care (Burns, et al., 2004).

Family Focus

Despite the current “family-centered” mantra in child welfare, biological parents may not be receiving adequate attention or services needed to successfully reunify with their children. Parents with children or youth in foster care show frequent evidence of mental health and/or substance abuse needs. Approximately 70 percent of parents involved with the child welfare system have at least one mental health problem (Faller & Bellamy, 2000). Likewise, substance abuse is understood to be an issue in 70 percent of child abuse/neglect cases (National Center on Addiction and Substance Abuse, 1999). Despite significant need, many caretakers are not getting or completing treatment for mental health and substance abuse (Gregoire & Schultz, 2001; Portland State University, 1998).

In addition to getting their own mental health or AOD needs addressed, parents must take an active role in their child’s mental health or AOD treatment. As Landsverk and colleagues (2006) remark, “Dropping a child off at a clinic for individual therapy for most of these conditions is of very little value”(p. 56). They go on to note that failing to involve families is particularly concerning given that most evidence-based psychosocial interventions for children

and youth involve parents and family as an integral part of the treatment protocol (Landsverk et al., 2006). In a recent review of adolescent substance abuse treatment programs, parental support was the variable most frequently associated with positive outcomes for youth (Williams, Chang & Addiction Centre Adolescent Research Group, 2000).

Systems Collaboration

Given their multiple needs, families with children in care are typically involved with a number of service providers, commonly mental health and substance abuse, as well as collateral systems such as court and education. Collaboration between these systems is critical to effective and efficient service provision. At both the case level and administrative level, interagency work can lead to creative problem-solving, mutual support, and better decision making (Tibrewal and Poertner, nd). In addition to mental health and substance abuse services, two other systems, education and the courts, play a critical role in services to children and parents involved with foster care and thus warrant specific consideration.

Mental Health and Substance Abuse Services

In striving to working across agencies, child welfare, mental health and AOD professionals are challenged by different mandates, values, funding streams, and perspectives on what constitutes success. Confidentiality and information sharing is frequently cited as a barrier to working across systems, particularly with AOD (Drabble, 2007). In addition, funding sources for mental health and substance abuse services commonly fail to support provider participation in collaborative efforts on behalf of their clients (Halfon, et al., 2002).

Brittain and Hunt (2004) offer this advice for communicating and collaborating with service providers:

- Obtain releases so pertinent information can be shared,
- Share reasons for referral including results of the family assessment, critical risk factors and a copy of the case plan.

- Clarify expectations around the type and intensity of services needed including expectations for communicating and reporting on progress

Strategies for building collaborative working relationships among agencies and systems include: interagency agreements, streamlined referral processes, co-location of professionals, cross-training and systems for information sharing.

Court

The court's responsibilities in foster care includes issuing orders, reviewing cases and providing judicial oversight to ensure appropriate services are provided in a timely manner. Flango (2001) further charges the judicial system with giving each case individual attention, treating families fairly and with respect, and taking responsibility for enforcement of court orders. Barriers to effective judicial oversight and decision making include heavy caseloads, mistrust between court and service providers, inadequate information systems and lack of understanding of child welfare, mental health and AOD issues. Too often, child welfare agencies and the court have adversarial or ineffective relationship (Outley, 2006). Marsenich (2002) points out that judges sometimes overstep their expertise in ordering specific medications, services or placements. As courts often have the "final say" about services, Ideally, courts operate as a part of the community team (Flango, 2001).

Education

Schools also play a significant role in the lives of children in out of home placement as they often offer a familiar, predictable place where youth can feel safe and competent (Marsenich, 2002). Children in foster care are more likely to face academic, behavioral and social challenges at school (Altshuler, 2003), yet too often child welfare does not see educational progress as part of their responsibility (Zetlin, Weinberg, & Shea, 2006). Feeling they lack authority to hold schools accountable for the education of foster children, both workers and

judges find it easier to simply ignore school issues (Zetlin et al., 2006). In focus groups with caseworkers and educators, both groups describe a mutual lack of communication and trust essential for effectively collaborating around the well-being of children in care (Altshuler, 2003).

Impact of Services

Systems that serve children and families involved with foster care are ultimately interested in determining if services meet youth and family needs and, particularly, if they enhance families' capacity to provide for their children's needs. Researchers are beginning to make these critical links between services and child welfare outcomes:

- Caretaker characteristics and “non-child welfare” (income maintenance, child and caregiver Medicaid services for mental health and substance abuse) service use patterns are strongly associated with likelihood of re-report to child welfare agency (Drake, Jonson-Reid & Sapokaite, 2006).
- Therapy contributes to placement stability while unmet behavior needs are a primary reason for placement instability (Harnett, Falconnier, Leathers & Testa, 1999).
- Substance abuse treatment increases the likelihood of family reunification (Green, Rockhill & Furrer, 2007; Smith, 2003). Furthermore, mothers who entered AOD treatment more quickly, spent more time in treatment or completed at least one treatment episode, decreased their children's time in foster care (Green et al., 2007).

Clearly, factors other than those discussed in this review may be related to the provision of services to children in care and their families. For example, caseload size and professional training are two factors linked to child welfare outcomes that might also significantly impact service provision. One limitation of this study is that it restricts examination of service provision to information available in the child welfare case file or through interviews with involved professionals.

The child welfare system's tendency to myopically focus on safety and protection may cause professionals to overlook areas of potentially effective intervention with families. For example, Drake and colleagues (2006) found that for each increase of \$1000 of income, there

was a measurable decrease in family risk. Typically, workers hone in on the “reasons the child came into care” overlooking other factors, such as income support, that can significantly affect family functioning. As the systems that serve children and families become more attuned toward general youth and family well-being there will be new opportunities to find connections between services and outcomes.

A gap exists between mental health and substance abuse needs and use of services for youth and families involved with child welfare. In recent GAO report (2006), states reported that the most important challenge to improving outcomes for children was providing mental health and AOD services to families. Examining critical components of service delivery in foster care will point toward areas of strength and improvement on which to build better outcomes for youth and families.

Chapter 2. Methods

This study represents the second phase of a study on children entering foster care for Non Abuse Neglect (NAN) reasons. This year's study focused on mental health and substance abuse needs and services for a group of adolescents. In general, this was a qualitative study that employed case file review and individual interviews. A limited quantitative analysis of data from the Kansas Addiction and Prevention Services (AAPS) database was also performed. An explanation of this analysis is provided in Chapter 4, where AOD findings are presented. Below is a description of the purpose of the current study, its research questions, and methodology.

Study Purpose

As discussed in Chapter 1, findings from research in FY 2006 suggested the need to gain a better understanding of the CINC-NAN population, and specifically, the utilization and potential benefit of mental health and substance abuse services among these Kansas children and their families. Accordingly, the present study sought to: 1) understand and describe the mental health needs of the CINC-NAN population; 2) gauge access to and impact of mental health and substance abuse services on the foster care experiences of CINC-NANs, including permanency outcomes; 3) inform the development of evidence-based service strategies to prevent unnecessary out-of-home placements; and 4) help mitigate barriers to timely permanency in those situations in which placement cannot be avoided.

Sampling Frame

A purposive sample of 30 cases was drawn from a pool of 255 cases selected in the FY 2006 CINC-NAN study. This original sample of 255 cases was randomly selected from the SRS database, FACTS, and included children who met the following criteria: 1) entered foster care

during FY 2005 (July 1, 2004-June 30, 2005) time period; 2) the reasons for removal did not include any of the abuse or neglect codes as established by the State of Kansas; and 3) did not have a sibling in the sample (see Moore, et al., Chapter 5, p. 5.2).

The 30 cases selected for this study were taken from a subgroup of adolescents identified in the FY 2006 CINC-NAN study as “Cluster B: Adolescents Without Abuse and Neglect Histories.” These “Cluster B” cases were characterized as having 1) significantly fewer prior abuse or neglect allegations than the “Cluster A” adolescent counterparts; 2) parents with fewer serious problems than the parents of their counterparts—such as incarceration, serious and persistent mental illness (SPMI), and serious alcohol and drug (AOD) problems; and 3) a history of running away, educational problems, and suicidal or parasuicidal behavior but no official mental health diagnosis. In the initial study, these cases were thought to be characterized by need for services, but perhaps not universally by need for out-of-home placement.

The subset of 30 cases selected from “Cluster B” became the focus of this year’s in-depth case review precisely because researchers speculated that these youth and families might comprise the group for which intervention prior to removal from the home could prove most beneficial. Moreover, Cluster B adolescents were thought to be those youth and families with whom timelier reunification could be achieved. Using this sample of children also allowed researchers to take a closer look at services and outcomes after a reasonable follow-up period from the time these children entered foster care (FY 2005). Finally, since these cases were examined in the earlier study, three researchers already had familiarity with the cases and with the relevant information known at the time of intake and placement decision.

The three researchers who conducted interviews during the first study reviewed FY 2006 cases to determine whether they met specified criteria, which were discussed and developed as a

research team. In general researchers sought cases that would bring into focus thematic topics that were identified in the FY 2006 study. Table 1 details the criteria that were used in the selection of 30 cases.

Table 1 – Sample Selection Criteria

Inclusion Criteria	Exclusion Criteria
<ul style="list-style-type: none"> • Likely need for youth MH &/or AOD services • Likely need for parent MH &/or AOD services • Placement may have been preventable • Presenting problems included the wide range of issues known to characterize NANs: runaway behaviors, truancy, parent-child conflict, and youth/parent refusal to return home • Exhausting all available services prior to placement, including family preservation services • Examples of good placement outcomes • Examples of JJA involvement 	<ul style="list-style-type: none"> • Case did not remain in the state of Kansas • Cases in which youth was very close to turning 18 y/o • Cases in which multiple children were removed from the home • Cases in which removal reasons included keeping others in the home safe (e.g. risk of youth sexually abusing a sibling) • Cases that appeared to be custody battles • Short-term placement cases that appeared easily preventable and not likely to provide insight on MH and SA services

Sample Description

The final case review sample consisted of 30 adolescent cases that had been designated as CINC-NAN. Age at intake ranged from 12 to 17 years old. The average age was 14.9 years old; however, more than half of the cases were 15 or 16 years old. In terms of gender, 60 percent of the cases were teen girls and 40 percent were teen boys. This sample reflects the disproportionate representation of children of color in the child welfare system (Hill, 2006). Fifty-seven percent of the youth were White and 40% were children of color. More specifically, 13% were African American, 13% were Hispanic, 10% were Bi-racial and 3% were Native American. Two thirds youth resided in urban areas, and one third resided in rural areas.

Research Questions

The following research questions guided this study.

1. What are the identified mental health and substance abuse (MH/SA) needs of children identified as CINC-NANs? Based on evidence available in case files, were these needs adequately assessed?
2. What MH/SA services were recommended?
3. Were needed services available, accessible, and provided in a timely manner?
4. What factors were identified as barriers and supports to MH/SA services?
5. What impact do MH/SA services have on achieving child welfare outcomes?

Data Collection

Data collection occurred during a five month period from December 2006 through April 2007 and included both review of case documents and interviews. Researchers used a semi-structured data collection tool that was organized into the categories listed below (see Appendix A).

- Mental health assessment and services (youth and adult)
- Alcohol and other drug assessment and services (youth and adult)
- Case planning
- Supports and barriers
- Systems Coordination

The data collection tool was informed by several important pieces of information and processes. As part of an overlapping preliminary study of services to parents of children in care, between September and December 2006, two researchers conducted key stakeholder interviews with 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 purpose of the interviews was to document barriers to serving children in care and their parents. The Administrator/Key Informant Interview Guide is included in

Appendix B. Key stakeholder interviews provided insight into essential topic areas that should be explored during the case review. For example, issues related to timely mental health referrals and service initiation were identified as significant.

Other important contributions to the development of the data collection tool included findings from FY 2005. Year one's CINC-NAN study shaped questions to be included in this year's study. For example, the following questions regarding placement prevention were included: "What could have been done to prevent placement of this youth? What services or activities would have been helpful?"

Finally, the data collection tool was tested in a single case review by the five-person research team. Data collection on this test case was discussed for the purpose of enhancing reliability and refining the data collection tool. This "testing" process led to revisions which included the addition of the final section, Expert Impressions and Summary Themes. The "summary themes" were informed by review of the test case, themes from the FY 2005 study, and best practice literature.

Interviews were conducted with individuals relevant to the case. The interview protocol was included in the data collection tool and was also semi-structured. Accordingly, questions included those individualized for each case as well as a common set of questions for all interviews. A total of 54 interviews were conducted with a variety of professionals including foster care case managers, foster care supervisors, mental health therapists, and family support workers. One interview included a resource parent. Notably, foster care case managers, the primary person responsible for managing these cases, were not available for interviews in half of the cases. Their unavailability primarily reflects staff changes at foster care agencies. When

case managers were no longer with the agency, the researcher sought a supervisor who was familiar with the case.

Analytic Approach

Data were imported into a qualitative software program (NVivo 7) for coding and analysis. A common coding scheme was developed by the research team. Each researcher coded the 30 cases with a particular emphasis on a topic of expertise (e.g., one researcher focused on mental health, another researcher focused on AOD, another on child welfare, etc.). Codes were added as needed and validated through discussion and consensus. Thus, major findings and themes were identified and verified through regular team meetings that focused on thematic analysis and recurring patterns.

Issues of inter-rater reliability and validity were addressed and enhanced in several ways. Inter-rater reliability was addressed with testing of the data collection instrument, regular meetings during data collection, a co-created coding scheme, and regular meetings during the analysis phase. Validity was addressed through methodological triangulation (i.e., use of case review and interviews) and investigator triangulation (i.e., co-creation of coding scheme, comparing analysis and findings, building consensus for major themes and findings) (Guion, 2002). The principal investigator of the study also provided “skeptical peer review” throughout the study process. This process of constant questioning and discussion toward consensus served as an additional check on the findings’ validity (Frankel & Devers, 2000).

Researcher Qualifications

Of the five researchers reviewing case files, four had clinical training and experience, two were clinical social work educators and current or past clinical supervisors, four had expertise in treating children and families, and one had advanced training in administration. All reviewers

have participated as researchers in multiple studies of child welfare, children's mental health, and cultural competence among clinicians and child welfare workers.

Limitations

Despite rigorous attempts to maximize data triangulation and inter-rater reliability, like all research, this study had a number of methodological limitations. First, the study relied on data from foster care agency case files. As the purpose of the study was to document mental health and substance abuse services to children in care, the rationale for this approach is sound. However, researchers' ability to characterize service adequacy was restricted to the information included in case files or obtained through interviews.

For AOD services, quantitative data from AAPS were used to triangulate services data from files. For a number of reasons, including data fidelity and availability, the Automated Information System database (AIMS) maintained by the CMHCs was not utilized for this purpose. However, as mentioned, to round out the picture of service delivery, an effort was made to conduct interviews with mental health center therapists. These interviews provided important insights which were incorporated into the overall findings.

Secondly, this was an in-depth case study of a small number of cases. Case study is considered the most appropriate way to capture the microlevel details of a youth's journey through the various service delivery systems under examination. Whereas large-scale, variable-oriented approaches allow for greater generalizability of findings, they also attenuate important case-specific details (Ragin, 1997). This study aimed to provide a thick description of the experiences of youth. Moreover, this study was intended to "drill down" into data provided by last year's variable-oriented project, in order to better understand the complexities of assessment and service delivery. But while in-depth case reviews reveal more nuances than do variable-

oriented approaches, they are limited in generalizability. Care should thus be taken not to extrapolate the findings of this study beyond its stated purpose.

Throughout this report, percentages are used to describe the proportion of the sample that presented with certain features or service levels. These numeric descriptors are intended to provide the reader with a general idea of the frequency with which certain characteristics, events, or behaviors occurred in the sample. They are not intended to be generalized to the entire population of children and youth in out of home placement. However, as this small sample originally derived from a random sample of the CINC-NAN population in Kansas, the study may be said to have significantly greater generalizability than a convenience sample.

Third, researchers recognize that changes in the system of child welfare were implemented in July 2005. In brief, the State revamped foster care, family preservation, and adoption contracts to include several family-centered practices that have been implemented subsequent to this study. These system-wide changes would likely moderate some of the findings identified in this report. Examples of changes include:

- Foster care agencies are now required to offer the use of family team meetings for case planning when youth are referred to foster care. These meetings are based on an evidence-based, family-centered model called Family Group Decision Making.
- Foster care agencies are now required to conduct an assessment within five business days of referral to foster care.
- Resource parent responsibilities now include an expectation that they will play a mentoring role with biological families.
- Foster care agencies have a new requirement referred to as “one case manager for the life of the case” which is intended to improve continuity of care for youth in foster care.

Chapter 3. Mental Health

Description of Sample

As explained in the previous chapter, this chapter summarizes findings from in-depth review of 30 children and youth who were placed in out of home care between July 1, 2004 and June 30, 2005. Youth in the sample were all designated CINC-NAN upon intake, and thus were removed for reasons other than those classified by the State of Kansas as abuse or neglect. Additionally, these 30 children were chosen because they belonged to a subset of adolescents identified in the first year of study (see Moore, et al., 2006) as youth who might especially benefit from placement-prevention services, including parent-child mediation, substance abuse treatment, and mental health treatment.

Research Questions and Data Source

The analyses described in this chapter specifically addressed the following mental health-related questions: What were the identified mental health needs of children identified as CINC-NAN? Based on evidence available in case files, were these needs adequately assessed? Were there any underlying needs which were not met? What mental health services were recommended? Were needed services available, accessible, and provided in a timely manner? What factors were identified as barriers to mental health services? What factors were identified as supports to mental health services?

Since the study relied on documents obtained from foster care providers, most data were child-specific. However, researchers also looked in the case file for pertinent information about the inclusion of parents in case plan meetings and goals, therapy, substance abuse treatment,

court orders, visitation, and the general life of the case. Findings regarding parent inclusion in mental health treatment will be presented in a separate section following the child information.

Mental Health Needs of Children in Foster Care

The mental health needs of children in foster care are significant, as are the challenges to serving them adequately (Kerker & Dore, 2006). Children in foster care have been found to have poorer mental health than children in the general population (Kortenkamp & Ehrle, 2002). Early abuse and neglect, the trauma of removal from the home, and their sometimes harrowing experiences in the foster care system can exacerbate existing biological and social vulnerabilities in this group of children. Prior to entering out of home care, many children have been exposed to socially and environmentally impoverished environments and have lacked access to appropriate educational or health care opportunities, further compounding these vulnerabilities (Pilowsky, 1995).

Once in the foster care system, and despite documented need, foster children often receive inadequate mental health care. Initial child and family services reviews (CFSR) conducted in 32 states by the Administration on Children and Families (ACF) found only one state in compliance with federal mandates for mental health treatment of children and youth in foster care (ACF, 2002). Like 31 other states, in 2001 Kansas fell short of achieving substantial conformity on CSFR Well Being Outcome 3: “Children receive adequate services to meet their physical and mental health needs.” However, in preliminary results from the most recent CSFR (Preliminary Results as of 6/15/07), Kansas has raised its performance from 78% to 87%. While the state is not yet in substantial conformity (95%), this improvement is noteworthy.

Also noteworthy are data from a recent regional and national comparison of the Kansas community mental health system (Hammond, 2006). The analysis found that Kansas exceeds all

neighboring states in penetration rates for children with serious emotional disturbances (SED). Kansas is also distinguished by its creative use of Home and Community Based Services (HCBS) Medicaid waivers to meet the complex needs of this at-risk population. Kansas is one of a handful of states to have HCBS waivers for SED youth, for SPMI adults, for DD children and adults, and beginning January 2008, for children with autism.

The state's clear commitment to delivering quality mental health services to its children and youth, particularly those in state custody, prompted this study. Policymakers and practitioners recognize the costs of untreated mental health needs, especially among this high risk population. Future incarceration, homelessness, hospitalization, and the intergenerational repetition of trauma are just some of these risks (Courtney, Piliavin, Grogan-Kaylor, & Nesmith, 2001). The mental health status of children in foster care is clearly a policy and practice priority.

In keeping with this priority, this portion of the study aimed to determine 1) the mental health needs of 30 Kansas CINC NANs and their families; 2) services recommended to meet these needs; and 3) congruence between identified needs and services delivered. As successful service delivery begins with comprehensive, timely assessment, assessment is the first area of examination.

Assessment of Youth

Child welfare as an avenue for mental health assessment

Of the 30 adolescents in this case review sample, at least 25 received some kind of mental health assessment during the life of the case. Of the young people who received a mental health assessment, at least half received more than one assessment. Moreover, more than three quarters received a mental health diagnosis from the American Psychological Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM IV-TR, 2000). While a small

number of youth had an assessment prior to placement, most were assessed once in out of home care. It appears that out of home care is an important avenue for mental health treatment among a certain subset of youth and families. To determine the effectiveness of mental health assessment and diagnosis in *preventing* out of home placement, future study could examine youth with child welfare involvement but no placement episodes.

Appropriate screening

In their review of mental health treatment of youth in foster care, Kerker & Dore (2006) noted a lack of systematic screening for mental health issues in this population. However, the CINC-NANs in our case review sample were, as a group, highly screened and individually assessed. Youth who did not receive assessments did not receive them for three main reasons: 1) because they were judged not to require assessment; 2) because they were in placement a short time (e.g., one month) and referrals or appointments were not made before they were released from custody; or 3) because they ran away or were otherwise not available for assessment.

Level of need

Assessing the level of need among the children, youth, and families in the study sample posed a significant challenge. Unlike studies in which assessment instruments are employed prospectively, in a study such as this one, need can only be ascertained retrospectively from case file documents. Case file documents, in turn, serve a number of complex purposes. Mental health assessments are used to justify placement in restrictive settings, to update the judiciary on treatment progress, and to confirm compliance with case plan tasks. Diagnoses are used to justify the appropriateness of treatment modalities and settings and to garner third-party reimbursement. Accordingly, researchers approached the assessment of need with caution, basing our conclusions on a number of proxies of need: diagnosis—type and severity; placement setting;

case file notes; communications between mental health providers and case managers; and information from wraparound meetings.

Diagnosis

As mentioned, mental health diagnosis is one proxy of need for mental health services. According to Kerker & Dore (2006), the mental health problems of foster youth “range from relational and coping difficulties; to emotional and behavioral disturbances, such as conduct disorders, attention disorders, aggressive and self-destructive behavior, depression, and delinquency; to severe and persistent mental disorders, such as autism and bipolar disorder (p. 139).” Despite findings from the FY 2006 CINC-NAN study which suggested potentially lower acuity among Cluster B adolescents, the youth in our small sample exhibited this range of disorders but appeared to cluster toward the more severe end of the spectrum.

Assessments and diagnoses were provided by CMHC clinicians, private providers, inpatient and secure care providers, and in some cases, foster care agency clinicians. In order of prevalence, the diagnoses³ most commonly given to youth in the study were externalizing in nature. These included conduct disorder, oppositional defiant disorder, attention deficit hyperactivity disorder, and disruptive behavior disorder. Given information from the FY 2006 study that this group also exhibited internalizing behaviors, such as self injurious behavior and suicide attempts, researchers were not surprised to find that a number of youth were also diagnosed with mood disorders. These included bipolar disorder, major depressive disorder, mood disorder not otherwise specified (NOS), depressive disorder NOS, and dysthymic disorder.

³ This analysis relied on all occurrences of a diagnosis rather than on discrete diagnoses given to unique children. In addition to having diagnoses on multiple DSM IV-TR (APA, 2000) axes, many children were diagnosed at two points in time.

If anything, researchers were surprised that externalizing and behavior disorders far exceeded mood disorder diagnoses or rule outs. Many youth in the sample had significant histories of loss, abandonment, unstable living situations, and marginal parenting. It is therefore surprising that more “acting out” youth did not also meet criteria for mood disorders, given that young people may exhibit emotional lability and irritability rather than the depressed mood and restricted affect one generally sees in adults. This finding may deserve greater scrutiny, as it is possible that disruptive behavior attracted more attention from the juvenile justice and child welfare systems than the subtler symptoms of mood disorders. Quick timeframes for assessment, unreliable or inadequate symptom reporting from resource and biological parents, and frequent placement moves for some youth may have further complicated clinicians’ abilities to gather sufficient evidence to make mood disorder diagnoses.

A number of youth also received relational or coping diagnoses such as parent-child relational problem and adjustment disorder with mixed disturbance of emotions and conduct. A subset of youth in the sample had co-occurring substance abuse or dependence diagnoses, including cannabis abuse and dependence, polysubstance abuse, cocaine dependence, and alcohol abuse. Also present was one case of anorexia nervosa, one case in which gender identity disorder was diagnosed, two cases in which the development of antisocial traits were noted on Axis II, and one case in which psychotic disorders were noted as rule-outs.

Trauma

Interestingly, despite documentation of some type of trauma in at least 18 cases and documentation of trauma sufficient to warrant mental health treatment in 13 cases, only one child actually met full criteria (or was diagnosed with) post-traumatic stress disorder (PTSD). This finding also merits further examination. Researchers discovered that at least half the youth in the

sample had experienced sexual abuse. However, treatment plans and other case documents did not indicate that much attention was paid to historical abuse of any kind, including the sequelae of trauma as youth encountered each successive developmental challenge. For example, one case reviewer wrote, “History of sexual abuse was identified by individual counselor, but not clear how well recognized by foster care case managers and whether this was seen as a significant issue needing to be addressed in the long term.”

Moreover, in at least four cases, youth were described as “acting out” sexually—online, with older men, and with members of both genders. However, emphasis was repeatedly placed on inappropriate behaviors rather than the etiology of the behaviors in those with trauma histories. Admittedly, one young person who introduces sexualized behavior to other children in a foster home, or who actively coerces other children, is one too many. Eliminating these behaviors is an urgent need, and the focus on the behaviors is entirely understandable.

However, researchers did not have the impression that the lifelong consequences of trauma were sufficiently assessed, included in treatment plans, or sufficiently understood by SRS caseworkers, foster care case managers, or courts. Too often, behavior was considered willful rather than compulsive. While everyone can agree that eliminating taxing conduct is a priority, this endeavor is more likely to succeed when its approach is based in appropriate theory. A prototype of one such approach was found in one agency in which clinicians routinely used a manualized, evidence based, trauma-specific treatment program.

Multiple assessments and diagnostic reliability

A small number of youth in the sample received three separate diagnoses. For the most part, these were appropriate updates for 90-day reviews or re-assessments when time had elapsed between the prior diagnosis and a new placement, discharge, or other event. In some instances in

which a child received three or more diagnoses, the parents or the court requested a new psychological evaluation as new symptoms appeared or problematic behaviors escalated. However, in two cases, at least four discrete diagnoses were given by three separate entities. This finding deserves more discussion.

It is well accepted that youth with behavior disorders have more placement moves than youth with less difficult behaviors. As mentioned, foster parents and case managers alike struggle to maintain placements in the face of attitudes and actions that are sometimes offensive, disturbing, aggressive, and bizarre. Thus, it is not surprising to find that youth in the study who exhibited challenging behaviors had more placement moves.

Placement disruptions, in turn, disrupt mental health care. Often, with each placement move—home, to another foster home, or to a more restrictive treatment setting—the child must be reassessed and rediagnosed. Medication management is also interrupted, and some youth find themselves unable to fill prescriptions in new placements. This presents problems with educational continuity because without the meds that help youth manage disruptive behavior or attention problems, some youth cannot attend school. Not only do frequent moves slow the treatment process, endanger therapeutic alliances, and interrupt medication continuity, they can refocus treatment in wholly unanticipated ways. Most importantly, without the support of a mental health professional, and without considerable coordinated effort and crisis management, placements may disrupt more often, fueling the cycle.

With this in mind, researchers noted situations in which multiple diagnoses raised suspicion about appropriate management of cases—clinically and otherwise. The two cases in question had multiple placement moves, which were precipitated in part by difficult behaviors. Vignettes from the two cases in question follow.

- One case involved a 13-year old African American teen who exhibited increasingly aggressive behavior and was placed in a succession of Level V and VI placements (now Psychiatric Residential Treatment Facilities, or PRTFs). Placement disruptions were due to various incidents of violent or aggressive behavior directed toward peers or staff. Placements disrupted so quickly that the screening for Level VI placement was itself hard to procure. Child finally stabilized in a Level VI facility. When interviewed, the therapist at this facility said that she thought the key to success was at least one person and place that didn't give up on the child.
- In another case of multiple placement disruptions, the teen in question was diagnosed at various times with gender identity disorder, conduct disorder, mood disorder NOS, PTSD, and depressive disorder NOS. The teen's transgender identity, cognitive limitations, unwanted sexual advances toward foster care peers of the same biological gender, and untreated trauma history presented a conundrum for foster parents and clinicians alike. Diagnoses conflicted, as did the foci of treatment. Some clinicians appeared to be inappropriately preoccupied with the gender identity diagnosis (or with the perception that the issue was sexual orientation rather than gender identity) to the exclusion of other important diagnostic indicators and mental health needs.

Teens in the above vignettes presented with complex clinical and cultural needs, and this combination seemed to contribute to the difficulties they experienced. Neither case had a particularly positive outcome. The above cases, and other cases in which four or more diagnoses are given, merit further investigation. It is possible that review by a multidisciplinary team, earlier in the life of the case, could have altered these unfavorable placement disruption trajectories. To shed light on this issue, future research could examine other cases in which youth of color and sexual minority youth experience multiple placement changes to determine the interaction of clinical and cultural needs.

Variations in diagnosis

While researchers had no ability to evaluate diagnostic accuracy, some variation was noted between different practitioners in different settings. An example follows.

- A teen placed in a secure care facility in November 2003 was given a diagnosis of oppositional defiant disorder (ODD). Slightly more than a year later, after testing positive for cocaine only eight days out of inpatient alcohol and drug (AOD) treatment, the teen was re-assessed by a Ph.D. psychologist at a CMHC. This psychologist dropped the ODD diagnosis in favor of an Axis I diagnosis of polysubstance dependence. He noted the

development of antisocial personality traits on Axis II, and his assessment could be characterized as “damning” at worst and “without strengths” at best. For example, the assessment states, “B is not particularly employable, since she will not likely tolerate a workplace setting that is in any way boring or frustrating to her. She would not tolerate difficult coworkers or entry-level pay long enough to advance to a better position or higher pay. While B is sufficiently intelligent to go to a university and earn an advanced degree, it is highly unlikely that she would stay the course long enough to complete a degree. She would more likely be able to complete a skill training course of 3-6 months’ duration.” Two months later, the same teen was assessed by a CMHC master’s level psychologist who changed the Axis I diagnosis to cannabis and cocaine dependence and deferred diagnosis on Axis II.

Inconsistency in diagnoses between clinicians is neither uncommon nor a cause for concern in most cases. Realistically, diagnostic variability is to be expected. Youth symptom pictures can change dramatically in different treatment settings, foster homes, school environments, and at various points in time. Moreover, clinicians themselves are diverse. They approach each case with different skills sets, theoretical orientations, agency guidelines, and funding requirements. Additionally, while useful for procuring third-party reimbursement, some diagnoses in the DSM IV-TR have contested interrater reliability (Kirk & Hutchins, 1999). Some variation in diagnosis is thus anticipated.

In addition to built-in variation among those giving assessments, the foster care system adds considerable complexity to an already complicated undertaking. The reason for referral, and in some cases, the circumstances of the referral, must be taken into consideration. The above case is instructive in this regard because the case file contained full assessments, performed two months apart, which permitted comparison. The chief difference in assessments could not be attributed to the child’s behavior, change in status, or placement change, as the teen was relatively stable during the period in question. Rather, the purpose of each assessment appeared to drive its findings.

The psychological evaluation was court-ordered after the child tested positive for cocaine following inpatient AOD treatment. The second evaluation was ordered by the independent living worker who formed a positive relationship with the youth and was focused primarily on helping the teen to age out of care with life skills. Prognosis in the psychological evaluation is decidedly poor, while prognosis in the second assessment is considerably more optimistic about the teen's ability to make meaningful changes in her life. In other cases of clinician differences, clinicians appeared to hold wide-ranging opinions about whether a teen merited a conduct disorder, or a less severe diagnosis like oppositional defiant or disruptive behavior NOS. Age did not appear to be a factor in some teens' transition from ODD to full-blown conduct disorder diagnoses, as some were given more severe diagnoses just months apart. In a few cases, diagnoses were "stepped down" from a more to a less severe diagnosis, another indicator of clinician variability.

Taken together, these findings suggest the need to evaluate carefully the purpose of assessment among youth in foster care. As the ultimate purpose of assessment is to guide appropriate treatment, assessments which are particularly stigmatizing (e.g., conduct disorders, personality disorders) or pessimistic (e.g., "In spite of R's disgust with his father's lifestyle, he is consciously or unconsciously moving inexorably toward becoming a clone of his father in terms of an addiction and an antisocial lifestyle") lack utility and risk iatrogenesis. In difficult cases, those giving assessments could perhaps improve outcomes by taking pains to suggest modalities, evidence-based practices, or alternative approaches that might be used to bring about the most optimistic outcome (e.g., Dialectical Behavior Therapy).

Training needs

Finally, in one notable case of diagnostic complexity, foster care case managers and SRS caseworkers routinely referred to a developmental delay in one youth with bizarre behavior. However, careful, descriptive notes from a case manager eventually led a PRTF clinician to diagnose the child with a psychotic disorder. The symptoms of internal preoccupation apparently mimicked a developmental delay. In this and other cases, researchers found that understanding of mental health symptomatology was uneven across workers. While the case manager above recognized symptoms of disordered thinking, several other case managers with “lay” understandings of mental illness described the youth as “just trying to get attention.” In other cases, youth were described as “maturing” out of conduct disorders, “acting out,” etc.

Interviews and case logs suggest the need for more comprehensive training among child welfare and foster care workers to: 1) recognize disordered thinking and behavior; 2) recognize symptoms of mood disorders in youth; 3) recognize the behavioral aftereffects of trauma; 4) distinguish between substance addiction vs. experimentation; and 5) accurately assess symptoms of severe psychopathology in youth and adults. While the ultimate responsibility for treatment lies with mental health professionals, with appropriate training and guidance in these areas, caseworkers and foster care case managers would be better suited to make appropriate referrals. On the foster care side, case managers would also benefit from ongoing group supervision to monitor frustration with difficult cases.

SED Status

As mentioned, children in Kansas may be served by a Medicaid Home and Community-Based Services (HCBS) waiver if they meet criteria for a serious emotional disturbance (SED). The term serious emotional disturbance refers to a diagnosed mental health condition that substantially disrupts a youth’s ability to function socially, academically, and emotionally.

HCBS Waiver services are intended to prevent hospitalization or other institutionalization. In order to meet criteria for the SED waiver, a youth must be assessed by a mental health professional. Of the 30 cases under review, 19 youth were determined SED. It is noteworthy that such a high percentage of youth met criteria for SED status. This finding likely confirms that youth in our small sample presented with significant mental health problems and difficulties in daily functioning. It may also indicate that youth in foster care, who are eligible for Medicaid-funded services, were screened in as SED in order to get additional services through this funding mechanism.

Of those 19 youth designated SED, 18 appeared to have received Community Based Services. These services include Independent Living/Skill Building, Parent Support and Training, Respite Care, and Wraparound Facilitation/Community Support. As mentioned, the purpose of CBS services is to prevent hospitalization. Of the 19 youth who met criteria for SED status and received CBS services, five experienced inpatient psychiatric hospitalization or Level V or VI placements. Four of the five youth were receiving CBS services prior to placement. One was in an inpatient psychiatric hospital when she came into care. Placement in more restrictive settings appeared to be necessary and appropriate in all cases.

In addition to the five youth on the SED waiver who were placed in restrictive settings, four other youth were placed in Level V or VI placements. Of these, at least one placement in a secure care facility was questioned by the case reviewer and by the case manager working the case. One case manager felt that this placement was not appropriate, and that the judge placed the youth there “teach her a lesson.”

Services Recommended

Individual therapy was by far the most often recommended treatment approach. Except for the nine youth who were placed in inpatient hospitals or Level V and VI facilities and required to participate in individual, group, and sometimes family therapy, most case plan goals called explicitly for individual therapy. By contrast, family therapy was not only *unrecommended* in most cases, it was explicitly *not* recommended in some cases in which the therapist perceived the youth or parent as “not ready” for family therapy. In other cases, family therapy was recommended, but it did not transpire. This finding will be discussed further in a subsequent section on Mental Health Treatment.

Overall Findings: The level of need is high, with some exceptions

Taken together, the case review suggests two things with regard to the *level of need* for mental health services among the 30 youth with CINC-NAN designations: 1) an overall high level of need for mental health care characterized by serious behavior and mood disorder diagnoses and SED status; and 2) a generalized approach to these youth typified by widespread assessment and diagnosis. It was impossible for researchers to distinguish diagnostic accuracy from the concurrent need for an Axis I diagnosis so that youth in care could receive Medicaid services. Moreover, the potential of early assessment and accurate, appropriate diagnosis cannot be understated. Therefore, researchers felt, on the whole, that the level of assessment was appropriate and warranted by the level of need among these youth. In turn, in most cases, the level of need was borne out by case file details.

There were exceptions in which researchers, SRS caseworkers, foster care case managers, and sometimes even therapists felt that the child or youth might have been better served by pro-social activities such as extracurricular involvement or employment rather than by individual

therapy. Additionally, some diagnoses were perceived as unnecessarily pathologizing and without appropriate treatment recommendations.

In many cases, researchers thought that assessments were unnecessarily focused on the child's behavior, without acknowledgement of the family context, both current and historical. However, as Medicaid requires clinicians to establish an identified patient in order to qualify for third-party reimbursement, the overfocus on the child was understood to be necessary, if not functional. Among researchers, the persistent lack of "focus on the family" and the attendant absence of family therapy were regarded as the biggest systemic shortcomings of the cases under review. These limitations will be explored in greater detail in the following section on comprehensiveness of assessment. First, timeliness of assessment will be discussed.

Timeliness of assessment

The Kansas Health Solutions provider manual (KHS, 2007) specifies the following definitions and access standards for mental health care in the state of Kansas. These are provider standards for a newly established Medicaid managed care entity which did not exist at the time the youth under review were in placement. However, to provide some sense of timely access, researchers used the following benchmarks as guidelines, with no expectation that providers would have met these standards prior to implementation. The definition of each access term is as follows:

Emergent Care – A medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention could result in:

- Placing the health of the individual in serious jeopardy
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part

Urgent Care – Any illness or severe condition that under reasonable standards of medical practice would be diagnosed and treated within a seventy-two (72) hour period and, if left untreated, could rapidly become a crisis or emergency situation. Additionally,

it includes situations such as when a Member’s discharge from a hospital will be delayed until services are approved or a Member’s ability to avoid hospitalization is dependent upon prompt approval of services.

Routine Care - Members assessed at this level of risk must be assessed within nine (9) calendar days of initial contact. Routine risk is determined based upon exclusion of needs consistent with emergent or urgent risk, as reported by the Member and/or family members or provider calling on behalf of the Member. Under any circumstances, Providers have a responsibility to assist Members to meet needs such as coordination of transportation and securing medication if necessary.

Table 2 – Access Standards

Access	Referral	Assessment and/or Treatment
Emergent	Immediate	1) Face-to-face assessment and crisis intervention initiated within 3 hours for an outpatient mental health services OR 2) Face-to-face assessment and crisis intervention initiated within 1 hour from referral for an emergent concurrent utilization review screen
Urgent	24 hours	1) 48 hours from referral for outpatient mental health services OR 2) Within 24 hours from referral for an urgent concurrent utilization review screen
Routine Outpatient	5 days	1) 9 working days from referral AND 2) 10 working days from assessment to 1st treatment.
Planned Inpatient Admission	48 hours	5 working days from referral.
Post Inpatient Discharge	Immediate	Within 7 calendar days from their discharge date

While the time required to complete a mental health assessment ranged from a few days to more than two months, researchers regarded as timely 20 of the 26 (77%) completed mental health assessments. Under current Kansas Health Solutions guidelines, most cases were considered routine. Researchers thus considered mental health assessments optimum if they took

place within ten days to two weeks of the child's placement. The outside limit on timeliness was one and half months. This amount of time was considered acceptable only when assessment was hampered by a non-mental health entity or event. Examples include the child running away or refusing assessment, the foster parent canceling or not attending the intake, or the biological parents refusing consent or taking a long time to fill out required paperwork.

In a small number of cases, it is unclear what hampered timely assessment. For example, in one case in which the teen was only in placement for one month, the mental health referral was made two weeks prior to her release from state custody; consequently, she was never assessed. Given the severity of mental health concerns in this case—alleged sexual abuse and sexual risk-taking by the youth—assessment might have changed the course of the case.

In another example of delayed assessment, the reviewer noted, "There was a two month lag between placement and initiation of services and no explanation offered for the time lag." In yet another, the reviewer wrote, "Child entered custody on March 15 and there was not an appointment with MH provider until May 16." Finally, in one unusual case, the child self-reported to SRS at age 13 that her parents were alcoholic and abusive. The child received no mental health treatment until she ran away from home almost two years later.

In FY 2007 researchers conducted key stakeholder interviews with SRS, mental health, AOD, and foster care administrators. Additionally, as part of this case review, each researcher conducted interviews with SRS caseworkers, foster care case managers, mental health case managers, therapists, and others. Child welfare and foster care administrators and case managers expressed concerns about the length of time from referral to intake at CMHCs and the amount of intake paperwork required before intake can occur. Conversely, mental health case managers and

clinicians complained that appointments are sometimes cancelled or that necessary releases are not returned to them prior to intake.

This study provides corroboration for both complaints. A number of case managers who were interviewed talked about the length of time it took to get required paperwork completed before intake (see Chapter 6). And in a number of other cases, delayed assessment was clearly not the fault of mental health clinicians. In a review period prior to implementation of the KHS provider access standards, it seems particularly noteworthy that almost 80% of cases under review were assessed timely. In some cases timeliness was not optimum. In the case example mentioned above, the effect was clearly detrimental. However, overwhelmingly, children and youth in the sample were referred for and received a mental health assessment in a timely manner.

Adequacy of assessment

Prior to the creation of Kansas Health Solutions, key representatives from HCP Children's Mental Health and Child and Family Services met to standardize expectations, roles, and responsibilities so that youth in the child welfare system who are in need of mental health services receive these services in a coordinated manner. This group produced a draft statement of a Statewide Partnership Plan which explicitly stated, "The outcome desired is a seamless system that is focused on the mental health needs of youth in child welfare, *as well as the families who are their caretakers, both biological and resource*" (Statewide Partnership Plan draft, 2006). While the need for the Partnership Plan may be obviated by new contracting at the state level, its goals are germane to this study. Perhaps most striking is the goal of family inclusion.

Family-based treatment has been shown to be an effective and empirically supported treatment for children and youth with behavioral health needs (Henggeler, Schoenwald, Rowland, & Cunningham, 2002; Lindblad-Goldberg, Dore, & Stern, 1998). Models of family

therapy with demonstrated efficacy include multisystemic family therapy (MST), functional family therapy (FFT), and home-based family therapy. Thus, in considering the comprehensiveness of assessment, researchers sought to ascertain the degree to which biological and resource families were included in case planning, and the degree to which family systems issues were acknowledged and addressed in mental health assessments and recommendations for service.

Findings in this regard were not, on the whole, encouraging. In response to the question, “How adequate were assessments in covering all relevant areas/family members and in identifying needs?” a representative researcher note read, “Assessment did not actively include either parent.” In another case, the researcher stated, “Assessments did not seem to address the home environment and how it would impact D’s successful reintegration with his father.”

In yet another case, the reviewer said, “Assessments ignore step-parents’ role in family dynamics and parenting.” And in another, “H’s assessment was very poor in covering mom, mom’s needs, and the impact of mom’s mental illness on H or the family system.” In general, researchers felt that while assessments *of the youth themselves* were fairly comprehensive, young people were approached as though they had no family context. In describing problematic behaviors or issues, assessments falsely extracted youth from families of origin. They were thus too narrowly focused on youth behavior and/or pathology.

Admittedly, in some cases, parental absence curtailed parent participation in the assessment and treatment planning process. For example, after petitioning unsuccessfully to return to extended family in her home state, one mother surreptitiously left her daughter in Kansas and moved without providing SRS with forwarding information. In other cases, parents were incapacitated due to incarceration, major mental illness, or medical issues. In yet other

cases, parents simply refused to participate in assessment, case planning, or services. However, while noncompliance and incapacitation must be acknowledged (and are likely common among this population), the lack of family inclusion and engagement in assessment was also so pervasive across all types of cases that lack of family focus appears to be a systemic issue.

While inclusion of family members was poor in most cases reviewed, there were notable exceptions. In one exemplary case, the researcher thought that assessments were thorough and comprehensive, especially the child's psychological evaluation. The researcher noted,

- At the second episode...the provider's assessment was particularly thorough. It is 8 ½ pages long and was conducted by a clinical specialist. This assessment notes that G may benefit from a treatment modality such as Trauma Focused Cognitive Behavioral Therapy. It also notes that G and her parents (including stepfather) may benefit from counseling to address G's sexual abuse and emotional abandonment issues. It further recommends Parent Management Training for all parents."

Especially commendable, but rare, was the willingness of the provider to pay for psychological evaluations of both parents, and the willingness of both parents to complete these assessments and to participate in family therapy.

In another case with a less promising outcome and a high level of psychopathology, assessments were also regarded as thorough. The reviewer noted,

- Assessments were more thorough than some other cases I've read... [For example, the CMHC] assessment ruled out depression, bipolar disorder, ADHD, and psychotic disorders and mentioned the strong history of antisocial behavior (at least two siblings in prison for murder) and AOD issues. This assessment also addresses abandonment by parents (mother moving out of state while M was on the run; father being inconsistent about wanting child to move in with him, family friends and aunts not cooperating with ICPC or being disqualified for drug use). CMHC Intake Assessment actually mentions the difficult transition that M had moving to Kansas at the age of 13. Had difficulty fitting in, started using drugs, got arrested for possession of marijuana, ran away, became sexually active, got in fights with mother.

This assessment, or collection of assessments, appeared to capture important details of family history, symptomatology, and precipitating events.

Underlying needs

In response to the question, “What were underlying needs that were not identified and/or addressed, if any?” researchers commented on the following commonly overlooked or insufficiently assessed areas: emotional or physical abandonment; loss of family members through death or separation; poverty and its associated stressors; domestic violence involving spouses, siblings, and children; multiple family disruptions; family instability through divorce or geographic separation from extended family; untreated parental mental illness or substance abuse; chronic medical problems among parents, such as brain cancer or traumatic brain injuries; and histories of maltreatment or other trauma. Illustrative vignettes of these areas are provided in Chapter 5.

Overall Findings: Lack of family focus

While there were certainly exceptions, in general, researchers characterized the adequacy of assessments as fair to poor because they consistently lacked: 1) information about or inclusion of family members—especially fathers, step-fathers, grandparents, and out of state or absent parents; 2) child, parent, or family strengths; 3) acknowledgement of intergenerational or systemic family issues; 4) recognition of the psychological and behavioral sequelae of trauma, particularly sexual abuse; and 5) recognition of parental AOD, developmental disability, or mental health issues.

Mental Health Treatment of Youth

Despite documented need for mental health services, children and youth in the foster care system often fail to receive adequate treatment (Kerker & Dore, 2006). “Financial costs, coupled with a fragmented health care system, often result in children’s mental health needs being unmet...Additionally, unmet needs place great demands on the child welfare system...Children’s

emotional and behavioral difficulties often ‘burn out’ both foster parents and caseworkers” (p. 138). In 2003, the American Academy of Child and Adolescent Psychiatry (AACAP) and the Child Welfare League of America (CWLA) published a joint policy position underscoring the importance of comprehensive, continuous care by caregivers who are trained and familiar with the behavioral needs of the foster care population (AACAP & CWLA, 2003). Unfortunately, there is little evidence to date that this recommendation has seen wide implementation (Halfon, Zepeda, & Inkeas, 2002 in Kerker & Dore, 2006).

This section the report describes adequacy of mental health treatment as it could be determined from case file documents. Cases were read with an eye toward the timeliness, comprehensiveness, and continuity of the mental health services delivered to CINC NAN youth and their families.

Timeliness of Service Initiation

In response to the question, “How would you describe the timeliness of mental health service initiation? Include discussion of mental health response to emergencies and crises,” case file evidence indicated that approximately two thirds of those who received mental health services did so within days to weeks of referral to mental health providers, mostly community mental health centers. In several cases, service initiation was described as “excellent.” For example, in one case, intake at the mental health center occurred two weeks after discharge from a Level IV placement, providing excellent continuity of care. In another case, the reviewer noted that the youth went for an intake with a therapist at the local CMHC six days after being referred. In yet another exemplary case, “Youth was in therapy within two weeks of placement.”

When interviewed about this last case, a foster care case manager acknowledged the relative ease with which she was able to make an initial appointment for therapy. However, she

also remarked about the challenges of maintaining continuity of treatment with this population, given the constraints of CMHC clinicians' schedules:

The problem is [that] once you get an appointment, it's important to make another appointment. If you run out of appointments and haven't scheduled another, you're about a month out before you're seen again. Scheduling is the foster parent or birth parent's responsibility. [We do] try to keep folks informed of this. They will schedule four [appointments] at a time.

Indeed, in some cases in which service initiation was less than timely, researchers noted the role of resource or biological parents.

For example, in a case in which a child was first seen at the CMHC one month after referral, the reviewer noted, "Foster parent was responsible for R missing his appointment. Given the circumstances, I would say that the CMHC did everything they could to complete a timely intake." In another case, "Service initiation with a new therapist after coming into care for the second time was poor (two months), but this is partly due to mother not returning paperwork and canceling many appointments." Moreover, another foster care case manager acknowledged the instability of some kids' lives and the challenge to timely service initiation that this presents: "[Services were] as timely as we could get them, given her changing needs and demands."

In at least three cases, service lags were explained by the vagaries of the case (e.g., trial home placements, the school year ending, and the family receiving concurrent family preservation services). For example, "Mental health initiation was a bit slow (3 months), but the context is that family preservation was tried first for truancy, then school ended, assessments were done, and then in September the child was removed from the home for continued truancy."

In other cases, researchers described lapses in service initiation which were not directly attributable to youth, parent, or resource parent follow-through. One reviewer noted that after a timely assessment in late November, there was an unexplained service lag: "Services did not

begin with consistency until February 2005.” Sometimes reliable evidence of service initiation was simply not available in the case file. “After M left Level VI in April, services were said to be ‘in place’ by mid-May. There were no specific dates in the file to indicate when services began.”

Finally, in a small number of cases in which youth displayed significant acuity, outpatient services and crisis stabilization were not the most appropriate front-line intervention. One case manager who said that services were not timely described the following situation:

She blew through everything so fast, I couldn’t get her stabilized long enough to get anything done... She was blowing placements, had threatened to kill herself. That’s when I said she needed Level VI. I couldn’t keep her in one place long enough to get someone out to do a Level VI screen. I’d have to make a new appointment and give them a new address.

It is not clear whether intervention earlier in the life of this case might have changed the trajectory of events. However, the child’s inability to remain stable even in Level VI placements attests to the high degree of psychopathology present and to a lack of fit with all but the most restrictive, structured environments.

Overall Findings: Most services were timely

Overall, findings indicate that while service initiation and continuity were not without challenges, at least half of the youth in the sample received services in an appropriate to exemplary timeframe. In half of the remaining cases, slow service initiation could be ascribed to circumstances beyond the control of CMHCs or mental health providers. In the remaining cases, services were not delivered in a timely manner.

Mental Health Response to Crises

In most cases reviewed, there was no evidence of a crisis for which mental health services could have been sought. In a small number of cases, crises were “handled appropriately,” but not much information was given. In one case, the reviewer noted, “There is

no indication that mental health provided increased services around crises (e.g., when A is charged in beating incident).”

In the few other cases in which researchers noted imminent harm, such as threat of suicide, mental health generally responded in a timely and appropriate manner. “There was one crisis mentioned in the file; the child stated suicidal ideation. She was hospitalized immediately (private insurance) and a plan was created and followed to handle this in future times.” One exception was recorded, but this may have been due to a lack of evidence rather than to a lack of intervention.

C seemed to be in crisis at the time of the juvenile intake, as indicated by his assessment, which reported high anxiety, depression, anger, and suicidal ideation. It is not clear if he received any mental health crisis intervention at that time. His first appointment (intake) with the mental health center occurred about a month after removal.

Overall Findings: Mental health responded appropriately to crises which were primarily psychiatric

Taken together, findings from case reviews suggest that crisis mental health care is, for the most part, available in cases of imminent threat of harm to self or others, but perhaps not sought out by foster care case managers in the “routine” crises typical of children in placement who have behavioral problems. Data from interviews with case managers and supervisors suggest that CMHCs are regarded as limited in their capacity to provide placement stabilization or crisis prevention services.

Adequacy of Treatment

In response to the question, “How well did mental health services match the youth’s needs? Consider frequency of services, type of service/treatment, and goals of services/treatment,” researchers documented a broad range of service adequacy. On one end of the continuum were exemplary cases in which service type, goals, frequency, and continuity produced demonstrably favorable changes in the case trajectory. For example, one reviewer

commented on the fit between the needs of the youth and family and the services delivered.

“Seemed to be a very good match. Mother and youth both actively participated in individual and family therapy and made considerable progress, with youth returning home and marked increase in both mother and youth’s ability to successfully negotiate parent/child conflict.”

Another favorable review noted, “Plan was for weekly individual therapy and weekly family therapy. Plan was followed very well.” About another case, the researcher observed, “Mental health services matched the needs identified throughout the case. The providers all tried very hard to meet this kid’s needs, and to target services. I think the treatment plan was followed, and the plan and notes changed appropriate to client needs.”

Successful Mental Health Treatment

Following is a partial list of the elements of successful mental health treatment as identified in case reviews:

- Family therapy was recommended and delivered when appropriate (rather than just individual therapy).
- Services that were tailored to the needs of the family or youth (e.g., specialized programs like “Survivor University” for teens).
- Services were delivered and attended with enough consistency to build a therapeutic alliance.
- Treatment goals addressed specific presenting problems, such as trauma history, rather than focusing solely on youth compliance (e.g., follow parents’ rules at home).
- Providers “hung in there” with especially difficult-to-treat youth and tried to get to “the heart of the matter” beyond the disruptive or violent behavior (e.g., especially one Level VI placement).

- Families received adequate aftercare services.
- Parents received support from parent support specialists.
- Cases were managed by wraparound teams, which streamlined decision-making or helped alleviate pressure on the case manager.

Problems with Mental Health Treatment

At the other end of the continuum, the adequacy of mental health treatment was hampered by factors extrinsic to the mental health system, and by the dominant systemic approach of individual versus family therapy. In a comment representative of a number of these issues, one reviewer wrote:

Mental health services were most engaging when C worked with male therapists, but frequency [1-2 months between appointments] was not sufficient to manage his behaviors. While I think he might have benefited from individual therapy on a more regular basis, he would have benefited more from family systems therapy that involved the grandparents on whose property C, his brother R, and his mom lived. C appeared to have a very deep level of contempt for his mother, who was unable to parent him due to brain injury and cognitive limitations. No clear goals of treatment were articulated or obvious.

In general, researchers noted the following concerns with treatment adequacy:

- Services were delivered or attended inconsistently.
- Services were interrupted when youth changed catchment areas, when a placement disrupted, or when the therapist left the agency temporarily or permanently.
- Acuity was not properly assessed, and the youth had multiple placement disruptions due to poor fit between needs and services.
- Family therapy was not recommended or delivered even when it was clearly indicated as the more appropriate treatment modality.
- Treatment goals were insufficiently formulated or recorded.
- Treatment goals specifically addressing sexual abuse were absent.

- Youth or parents failed to comply with treatment goals.
- Mental health personnel failed to engage youth or parents.
- Little aftercare was provided.
- Service coordination or crisis management were poor.

Frequency of services

Frequency of outpatient services ranged from weekly to monthly (mostly) individual therapy. While a subset of youth received regular weekly therapy, sometimes for a significant period of time (e.g., 11 months), the norm across cases was short-term (e.g., 6-8 sessions), sporadic attendance, with an average frequency of one session every two to four weeks.

Researchers repeatedly commented that service frequency might be insufficient to make progress toward treatment plan goals. However, parent and youth non-compliance (or non-engagement) was thought to contribute to problems with infrequent services. Moreover, some youth and parents on the SED waiver did make use of all the services available to them, both in terms of frequency and service types.

For example, one reviewer noted that mental health services to a child on the SED waiver were inconsistent, but that, “This was due in part to C and mom refusing to go to therapy, to placement moves which resulted in therapist changes, and to the fact that C’s case got closed and reopened several times because they cancelled appointments so much.” Also noted were continuity problems when a placement disrupted or the youth was placed in a more restrictive setting.

Youth placed in more restrictive settings generally had more case documentation of treatment goals and progress. In these cases, youth received individual, group, and family therapy weekly except in cases in which the parent could not attend family therapy.

Type of service/treatment

Like adequacy of assessment, types of services and recommended treatments were evaluated with an eye toward inclusion of relevant family members, resource parents, or other kin. A lack of recommended or delivered family therapy was a major finding of the study. Although almost all cases could have benefited from some form of family therapy, family therapy was delivered in less than one quarter of cases reviewed. Importantly, cases in which family therapy was delivered and consistently attended had better overall outcomes. This finding may be due to selection bias. That is, less troubled, motivated families are more likely to participate in and make use of family therapy. Selection bias notwithstanding, greater involvement of biological parents and other meaningful attachment figures was regarded as a profound missed opportunity in the majority of cases reviewed.

Goals of services/treatment

Case files were inconsistent with regard to the inclusion of treatment goals and progress reports. Generally, youth receiving treatment in inpatient or secure care facilities had more thorough, articulated treatment goals. Overall, treatment goals were thought to lack specificity. As discussed previously, researchers consistently noted a lack of information regarding treatment of trauma, particularly sexual abuse. In some cases, trauma treatment may have emphasized structure and containment and thus may not have included therapeutic content specific to traumatic events. However, given the paucity of evidence that trauma was recognized by caseworkers, case managers, and therapists, researchers worried more that trauma histories were simply not addressed. Given the inconsistency with which they were included in case files, case plan goals are difficult to characterize in toto.

Overall Findings: A range of treatment adequacy

While some youth received weekly individual and family therapy for a significant period of time, most did not. The norm across cases for mental health treatment was short-term (e.g., 6-8 sessions) sporadic attendance of individual therapy, with an average frequency of one session every two to four weeks. Treatment continuity—that is, consistency in the provision and receipt of mental health services—was fair to good. Notable exceptions were those cases in which parents and/or youth were not engaged in therapy and did not attend sessions, when youth moved from one catchment area to another, or when therapists were absent for personal or other reasons (e.g., maternity leave). Treatment goals were most explicit (and more often found in case files) when youth were in Level V or VI placements or inpatient treatment.

Finally, researchers found a wide range of treatment adequacy. A number of cases were considered to have excellent outcomes. These cases were characterized by the active engagement of relevant family members (including resource parents if appropriate) in the therapeutic process, sufficient intensity, and use of evidence-based approaches (e.g., Dialectical Behavior Therapy, Trauma Focused Cognitive Behavioral Therapy). Furthermore, some youth with poor response to mainstream services (e.g., individual therapy) responded well to specialized youth-oriented programs (e.g., Survivor University) or alternative modalities (e.g., group therapy). The SED waiver and the CBS services it provided were recognized in a significant portion of cases as positive distinguishing factors. For example, parents felt particularly bolstered by parent support specialists, while foster care case managers felt buoyed by wraparound teams.

Most cases were characterized as good to fair. While perhaps not optimum in terms of frequency, intensity, or continuity, youth and family formed relationships with helping

professionals. These relationships, while not explicitly recognized as promoting specific outcomes, likely helped to stabilize the youth, family, placement, or reintegration.

A small number of cases were characterized by poor service adequacy. In these cases, family members were not included or did not participate in treatment or treatment planning, youth had multiple placement moves and many treatment disruptions, or youth lacked appropriate initial assessments and/or acuity screenings.

In at least two cases, teens with severe psychopathology did well only in the most restrictive placements. Attempts to deliver outpatient services prior to Level VI screening were sometimes ill-advised. The consequences were injuries to the child, to resource parents, and to other children or youth in placement. Moreover, once stabilized in a more structured setting and then stepped down to a less restrictive placement, youth again experienced disruption.

Finally, in some cases, the lack of family therapy was thought to contribute to the initial out of home placement and to the youth's length of stay in care. In one case, the child's individual therapist was thought to have an excessively negative attitude toward the biological mother. This was found to impede progress toward family reunification.

Barriers and Supports

Barriers to Treatment

In their comprehensive review of mental health needs and treatment of foster youth, Kerker & Dore (2006) identify three types of barriers to services: Barriers which originate in child-serving systems, barriers which originate in the mental health care system and resource parents. These types of barriers were identified in this review of 30 CINC NAN cases. Mental-health specific barriers are listed below:

Child-serving system barriers

Primarily, barriers which originated with SRS, foster care agencies, or the courts included: referrals which were not made in time for youth to receive treatment before custody ended or placements disrupted; lack of resources in the youth's geographic area and thus the need to relocate; inadequate recognition of parental alcohol and drug or mental illness; the absence of a judicial mandate for parental treatment or involvement; and a general lack of family-centered practice.

Mental health system barriers

Barriers to service which originated within the mental health system included: complicated intake process; little ability to respond to less acute crises which might have helped stabilize out of home placements; little in-home service delivery; little family therapy; lack of engagement of mandated or difficult-to-engage family members; scheduling difficulties/therapist overload; and some indication of inadequate length of stay in secure treatment settings.

Resource parent barriers

Treatment barriers which can be attributed to resource parents include: parents who cancel a youth's mental health appointment because they have scheduling or transportation problems; insufficient training and support to handle difficult behaviors; and insufficient parents for children in some geographic areas.

Treatment Supports

Some of the factors found to be especially supportive in helping youth to reach permanency, finish school, or stabilize emotionally and behaviorally include: dedicated resource parents; parent support specialists and mental health case managers; foster care case managers; family support workers; supervisors; wraparound teams and meetings; therapists, especially family therapists— both outpatient and Level VI; specialized mental health programming for

treatment of trauma; developmentally appropriate mental health treatment for difficult-to-engage adolescents; resource parents; Level VI treatment facilities for severely disturbed youth; and school personnel.

More information on supports and barriers across all cases may be found in Chapter 7.

Assessment and Treatment of Parents

While this year's study gathered data on parent participation and services for later analysis in a study planned for FY2008, findings were sufficiently striking to merit brief mention. On the whole, few parents received assessment, diagnosis, or treatment. Few participated in family therapy or AOD treatment, even when there was clear need. At least seven parents had mental health diagnoses of severe and persistent mental illness (SPMI). Moreover, many had acknowledged untreated AOD problems. Only one parent received AOD treatment, and this treatment was delivered in lieu of more comprehensive mental health care for her bipolar disorder because she refused to be seen at the CMHC. With the exception of this mother, none of the parents who received individual treatment while their child was in care did so because their child was in care. Those who received treatment were already receiving treatment when their child came into care.

Despite the child welfare system's emphasis on family reunification, researchers saw very little evidence that foster care agencies, courts, or mental health centers feel or claim the authority (or monies) to provide parents of children in care with appropriate treatment. While there were exceptions of families participating successfully in family therapy (seven participated in at least one session), the norm across cases was little participation of parents in treatment. The absence of dedicated funding source for parent treatment is a long-recognized but unacceptable barrier to adequate service provision. This issue will be further analyzed in a KU SSW study in

FY 2008: Mental Health and Substance Abuse Services to Parents of Children in Out of Home Care.

Key Findings-Mental Health

Assessment of Youth

- Youth in the sample presented with a significant level of acuity. 19 of 30 youth were considered to have a serious emotional disturbance. The most common diagnoses among them were behavior and attention diagnoses, followed by mood disorder diagnoses. Unreported maltreatment or other trauma was the norm across cases. This high level of need likely reflects unmet needs for services earlier in the life of the case.
- Nearly 80% of youth with identified mental health needs received timely mental health assessments.
- While some assessments were particularly comprehensive for the youth as *individuals*, assessments showed a chronic lack of attention to family of origin issues and members—historically and in the present. Few assessments included information relevant to the child's immediate family environment.

Mental Health Treatment of Youth

- Service initiation was considered good to adequate in about half the cases reviewed. Slow initiation was attributable to many non-mental health provider variables in one quarter of cases. Service initiation appeared problematic in the remaining quarter of cases, but case documentation does not permit characterization of barriers to timeliness.
- Treatment adequacy ranged from excellent to fair. Successful treatment was distinguished by effective engagement of family members, specialized services, and case-specific treatment goals. Service gaps included: lack of family therapy and lack of attention to sexual abuse. Systemic issues included: lack of compliance among youth and parents, insufficient attendance to develop therapeutic alliance, and vague treatment goals.

Assessment and Treatment of Parents

- While there were some exceptions, the norm across cases was little participation from family members, in family therapy or in their own individual treatment.

Barriers and Supports

- Major barriers to services included: Service disruption due to placement changes; inconsistently delivered or attended services; lack of family focus; parent or youth non-compliance; geographic barriers; and lack of a dedicated funding source for parent treatment.
- Major supports included: resource families, wraparound services, and family therapy.

Chapter 4. Alcohol and Other Drug Abuse

This chapter summarizes findings from two different sources. First, findings from a quantitative analysis of data from the Kansas Addiction and Prevention Services (AAPS) database are provided. Second, findings are presented on AOD-related information from in-depth case review of 30 CINC-NAN cases.

Exploratory Data Analysis

As an exploratory endeavor, researchers utilized the Kansas Addiction and Prevention Services (AAPS) database in an attempt to view youth who received treatment for alcohol or drug problems through the “eyes of the addiction service provider.” Kansas AAPS maintains a database that contains assessment files on every person who receives an assessment. This system utilizes what is known as the Kansas Client Placement Criteria (KCPC) for determining treatment needs. The KCPC is an adapted form of the American Society of Addiction Medicine (ASAM) patient placement criteria, and contains a version specifically for adolescents. An assessment for substance abuse takes into consideration six dimensions of AOD use: detox/withdrawal, physical health, emotional condition, treatment acceptance, relapse potential, and recovery environment. In addition to assessing the impact of AOD use on these dimensions, the KCPC tracks all case activities from assessment to discharge. Included in these activities are client goal setting, monitoring activities and results, progress notes, and case management activities.

A dataset containing the assessment records of youth in the CINC-NAN study was generated by one CINC-NAN researcher. Sixteen of the 30 youth selected for in-depth case review were represented in this dataset. Two cases known to have received assessments (and in one case, treatment) could not be located at the time of the analysis. This is most likely due to

researcher error and lack of familiarity with the database. This researcher attempted to find these cases to verify that an assessment had occurred, and to ascertain the level of treatment recommended. The service experiences of these youth were not sought in this exploratory effort.

Findings

Of the 16 youth who received assessments represented in the KCPC database, a descriptive analysis of the data showed the following:

Demographics

- The mean age at screening time was 15.9 years, with a range of 13-18.
- Gender was equally divided between females and males.
- This group of youth contained one 5th grader, three 8th graders, four 9th graders, six 10th graders, one 11th grader, and one child's educational level was not noted.

Youth Needs

- Four of the youth had more than one episode of previous treatment.
- One youth was currently pregnant
- Two youth had experienced suicidal ideation.
- Nine of the cases had co-occurring disorders
- Six of the youth had received some past treatment for emotional disorders.
- Eight of the youth had JJA involvement with pending charges

AOD Treatment

- Of the 16 in the AAPS database and the 2 additional cases found in the case reviews, 10 youth received outpatient services, 2 received inpatient services, and 6 were referred for education only or did not have treatment needs.

Case Review Findings

Despite the high prevalence of AOD abuse in the child welfare population, relatively little is known about the assessment, treatment, or service experiences of these families while in the child welfare system. It is estimated that parental AOD abuse is a factor in 60% of all child welfare cases. These cases are often cited as the most likely cases for service failure by social service agencies (Young, Gardner, & Dennis, 1998). Recent research findings have also revealed that youth who have ever been in foster care are at increased risk for developing substance use disorders and presenting for treatment in publicly funded treatment centers when compared to youth with no foster care histories (Office of Applied Studies, 2005). Whether AOD issues “belong” primarily to parent, youth, or both, the presence of AOD abuse places the family at increased risk for longer time to reunification, greater likelihood of reentry, and higher risk for service failure.

This portion of the study sought to understand in greater depth the need for assessment and treatment of substance use disorders among youth and parents. Beyond the recognition of needs, researchers sought to discover how these needs were addressed by the respective service systems and how service delivery (or lack thereof) impacted the foster care experiences of these families. In reviewing cases and conducting interviews, researchers asked questions such as: What AOD needs were identified? What recommendations were made to address these needs? Were these recommendations made in a timely way?

Youth Assessment

Level of Need

Researchers found a significant level of need among youth for AOD assessments and treatment. As is stated in the AAPS data summary section of this report, 18 youth were referred

for and received substance abuse assessments. Researchers' case read activity documented these same 18 cases. Ten of these youth received outpatient treatment services, while two received inpatient services. The remaining six were either referred to educational classes or received no services, per recommendation that services were not indicated. Youth in four cases had received treatment more than once. In the area of level of need, researchers noted the following themes throughout the cases.

Changing Need

Case reviews revealed the need for continual assessment and monitoring of AOD abuse status among youth in the sample. In other words, AOD abuse screening should not be viewed as a single point-in-time activity. In some cases, youth were exhibiting using behaviors witnessed by child welfare, juvenile justice, school, parents, and others— yet substance abuse assessments were not indicative of a problem level of use. It was noted in several of the case records that youth “must have lied to cover their use” during the AOD assessment. One case reviewer wrote:

The SRS worker commented that she did not feel confident in the RADAC assessment. The worker was concerned about this because it is all self-disclosure and the worker believes that if someone does not want help, they shape their responses accordingly.

Data sharing is limited between the two service systems, and it was evident that communication between the assessment professional and the child welfare worker was often lacking. Interviews with case workers also revealed that this lack of congruence between what child welfare sees, and what the assessment professional recommends, undermines the confidence of child welfare workers have in the assessment process.

Documentation Issues

Documentation surrounding AOD assessment, recommendations, urine screenings, and treatment activities was repeatedly found to be incomplete or missing. In general, there was a

lack of dates on many forms, and it was thus impossible to assess timeliness by looking at just one document. Researchers tried to use other sources in the file to help piece together whether the service was timely or not. Results from requested urine screens were often missing. Typically there was a notation that an AOD related issue occurred, but there was no follow up on this issue in the same section of the file. For example, the case reviewer may have found the need for an AOD assessment in the section of the file marked “assessment” but then have not discovered the results of the assessment until reading through the “family” section.

Timeliness

When addressing the issue of timeliness of referral and service, it is important to distinguish between two separate and equally important events. First, was child welfare timely in making a referral for assessment and screening? Second, from that point forward, was screening and initiation of service handled in a timely way? The researchers observed differences in these two items.

Timeliness of Referrals for AOD Assessment

In response to first question, “Were child welfare workers making referrals for youth assessments in a timely way?” researchers thought on the whole, child welfare workers made timely referrals. However, there were several poignant examples of referrals not occurring in a timely way and the impact this may have had on the life of the case. The following examples provide the reader with more information about these scenarios.

- Youth was placed in December, 2004 for reasons associated with truancy. He was arrested for possession of THC in November, 2004, and this was noted on the intake papers. The court ordered a substance abuse evaluation at the hearing on December 29, 2004. He was not referred for substance abuse evaluation until February 28, 2005 and did not complete the assessment process until the end of April, 2005. This timeframe represents four full months of placement in State custody before the youth was evaluated.

- Youth was placed in State’s custody in March, 2004 and quickly reintegrated. No substance abuse assessment was done at that time. In November, 2004 he was arrested for possession of THC. There was a second placement beginning December, 2004. In his second placement, he was assessed within five weeks of coming into custody. However, initial intake documents on this case (for the first episode) noted drug use, yet no referral was made for assessment.

The noteworthy item in both of these cases is the presence of an arrest for THC possession. It is the opinion of these researchers that *any* history of an arrest for a drug related offense (including alcohol) warrants an assessment.

Timeliness of AOD Assessments

The second question, “once referrals were made, were the assessments conducted in a timely way” was impossible for researchers to answer with any degree of confidence since evaluation forms rarely contained dates.

Adequacy

Researchers noted with concern the level of complexity of many of these cases, especially the 12 cases in which treatment was received. The cases were complex both in the severity of need for some of the youth as well as the co-occurrence of other issues (such as mental health problems and runaway behaviors). For example, several youth were using methamphetamine, cocaine, and inhalants from an early age (e.g., age 8) and in great quantity/frequency. The youth who abused substances at this level also experiencing a host of other difficulties often associated with substance use, such as criminal involvement, trauma, and educational difficulties.

Youth Treatment

Timeliness

If treatment referrals were made in a timely way, most treatment was accessed in a timely way. Youth also appeared to change levels of treatment in a timely way. This is to say that if a

child needed a higher level of treatment due to relapse or increased need, this service was usually provided to them in a timely way. The following quote, taken from case reviewer's notes, illustrates this finding:

- It seems it took several positive UAs and giving T several warnings before recommending inpatient treatment, but once inpatient was recommended, services were provided within a matter of days. After leaving inpatient, the outpatient services began without significant disruption or delay.

Adequacy

It was very difficult to assess adequacy of treatment services, due to limited information sharing between AOD treatment systems and child welfare providers. It is difficult to assess adequacy when information does not contain a description of the services provided and how frequently the service occurs.

An area that was noted multiple times in case reviews was the inadequacy of individualized discharge plans for youth. In certain cases, discharge plans did not include provisions for the fact that the youth may have to return to a home where AOD abuse is also present. Other discharge plans failed to strategize around particular relapse challenges faced by youth, such as gang involvement. Youth were often referred to mental health centers for individualized services rather than to AOD counselors. Additionally, discharge plans seemed to be conceptualized without an adequate understanding of the scope of the youth's life. One youth was given the recommendation of five follow-up sessions a week, in addition to weekly mental health counseling and school assignments. Predictably, this child could not keep up with all of these tasks, especially when the case plan also included child welfare-related tasks. While this recommendation may have matched her AOD needs, it did not represent consideration of life needs as a whole.

Adult Assessment and Treatment

The description of timeliness and adequacy of AOD services for the parents in the sample is limited by the fact that among our sample, only five parents were referred for assessments. Further, despite evidence of pervasive parental AOD abuse, only one parent was referred for treatment. This finding, though alarming, is not incongruent with national estimates of the lack of AOD assessment in child welfare cases. One study (Guo, Barth & Gibbons, in press) reports that child welfare workers do not identify substance dependence in over 70% of the cases in which it exists. Moreover, they miss the cues for screening in over 85% of the cases. Additionally, in many cases that researchers reviewed, the court ordered urine screens but the parent did not follow through. Often, there were no apparent consequences for this refusal to comply.

If the need for referral for assessment and treatment was not apparent to child welfare workers at any single point in time, it was abundantly clear to researchers who reviewed the “life of the case” by looking at the whole record. In a surprising number of cases in which clients were not referred for an assessment, case reviews revealed that parental substance abuse was a “driving factor” in the reason for placement. The following case synopses illustrate this finding:

- This case involved a 15 year old boy who came into custody for reasons associated with truancy and running. This young man was previously sexually abused by a friend of the family, and had a past and present history of physical abuse from his father. The child’s relationship with his mother was intermittent, and she went long periods of time without contacting the child or child welfare authorities. The youth and mother tried to restore their relationship, but the mother continually had periods of disappearance from the child’s life. The case file documents that the worker had knowledge that mom had a past history of substance abuse, and this had been reported to the caseworker from multiple sources at multiple times. Yet, no referrals were ever made for mom. At one point, the youth was reunified with his mother, and the mother and child began therapy to repair their relationship. There is no evidence in the case file that therapy addressed substance use. The child’s mother was arrested on drug charges, and it was reported to the case reviewer during interviews that the child’s mother had a significant history of consistent substance abuse that was well known in the community.

- This case involved a teen girl who had a past history of CINC-NAN self reports. Her first case was opened at age 13. She reported to authorities that she was afraid of her mom and dad, due to their “drinking and fighting all the time.” She ran from home and was reported as a runaway, though her father knew where she was at the time and made no attempts to get her home. There were multiple child welfare assessments in this case, but no assessment or treatment recommendations were made to address parentally acknowledged alcoholism, or deal with any possibility of domestic violence. This youth cycled in and out of resources in the system (secure care on several occasions, trial periods with her dad, three foster homes, and stays with family friends). The youth was assessed, and completed treatment (outpatient) for substance use. At no point in time is it documented that either parents’ substance abuse were issues, yet it was documented repeatedly that this was a part of the home. At one point in this case, the father of this child was administering urine screens on his daughter to monitor *her* addiction recovery. This youth aged out of foster care, and was pregnant at the time of release from custody with the baby of another youth she met while at secure care.

Barriers to Treatment

There are two significant barriers to treatment that researchers believed to be worthy of attention. The first was the lack of family involvement in AOD treatment for youth. It is interesting that while 18 of the kids in our sample received assessments, and 12 received treatment, only five parents received assessments and one received treatment. In researchers’ opinions, at a minimum, each parent of a child in substance abuse treatment should have received an assessment for substance use. In very few cases of child AOD treatment did the researchers see any evidence of parent participation. Perhaps the participation occurred and was not documented, as case records for AOD treatment are highly protected. It is also important to note that researchers saw very few instances of child welfare and AOD worker communication. It would appear from our review that when a child is in treatment, the child welfare worker is monitoring the case to ensure that the child is there, but is not integrating child welfare work while AOD work is occurring. In other words, youth are in one system or the other, but they are not usually in both at once.

Finally, the case reviews revealed an absolute absence of court authority as it related to parental needs for treatment. If a young person was acting out, the young person was the focus of attention. In many instances we saw “standard” orders for parental urine screens completely ignored with no consequences or further explanation. Researchers observed something of a parallel process between families and children and the courts and parents: In many of these cases, parents could not impose consequences for youth at home, so the youth entered State’s custody. Then the courts could not impose consequences for the parents, but this fact was ignored.

Key Findings – AOD

Youth Assessment

- There was a very high level of need for AOD assessment and treatment among youth in this study. Eighteen of the 30 youth were referred for an AOD assessment.
- Findings on timeliness of assessments were mixed. Child welfare referrals for assessment were not always timely. AOD assessments were implemented in a timely manner.
- The level of need for AOD assessments is best met by viewing the need for assessment at multiple points in time instead of at one point in the life of a case. Continual assessment and monitoring of AOD abuse is needed.
- Documentation surrounding AOD assessment, recommendations, urine screenings, and treatment activities was repeatedly found to be incomplete or missing.
- The AOD needs of these youth were complex both in the severity of need as well as the co-occurrence of other issues (e.g., trauma, criminal involvement, runaway and other out-of-control behaviors)

Youth Treatment

- Twelve youths received treatment, two of them inpatient and ten of them outpatient treatment.
- Most treatment was accessed in a timely way. Youth also appeared to change levels of treatment in a timely way.
- Discharge planning for youth in custody is a specialized task which requires a targeted approach that may be different from discharge planning for youth who are not in custody. Cases were marked by a lack of specialized discharge planning.

Adult Assessment and Treatment

- Despite evidence of significant parental substance abuse issues, referrals for parent substance abuse assessment were rare. Even more rare, were parents receiving AOD treatment.

Barriers

- The lack of family involvement in treatment was found to be a major barrier among these case.
- A second major barrier was an absence of court authority as it related to parental needs for treatment.

Chapter 5. Child Welfare

Child welfare case managers play a critical role in facilitating the provision of treatment and supportive services with families involved in the foster care system. This chapter includes findings related to child welfare case management responsibilities for assessment, case planning, service implementation, and child welfare case outcomes.

Assessment

Assessment provides the basis for understanding the needs and strengths of each youth and family and the interventions that best match them. Referrals for mental health services, substance abuse treatment, and other services are based on case managers' assessments. In an attempt to understand how the child welfare system addressed mental health and substance abuse needs, researchers studied assessments in each case with particular attention toward:

- Comprehensiveness and family focus
- Strengths orientation and cultural relevancy
- Recurring review of needs and strengths

Comprehensive Family Assessment

Researchers examined child welfare assessments for comprehensiveness and family focus. Researchers noted that a major strength of the child welfare assessment process was the timeliness with which case managers made referrals for youth mental health and AOD needs. Additionally, case files contained individual screens and youth assessments. Researchers noted some use of the Child and Adolescent Functional Assessment Scale (CAFAS) and observed that agencies that routinely used such standardized assessment instruments conducted more thorough assessments. Overall, child welfare assessments clearly addressed the main areas which are the

focus of the current study: mental health and substance abuse. Many assessments led to youth referrals to mental health and AOD agencies and for the most part, these referrals were timely.

While timeliness of referral was, for the most part, a strength in the 30 cases reviewed, comprehensiveness of assessment was found wanting. Consistent with findings from Chapters 3 and 4, which documented a lack of family inclusion in mental health and substance abuse treatment and planning, child welfare assessments were also myopically focused on youth. In many cases, both the SRS family-based assessment and the child welfare provider assessment focused exclusively on the identified youth. While it is possible that family members and their roles in the situations which precipitated removal from the home were considered, there was scant documented evidence of this consideration.

Admittedly, documentation varied among child welfare provider agencies. Cases from some agencies included forms for family assessment, while others did not. In some cases, these forms were essentially blank. However, some agencies appeared to require a social history as part of the assessment process. The social history covered a range of topics (e.g., parents, siblings, family status, school, and relationships in the home) and in a good number of cases, the social history was quite thorough, synthesizing information from previous assessments and in some cases, providing important information that was not recorded elsewhere. For example, in one case, the social history was the only form to document a sexual abuse history and to include mention of the stepmother's resistance to having the children placed in the home. In some agencies, the social history appeared to be developed more for succinct communication with the court rather than to guide service provision.

Despite the thoroughness of select social histories, researchers found that assessments commonly overlooked parents, parent needs and other family members. Aside from a couple

examples, step-parents and unmarried live-in partners were routinely omitted from the assessment process entirely. Assessment of the status of other youth and children in homes was seldom evident in the case records. In one case, it was clear from the case file that the case manager spoke only with the youth when completing the “family” assessment. In another case, it wasn’t possible to determine the name of the custodial parent’s live-in partner from the information recorded in the case file. Despite clear indications of parental need in the same case records, the focus was usually on youth’s presenting behaviors.

Examples follow that illustrate how exclusion of parents and other family members in assessments can be problematic.

- In one case in which the child was receiving SED waiver wraparound services, reunification was attempted three times. The mother in this case had sustained a traumatic brain injury which compromised her functioning. While the youth consistently did better in foster placements, the wraparound team felt that parent support services through the CMHC would help mom with parenting. However, the mother’s actual functional capacity was never assessed by a CDDO. Moreover, the grandparents, who were the youth’s legal guardians and financially supporting the mom and her two children lived, were not involved in assessment or case planning for this family. They were reported to undermine mom’s parenting, and thus, the case would likely have benefited from their greater involvement.
- In a nearly successful case, a youth’s mental health, substance abuse, and school behaviors were addressed. With family therapy and in-home mental health case management, this family was able to reunify. However, this success was thwarted by parental substance abuse. Although the substance abuse issues had been reported to the case manager, the parent and live-in partner were never assessed and never received treatment.

While the above examples focus on weaknesses, the researchers did identify the following noteworthy example of comprehensive family assessment.

- Upon re-entry into foster care, a youth and her family received a comprehensive assessment which was conducted by a clinical master’s level specialist of the foster care agency. The assessment was an 8-page, single-spaced document that demonstrated many effective assessment traits. It was comprehensive, family-based, strengths-oriented and evidence-based. The assessment reported on multiple life domains, several but not all family members (no siblings and only some involvement of stepfather), underlying needs, individual strengths, family strengths and some specific recommendations.

This example is significant because it represents the potential utility of in-house clinicians who can assess and treat the family onsite. Statewide changes in the delivery of mental health outpatient services may present the opportunity to provide outpatient therapy within the agency. Those agencies with experience in providing mental health treatment in-house may prove to be valuable resource for agencies that have not previously provided clinical services.

Strengths-Based and Culturally-Relevant Assessment

Recognition of youth and family strengths and cultural needs provides a foundation for family-centered intervention. Researchers looked for documentation that acknowledged parents' and youths' help-seeking behaviors as strengths, or that recognized family qualities that could help families achieve their goals (e.g., sense of family identity and wanting to stay together, perseverance, openness, resourcefulness, flexibility).

Identifying strengths in case documents proved to be difficult. Researchers found little evidence in the case files to suggest that assessments (and, consequently, permanency plans) acknowledged and addressed youths' and families' strengths in addition to their challenges. There were a handful of examples of strengths in intake documents, but they were regarded as superficial or perfunctory in most cases. Help-seeking behaviors were not recognized or documented as strengths, even though several youth, parents, or another member of the family approached a community mental health center, a law enforcement officer, or SRS for help with family troubles.

However, importantly, interviews with practitioners and supervisors indicated that a strengths orientation may be more prevalent than the case documents revealed. For example:

- A case manager spoke in an interview about the positive traits of a youth and expressed her confidence in his ability to continue with a successful reintegration.
- A supervisor commented on a parent's high motivation and willingness to change. She described how the parent faithfully attended parent education classes even though access

issues had to be overcome. This supervisor spoke with respect and admiration for this parent's efforts.

- An SRS caseworker acknowledged a parent's help-seeking behavior and unrelenting advocacy to get services for her youth as a definite strength.

A strengths orientation to assessment would also include assessment of families' natural resources and informal supports (e.g., connection to church, neighbors, coaches, clubs, and other friends). Unfortunately, researchers noticed little evidence of informal supports being documented in assessments. The following is an example that shows how a problem-focused assessment process can limit the opportunities for capitalizing on youth and families' natural supports and protective factors.

- A Hispanic foster youth came from a large family, including extended family members. An intake form contained a note that an older, adult sibling might be a resource. No comprehensive family assessment was conducted and no other mention in the case indicated that the older sibling was included in assessment, case planning or services. While this sister was no longer in the home, she might have been brought into case planning as a support to the younger foster youth in a variety of ways, especially when it came time to reintegrate.

Culture appeared to be another overlooked aspect in the assessment process. In 40% of the cases reviewed, the identified client was a child of color. In some cases researchers found that race or ethnicity was recorded on the face sheet but not subsequently mentioned within the case file. The following two examples provide evidence of a lack of adequate attention to culture.

- This researcher believes that another significant problem was M's isolation in her Kansas community. She was one of very few African American girls in her school, and she lacked pro-social activities and involvements. I also wonder about the level of cultural competence on the part of family preservation. This was a family with a history, so I don't want to jump to that conclusion with no evidence. But there is no mention anywhere of the family's isolation or the need to understand things in cultural context: African American family in a predominantly white community, the transition from living in the South to living in Kansas, etc.
- Bio mom is Native [American]. There is nothing in the file to indicate whether C identifies with this part of his cultural heritage and there is no indication that Indian Child Welfare Act (ICWA) was followed.

While culture was often underreported in case file documents, there was at least one case in which it was given appropriate attention as exemplified by the following vignette.

- The language and cultural issues in this case were really attended to. All of the therapy and case management services were linguistically appropriate. Therapist was Spanish-speaking and was able to address many of the cultural issues in the case (e.g. family's immigration from Mexico, youth wanting to work rather than attend school, youth running away to do roofing work with an uncle in another state. The youth was moved to an all ESL high school.

Routine Re-Assessment

Reassessment provides up-to-date documentation of risks, strengths, and needs to reflect progress, guide permanency decisions, and refocus case planning efforts as needed (Brittain & Hunt, 2004). It was clear from the case records that most youth's circumstances were reassessed informally over the lives of their cases. However, there was very little evidence of structured or systematic reassessment as a guide for case planning decisions. For example, researchers did not find any examples of identifiable comprehensive reassessment to inform case closure decisions. In several cases in which the case plan goal changed from reunification to other planned permanency (OPPLA), the decision making process appeared to be a reaction to changes in case circumstances rather than the result of comprehensive assessment and permanency planning. In some cases, the case record indicated that reunification decisions were based on a lack of suitable placement resources rather than completion of treatment and other permanency planning.

Case Planning

A thorough and comprehensive assessment logically leads to a case plan that guides child welfare intervention. Researchers reviewed case plans with attention to the following topics:

- Timeliness
- Individualized and family-focused
- Active participation of parents & youth

- Building upon strengths and informal supports

Timeliness

Overall, case managers were very consistent in meeting timeliness requirements for permanency planning conferences; no planning conferences fell outside the six month timeframe. While there were a small number of exceptions, for the most part, additional permanency planning conferences were not held when significant changes occurred in the case, such as a youth moving from a family resource home to a higher placement level.

Individualized & Family-Focused

On the whole, case planning documents yielded evidence of general, vague case plans that lacked both individualization and a family-focus that would naturally flow from comprehensive family assessments. Although they were not considered the predominant norm, some good examples of individualized youth tasks were identified.

Most permanency plan tasks addressed youth behaviors and services. Overwhelmingly, mental health and substance abuse needs or services were addressed in permanency plans, although they were often expressed in very general terms (e.g., “Youth will participate in RADAC assessment and follow all recommendations”). While researchers were struck by the uniformity of case plans sometimes referred to as “cookie cutter” case plans, they also identified strengths in some individualized tasks. For example, tasks sometimes addressed very specific youth needs or desires such as learning to drive a car, getting a driver’s license, getting a lifeguard certification, doing laundry at the foster home, age-appropriate activities, academic goals, and career-related goals.

There were many examples of permanency plans that lacked individualization for the youth. Researchers found that permanency plan tasks were often the inverse of the youths’ presenting problem behaviors. For example, “Youth will attend school every day” or “Youth

will follow all rules and not run from placement.” Other case plan tasks appeared to be reiterations of court orders, “Youth will attend therapy as recommended.”

Youth tasks far outnumbered the tasks assigned to all other parties to the case, particularly the parents. Overwhelmingly, researchers concluded that permanency plans were not family-focused. An exclusive focus on youth tasks and behaviors in assessment and permanency planning may effectively disengage parents and caretakers at a time when their involvement is critical to their child’s successful treatment. In many cases, there were multiple missed opportunities to use the permanency planning process to articulate the importance of the parents’ role in their youth’s treatment and success. Case records gave researchers the impression that parents were either not held responsible for their part in the case or were marginalized from assessment, services, treatment, and the permanency planning process.

For example, researchers found case plans that listed 25 youth tasks and two or three parent tasks. Moreover, in cases in which parents did have specified tasks, there were few consequences when parents did not follow through with their tasks. Often, when permanency plans changed from reunification to OPPLA, all parent/caretaker tasks were removed from the case plan. This correctly occurred in cases where termination of parental rights was planned, but it also occurred with regularity in cases in which termination was not planned. Researchers noted that while effort was made in some cases with an OPPLA goal to help the youth remain connected to their parents, in other cases, the parents disappeared entirely from case planning documents.

As mentioned previously, permanency plans rarely included all members of the youth’s household; while there were a few exceptions, plans seldom included tasks for stepparents, significant others, and non-custodial parents. Researchers observed a number of circumstances

in which these omissions, consistent across assessment and case planning, seemed to contribute to negative case outcomes. A case example follows.

- Despite a permanency goal of reintegration, there was little evidence of attempts to engage a clearly reluctant stepmother in the process. The stepmother ended up delivering an ultimatum to the father to choose between her and the youth. The father chose the stepmother and moved out of state with his wife and her children. The youth aged out of care.

Conversely, when permanency plans were implemented with a clear family focus, the plan produced positive results. For example:

- Tasks were individualized and to be completed by child and grandparent. Tasks included: independent living, improved family communication, and court-ordered counseling for grandparent and youth. Some tasks were discontinued or changed over the course of the case planning. Child and grandparent participated in the planning. Case work and services focused appropriately on the conflicts in the relationship between grandparent and youth rather than trying to “fix” one or the other of them. Family preservation services were appropriate and timely for youth and grandparent. Services facilitated their working through the conflicts and helped to maintain placement at home.
- Reviewer believes individualization improved during the second episode when the provider used a very thorough clinical assessment at intake and the Family Meeting process to develop a case plan. As evidence, the Family Meeting resulted in them discovering a resource (relative placement) that they never considered for an entire year when child was in a non-relative placement.

Active Participation of Parents & Youth

Active participation of clients in identifying needs, strengths, and solutions is fundamental for getting their buy-in and achieving case plan goals. Overall, researchers observed that parents and youth were invited to and included in planning meetings, but the majority of case plans showed minimal evidence of *active* participation of parents and youth. However, some good examples of active participation were found. The following researcher notes are evidence of parents and youth actively participating in the development of their permanency plans.

- Youth participation in case planning was evident, especially after the case plan goal changed to OPPLA. Youth requested placement with family friends. Goals reflected youth’s wishes regarding employment, career interests, getting a driver’s license and daily living.

- Parents participation in case planning was evident for bio mom, who recommended a specific family whom she wanted to be youth's guardians.
- In an excerpt from the case file, "...B made her wants and needs known—loudly. She is the one who stated that she wanted to live with her aunt."
- Permanency plans were hand written, indicating that they were completed at the time of the meeting.
- Mother actively participated, and considerable effort was made to engage father's participation, including the offer of separate case planning conferences.
- Mom participated in case planning by phone from jail.

Researchers also found examples of permanency plans that indicated very little active participation of either youth or parent, as seen in the example below.

- Dad did nothing; he was invited but didn't attend in person or by phone. The parents (father and stepmother) were not required to do anything in case plans. They just didn't show up, and eventually, they were tasked with nothing. No one expected anything of father due to a medical condition, even though a note from a doctor testified that he could have participated to some degree.

Researchers commonly observed that many case plan tasks were typed on the forms before the case planning conference, which seemed to indicate that plans were pre-formulated without parent and youth input or, importantly, buy-in. In these cases, youth and parent participation in case plan development appeared to be limited to initialing the tasks that had already been typed on the permanency plan form for them. For the most part, the case plan goals were written in language that appeared to have originated with the case manager or the court rather than the youth or family. In a few cases, there were hand-written items added to the permanency plan, but these sometimes lacked specificity. For example, one youth was to be allowed to engage in 'age-appropriate activities.' However, this was not further defined, nor was it specified how the case manager, youth, or parent would know that the permanency plan goal/task had been met.

Building Upon Strengths & Informal Supports

Researchers sought examples of permanency plans that built upon youth and family strengths and informal supports. Some mention of youths' personal hopes and dreams were observed in the case records and permanency plan tasks. The positive influence of this practice orientation was evident. A successful case example follows. This example highlights the potential value of strengths-oriented and family-centered practice for engaging both reluctant youth and challenging parents.

- One youth wanted to complete CNA classes. The last of several case managers included this goal in the permanency plan and worked to secure funding for the training. The youth responded positively to the opportunity to complete the CNA training, which was central to his dream of getting a job to save money so that he might move to Europe. The last case manager on the case did not discourage this dream, but rather used the dream to engage the youth in an activity that clearly will support a more successful transition to adulthood and give the youth a sense of agency in his own life.
- In this same case, the differences between previous case managers' and the last case manager's perceptions of this youth and parent were great. In particular, the youth was portrayed as uncooperative and defiant prior to the last case manager. The parent was portrayed as unreasonable, argumentative, and difficult by previous case managers. The last case manager, however, viewed this parent as a loving parent who understood the need for help to be a more effective parent. Under the direction of the last case manager, the community mental health center, more than a year into the youth's placement, initiated family therapy. The youth, who had been very resistant to individual therapy, quickly responded to family therapy with the parent.

Some case documentation made note of a youth's goals and aspirations. For example, one teen wanted to become an attorney, and the independent living worker took her to the nearby law school for a tour. Another youth who wanted to become a hair stylist attended an introductory session at the local beauty college.

However, on the whole, the future aspirations of youth in care were not regularly included in permanency plans. An example of a missed opportunity for integrating a strengths-orientation in case planning follows.

- One youth was interested in exploring a military career, an interest that could have been included in the permanency plan. In foster care, the youth enjoyed participating in high school athletics, particularly football and weight training. While the resource parents did successfully support the youth in pursuing these interests, including them in the permanency plan as goals might have provided the case manager, the judge, and the youth's parents with the opportunity to formally acknowledge and recognize his achievements on these goals.

Including the youth's personal goals in the case plan provides an opportunity to communicate to the youth and the youth's parents that his or her dreams and success are important and attainable.

Reviewers also noted the lack of natural supports in case planning. For example, a reviewer wrote: "It seems as though there were not a lot of natural supports identified for this family. The reviewer is concerned that M might not be able to identify one caring adult in her life."

Overall, researchers concluded that case plans could have articulated and used more youth and family strengths and informal supports.

Service Implementation

Child welfare case managers are responsible for facilitating the implementation of the case plan. They make referrals to appropriate service providers, facilitating youth and parent engagement with services, monitoring service progress, and collaborating with other service providers. Mental health and substance abuse service delivery are discussed at length in Chapters 3 and 4. The following section focuses on the case management role in service implementation.

Appropriate Service Provision

Linking assessment findings to the provision of appropriate services is one of the main responsibilities of child welfare case management. As previously discussed, service referral and provision to youth was mainly timely and appropriate. In contrast, service referral and provision for parents was infrequent, despite clear needs indicated in case files.

A number of the youth in our sample were in foster care primarily because the parent or caretaker refused to have the youth in their home. In 11 cases, parents refused to have their teen

return home and in another three cases the youth refused to return home. Researchers found troubling the extent to which such refusals, often made in the heat of a crisis, were accepted as absolute. Prevention opportunities seemed to have been missed in a number of these cases. This was clear when youth were placed in care and within a week or two the parent was advocating for the youth to return home. There was little evidence of any effort to offer respite or mediation services to these families rather than placement.

However, this observation is limited to the sample at hand and cannot reflect the prevalence of such practices among parent/child conflicts that did not ultimately result in placement. Even when parent-child conflict was the precipitating factor for out-of-home care, family therapy or other services to address family functioning were not always forthcoming. Also disconcerting were cases in which the courts decided to return the youth to the parent after a short stay in foster care, but without a thorough assessment of needs or the provision of mental health or substance abuse services. While placement may not have been needed or could have been prevented, there were still indications of mental health and substance abuse needs that could be addressed outside of foster care.

A large number of parents in the study received no services to support timely reunification with the youth or to promote positive family connections for youth aging out of care. In several examples, the case focus shifted from parent needs and toward the youth. For example, in one interview, a case manager shared a perception that foster care services had prepared the 16-year old youth to look out for himself so concerns about the parent's capacity to parent were secondary. Rather than addressing parental treatment needs, some cases appeared to be geared toward boosting youth self-sufficiency and coping capacities, so that the youth could learn to manage their parents' mental health or substance abuse issues.

Underlying Needs

Researchers observed several underlying needs that were not addressed by the services provided to youth and parents. Underlying needs appeared to be overlooked or misunderstood, while many could have been readily identified through more comprehensive family assessments. These services gaps likely contributed to poor child welfare case outcomes. Researcher notes on a number of cases illustrate the underlying needs.

History of maltreatment or other trauma

- Both children report history of physical and emotional abuse by both parents. Dad is a registered sex offender, yet this is never mentioned in any documents other than his record search. Mom was in prison for a violent felony. Sister reports sexual abuse.
- One discharge summary states that child was abused physically until age 3 and that her birth mother was a prostitute and her bio father was in prison.
- Trauma of witnessing violent death of family friend; unclear if this was identified as an ongoing need. Both assessments reference it but essentially dismiss it.
- The researcher believes that there may have been a history of sexual abuse and physical abuse that was not clearly assessed or addressed.

Abandonment, loss, and grief (e.g., emotional/physical abandonment, death, loss)

- A friend of T's from school died in car accident in September 2004 right before T came into care for the first time. This is also nearly the year anniversary of his older sibling's death in a car accident. There is no indication that grief and loss from either of these deaths is dealt with individually or as a family.
- Grandma's death in 2000 left Grandpa as sole guardian for his granddaughter. The case does not address whether Grandpa needed or received any help in dealing with his grief and assuming the role of primary caretaker for A.
- Child is angry at parents for essentially abandoning her, emotionally and physically. Mom dealt with conflict by lashing out at child and sending child to live with father. When given an ultimatum between the child and the stepparent, father chose the stepparent. Child moved out of state.

Basic needs (e.g., poverty)

- Step-mom seems overwhelmed with taking night courses and raising three children plus caring for nieces of sister who has kidney failure. With dad working out of state,

mom takes on a lot of the parenting responsibilities. Finances seem to be a stressor for this family.

- Mother has major mental illness. She works, which helps organize her, but she does not make enough money to pay for expensive antipsychotic meds. She works too much to qualify for SSI.

Domestic violence

- History of domestic violence with mother was not addressed by anyone.
- Child reports domestic violence between dad and step-mom.
- Youth reports being “kicked out of mom and step dad’s home.” She also reports that her “mother is an alcoholic but she does not recognize it.” The youth says that mom gets violent when she drinks. This information is further corroborated by an interview with a younger sibling. They both describe conflict between the parents when the mother drinks—including violent incidents, one in which the father shot a gun at their mother and it nearly hit the younger sibling.

Family disruptions & instability (e.g., divorce, geographic moves, hospitalization)

- Instability in homes; many moves occurred in this youth’s life. Had moved between parents, including different states. Not clear that this was addressed—how it affected her education, relationships, and self confidence/esteem.
- Frequent moves following departure of stepfather/boyfriend.

Parent issues (e.g., major mental illness, AOD issues, other health issues like traumatic brain injury or cancer)

- A youth was reunified with a parent with significant health and substance abuse problems. There was no evidence in the case file of any services provided to the parent.
- The family therapist involved during Level V treatment suspects that mom may be depressed. It is not clear that this is followed up on with mom.
- According to the therapist, mom suffers from a brain damage following a car accident so needs more support and guidance at this time. No one ever did a functional assessment of this mother to determine whether she actually had the capacity to parent this child.
- Mom’s untreated bipolar disorder was *the* underlying issue in this case. Mom couldn’t afford her meds, but she wouldn’t go to the mental health center to be evaluated and to qualify for the medical card. She went off meds and became psychotic and abusive.

- Logs note that mother requested parenting video tapes for the father instead of written materials did not appear to elicit any awareness from the worker that other written case materials might not be accessible to the father because of illiteracy or a learning disability.

Among these underlying needs the most prevalent was sexual abuse. Nearly half of the youth in this sample a known sexual abuse history prior to the current placement episode. There were few indications in the case records that showed an understanding of the relationship between these youths' acting out behaviors (substance abuse, promiscuity, anger, violence) and the youths' sexual abuse history. Researchers were also unable to find indications of efforts to educate parents about how common it is for adolescents with sexual and physical abuse histories to act out in ways that challenge and frighten their caretakers. Historically to the current study, there were also few indications of ongoing and/or preventive mental health services for these sexual abuse survivor youth prior to the current placement episode. Two examples follow:

- When a 10 year old child was substantiated, with an older sibling, for sexual abuse of younger siblings, there was no indication of any consideration of the etiology of the children's sexualized behaviors and no indication that any mental health services were provided to the youth or family following this substantiation. At the time of the current placement episode, the nearly 18 year old youth was described as 'suicidal and obsessed with sex.'
- Another youth had experienced long term sexual abuse by a family member who was incarcerated following the youth's report and subsequent placement. One parent and extended family never acknowledged the youth's sexual abuse, choosing to believe the perpetrator over the youth. Clear evidence of the lack of case managers' preparation to work with this unfortunately common family problem was found in the case manager's report to researchers that this youth's behaviors (parent-child conflict, sexual activity with potentially dangerous partners, and self-injurious behavior) were "typical teenage testing behavior." At the time this youth re-entered care, one parent refused to continue to care for him/her, the other parent had threatened to kill him/her, and the grandparents had 'disowned' the youth. The more threatening parent's heavy drinking (reported by the youth) was never addressed through assessment or treatment.

In the second case above, a comprehensive family assessment, including all family members regardless of their attitudes toward the youth's sexual abuse might have served to educate and engage this family more effectively. The case management task of engaging a

single individual in this youth's family as a family advocate for this youth represents a 'missed opportunity' that might well have mitigated some of the grief, loss, and isolation the youth experienced after reporting his/her sexual abuse. In general, there was little evidence of assessing and addressing family dynamics for sexual abuse survivor youth. Often, these youth's behaviors were very difficult to manage both in their placements and in their homes. Again, there was very little evidence of treatment for the family system dynamics in these cases.

Realistically, the child welfare system is limited in its ability to remediate the broad range of problems that these underlying needs represent. A cross-system, collaborative effort is required to address the multiple and complex needs of these youth and families. Importantly, case reviews suggested that these overlooked factors significantly impacted the safety, permanency, and well being of youth in care. Moreover, so as to prevent unnecessary re-entries into care, attending to these factors could add stability to family reunifications.

Engaging Parents

As mentioned, researchers observed the need for additional efforts to engage parents. In multiple cases, parents were offered a service one time. When parents declined services, they were declared 'uncooperative.' Thus, case planning proceeded with a singular focus on the youth. Child welfare literature clearly documents the expectation for resistance among parents and the need for whole-hearted efforts to engage them (Morton & Holder, 2000).

Similarly, in some cases, a single incident often seemed to precipitate case managers' dismissal of parents as suitable or requiring services to resolve their youths' need for placement.

For example:

- One youth's father was excluded from services and case planning because the case manager believed he behaved inappropriately at a case planning conference. The father reported the mother's and youth's arrests to SRS, but he was still not included in the case. The father also reported concerns that this mother was using methamphetamine. None of the father's reports

were addressed through assessment or services despite the fact that his concerns consistently appeared to be supported by case events.

Moreover, while assessing parents' readiness and motivation for change is a key component of positive child welfare outcomes (Morton & Holder, 2000), parental readiness for change was little emphasized in case file documents. An example follows.

- In one case, the youth presented with a severe trauma history, extensive loss and grief issues, and a serious substance abuse problem. The mother consistently refused to provide urine analyses and consistently undermined the youth's substance abuse treatment by arguing about the content of treatment and related behavioral expectations. The youth repeated inpatient treatment twice in a very short period of time. There was no case documentation of any effort to persuade the mother to participate in these weekend activities or any efforts to provide the mother with transportation to these weekend activities.

Family participation has been identified in the research literature as a critical part of AOD treatment for youth (Williams, et al., 2000). It would appear that the above case example would have benefited from a frank assessment of this parent's readiness to change and from efforts to overcome motivational obstacles to participation in her child's treatment.

Monitoring and Facilitating Progress

In general, few permanency planning tasks or goals were presented in a manner that clarified how successful attainment or completion would be measured for the youth or parent. Since resolution of placement issues forms the foundation for reintegration decisions, this is an area that deserves greater scrutiny. It is likely that youth and parents would benefit from clearly defined, partialized interim goals. Youth and parents alike may be more successful in meeting permanency planning goals that measure both the work they have accomplished and the distance they have yet to travel toward permanency. For example:

- In one case, the case plan goal changed from reunification to OPPLA fairly early. Although the case plan goal continued to be OPPLA, the parent/youth relationship improved dramatically once family therapy was initiated after the youth was in placement for more than a year. In less than a month's time from changing the case plan goal from OPPLA back to reunification, the youth was reunified. The case file clearly documents that this

reunification decision resulted from a placement disruption rather than measurable attainment of permanency plan goals.

In sum, these 30 case files did not provide evidence of agencies having a systematic approach for determining reunification readiness. There were few examples of measurable permanency plan goals for this sample. When permanency plan goals are not articulated in a clear and measurable way, youth and parents face an even greater challenge in their efforts to resolve child welfare issues and to achieve family reunification.

As the case progresses, it is important for case managers to continue to deepen awareness of family issues and utilize this information to facilitate progress with parents. Historically, the child welfare system has been reactive or tertiary rather than proactive or preventive. However, when possible, attempts to foresee needs and issues would likely lead to more favorable outcomes. For example, in one case, the youth was scheduled to begin a trial home visit at the same time that his father was returning home from prison. The worker encouraged mom to get family therapy started, but mom did not do this until there was a report of violence between dad and youth. Since it was likely that the teen's trial home placement and the father's return from prison would change family dynamics, some transitional time between events might have prevented the altercation.

Key to assessing and facilitating family progress is ongoing communication and collaboration with service providers. This topic will be fully addressed in Chapter 6.

Child Welfare Case Outcomes

The Child and Family Services Review (CFSR) highlights the importance of timely and permanent case outcomes for youth in foster care. Less than one third of the youth in this sample experienced timely reunification without re-entry. Reunifications did not always appear to result

from case planning or the resolution of presenting problems. In some cases, reunification decisions appeared to be expedient (e.g., when youth were considered too difficult to maintain in placement due to sexual experimentation). Child welfare case outcomes for the 30 cases reviewed are summarized below.

- Timely Reunification – Sixteen of 30 youth achieved reunification by the end of the study period. Only eight youth in this sample achieved reunification within 12 months of entering care.
- Re-entry – One third of these 30 youth experienced at least one re-entry into foster care following the FY 2005 placement episode. Half of the reunified youth experienced at least one foster care re-entry.
- Length of stay - More than one third of youth were in care for 12 continuous months or longer, some in excess of three years.
- Aging-Out - Eleven of the youth in this study aged out of foster care without achieving permanency. At the time this study ended, some youth were still in care and likely to age out as well.
- Distal Outcomes - Many of the foster youth in this sample who aged out of care, as well as several who achieved reunification shortly before their 18th birthdays, appeared to be poorly prepared for transition to adulthood as evidenced by:
 - Lack of firmly established family or other adult connections
 - Lack of high school education
 - Lack of employment experience
 - Lack of savings
- One third of the girls in the sample became pregnant while in foster care.

Other Factors Related to Service Provision

Common themes related to child welfare case management responsibilities included resource parents, placement proximity, placement stability, worker continuity, youth preparation for adult life, and case documentation. These themes are briefly discussed below.

Resource Parents

Placement can contribute to or impair attempts to meet case plan goals. Chapter 7 provides several examples of resource parents going above and beyond the call of duty to

maintain youth with difficult behaviors and multiple needs. On the other hand, one youth missed appointments because her foster parent didn't think she needed therapy. In other cases, interviews with case managers revealed that resource parents didn't particularly like the child placed with them. One supervisor believed that a particular resource family was "in it for the money." However, on the whole, foster care placements were thought to contribute positively to youth. In some cases, youth did far better in placement—in school, with their behaviors— than they ever did at home with their parents. Placement was clearly a resource in many of the cases reviewed.

Placement Proximity

Placement proximity contributes to continuity in service provision and support for youth and their families. Cases revealed several instances where placement proximity was a barrier to services:

- Youth placed 3 ½ hours from her hometown. Mom received gas cards which helped with transportation expenses but by the time mom got off work, drove to pick up the child and returned back home, there were no family therapy sessions available during the weekend hours.
- Placements for teens limited in the local area. Had youth been placed closer to home, she and parents could have participated in family therapy at an earlier point than during aftercare.
- Mom was not able to participate in family group and parenting education during youth's AOD treatment due to the 4 hour distance from her home.

Placement Stability

Placement stability is another important factor for youth in foster care. The CFSR includes placement stability as an indicator for the outcome of permanency and stability in living situations. While researchers had insufficient information to determine whether cases met CSFR criteria for placement stability, based on the information available, researchers characterized placement stability in half the cases as "good," "not an issue," or "stable." Researchers recorded

efforts of the foster care agencies and resource parents to maintain placements. Following are examples:

- Teen had one placement with his sister. Resource parents appeared committed to the two youth.
- Early in placement, the resource parents wanted to end placement because of youth's lying. However, the agency supported the resource parents and maintained placement. Youth had no placement changes during short foster care episode.
- Agency worked closely with resource family to maintain youth's initial placement. His behaviors were most problematic early in the placement and resource parents gave notice within the first 30 days. But agency worker provided respite placement and persuaded them to reconsider and youth successfully completed his foster care stay in that same home. This was a particular strength in this case as it kept youth in his home school district, and that was a district that appeared to have the commitment and resources to address his academic needs.

A quarter of remaining cases are characterized by multiple placement moves that cannot be attributed directly to the foster care providers, but rather to youth running away or engaging in such serious or violent behaviors that placement in a more restrictive setting was clearly indicated. Researcher notes indicated:

- Placement stability was really a problem in this case. At least 11 moves were recorded. Child assaulted staff members and/or foster children or parents. Not even Level 6 placements contained this child's acting out behaviors. That's why I'm confused about her being stepped down from Level 6.
- M's behaviors resulted in frequent placement changes, and a number of institutional placements. Services were interrupted and/or not available in some of these placement settings.
- Youth was readily able to disrupt placements, sabotaging success of therapeutic interventions and derailing educational success at the same time.

In the remaining quarter of cases, placement stability was an issue that researchers thought could have been improved, as it affected not only the child's well-being but the

continuity of needed mental health services. The lack of suitable long term placements for the highest need youth appeared to be related their frequent placement disruptions. For example:

- In the case of a youth in care for nine months, there were five different individual therapists due to moves in levels of care.
- There seemed to be an issue with the girl's sexual acting out with both sexes that threw the system for a loop. This seemed to get the kid home more quickly, because they did not know what else to do with her.
- Youth had 27 placement moves. Mental health services provided more quickly might have helped stabilize the case, but it appeared that the youth's conduct disorder, sexual aggression toward same-gender peers, transgender identity, and general acting out confused and frightened everyone: resource families, the foster care provider, and the mental health system alike.

Worker Continuity

Worker continuity was an important issue meriting consideration. Due to child welfare's notoriously high turnover, and to the number of professionals involved in cases, continuity is a central factor in promoting positive permanency outcomes. In some cases, worker visits did not occur because of changes in workers. The transition from one foster care provider to another during this time period also appeared to compromise some cases. In these cases, there appeared to be gaps in coordination. One case, in which the child had 11 placement moves and could not be screened for Level VI placement because she was "blowing placements" too fast, appeared to need better planning and coordination.

Adult Life Preparation

The child welfare system is responsible for preparing older youth with the skills needed for adult life. There was evidence that this happened for several youth.

- A youth who enjoyed a supportive relationship with a kinship care provider, a former teacher, graduated from high school and was attending a Kansas college at the time of the interviews for this study.
- One teen with the dream of becoming a lawyer was encouraged by his resource parents to do well in school. This boy, with a history of behavioral problems and parents who essentially

abandoned him and his sister, graduated from high school and was preparing to enter college at the time of the interview.

In contrast, several youth aged out of care without sufficient preparation or planning for adult life.

- In the case of a pregnant teen, a therapist recommended placement in a specialized home where the girl could develop independent living skills and prepare to become a parent. This suggestion was disregarded, with no explanation given in the file. Much to the therapist's and foster parent's dismay, this youth ended up aging out of custody without a driver's license, crib, or other basic necessities to equip her for impending motherhood.

For many of these youth, the stay in foster care did not appear to have yielded improvements in family relations or other types of positive adult relationships to support the youths' transitions to adulthood.

Case Documentation

Finally, documentation is an important part of child welfare case management responsibilities especially in light of laws and policies requiring reasonable efforts. Documentation tracks the child welfare and collateral systems' work with families and provides a record of efforts and accountability. This review revealed some major gaps in case documentation. Researchers found that copies of screening instruments included in some case files often lacked identifying information such as who administered the screen, on what date, and with what results or findings. Likewise, files often lacked copies of service providers' assessments. Sometimes, findings or recommendations from the assessments appeared in court reports, case logs, or case plans, but at times these were missing as well. With these documentation gaps, it was often impossible for researchers to ascertain when services began or the frequency with which they occurred. There was also evidence of apparent misstatements in the files that got carried on in subsequent reports. For example, in one case, the youth was diagnosed with a conduct disorder and with a provisional diagnosis of both psychotic and bipolar

disorders. However, the child was described in several successive court reports as having all three disorders.

At times, information conflicted regarding pertinent events or child or family risks. In one case, screens conducted within days of one other indicated conflicting information about a youth's history of fire-starting, sexual offending, and suicidal ideation. In at least a handful of these disorganized or incomplete files, the state of the files might be possibly attributed to, or compounded by, worker turnover. However, the fact that the case was transferred among workers seems all the more reason to ensure that files are complete and thorough.

One other element of case documentation found missing was information from SRS case files. Researchers were able to compare findings of last year's study of SRS case files to findings from this year. Some seemingly significant historical information (from the SRS files) did not reappear in the provider files: a parent's previous drug abuse, father being a registered sex offender, and youth medical information. Without pertinent historical information, case managers are hampered in their abilities to provide comprehensive assessments and services.

Summary

Review of 30 CINC-NAN cases revealed, overall, that several basic procedural expectations were met. Case planning occurred within the six month timeframe. Youth were generally referred in a timely manner for appropriate mental health and substance abuse services. While more training to recognize the behavioral effects of trauma in children and families appears to be needed, more often than not, referrals were made. However, the most urgent findings are the poor case outcomes and an absence of parent participation in assessment and

services. The absence of strong engagement strategies and comprehensive family assessments impacts case planning and service provision and likely contributes to poor case outcomes for these youth. Cases were initially described as ‘youth only’ cases by the SRS intake caseworkers and that orientation appeared to carry through to the provider case managers’ assessments. Importantly, researchers observed many missed opportunities to engage parents and support positive youth outcomes that would have been clearly indicated.

Consistent with the absence of comprehensive family assessments, reviewers found a pervasive lack of attention to the needs of biological or birth parents once the youth entered out of home care. Family assessments rarely included all household members, much less extended family. Parents and caretakers rarely participated in family or individual therapies to remediate mental health, substance abuse problems, or to improve family functioning. Successful reunification was hampered in some cases and stable reunification was compromised in others by lack of engagement with parents, by lack of parent accountability to participate in treatment, and by a lack of follow-through with parent’s case plan tasks. Without a thorough, family-centered assessment of family problems *and* strengths, case plans and services seldom reflected individualized, strengths-oriented approaches.

Resource families provided safe, stable homes in which youth stabilized markedly with school attendance, academic performance, and conduct. Placement proximity was noted as a problem with mental health and school continuity in some cases. Also, placement stability was a major issue in a small number of cases in which youth presented with severe psychopathology and cultural differences.

While half of these youth achieved reunification, only eight youth in this sample of 30 achieved stable reunification within 12 months of entering care. More than one third of youth

were in care for 12 months or longer. One third of the youth in the sample re-entered care at least once following the FY 2005 removal episode.

Eleven youth aged out of care without achieving permanency; others are still in care at this writing. Many of the foster youth in this sample who aged out of care, as well as several who achieved reunification shortly before their 18th birthdays, were poorly prepared for transition to adulthood. Six girls became pregnant during the review period.

Key Findings – Child Welfare

Assessment

- Youth's assessments demonstrated timely referral for mental health and substance abuse services.
- Assessments largely focused on the youth without sufficient attention to parents and the family system.
- Assessments did not routinely address youth/family strengths and culture.
- Systematic reassessment rarely appeared to guide case decisions.

Case Planning

- Case managers consistently met timeliness requirements for permanency planning conferences.
- Although there were some examples of individualized and strengths-based goals, case plans largely lacked individualized and strengths-based goals; and, they were seldom family-centered.
- Youth and family participation in plan development was more the exception than the rule.

Other Factors Related to Service Provision

- Placement proximity and placement stability negatively impacted case outcomes for several youth.
- Placement stability ranged from excellent to problematic. About a quarter of cases appeared to have preventable stability issues.
- Gaps in case documentation included incomplete and conflicting information. These problems were compounded by worker turnover, which is precisely when complete documentation is needed.

Service Implementation

- Mental health and AOD services were frequently provided to youth. Service provision to parents was sparse.
- Missing service areas suggest lack of attention to underlying needs (e.g. sexual abuse, trauma, abandonment, grief).
- Improved engagement of parents and other relevant family members is needed.
- Monitoring service implementation and case plan goals appeared limited. Progress on case plan goals was neither specific nor measurable. This would help families and case managers alike to measure progress. Clearer case plan goals with more intermediate steps would provide more direction for those involved and also make clearer the basis on which permanency decisions are made.
- Agencies did not seem to have a systematic approach for determining reunification readiness.

Child Welfare Case Outcomes

- While sixteen of these 30 youth achieved reunification, only eight achieved reunification within 12 months of entering care. One third of the 30 youth experienced at least one foster care re-entry subsequent to the review period. Only eight youth experienced timely permanency with no re-entry.
- Eleven of the thirty youth aged out of care, few with adequate preparation for adult life.
- More than one third of youth were in care for 12 months or longer.
- The most urgent findings are poor case outcomes and an absence of parent participation in assessment and services. The absence of strong engagement strategies and comprehensive family assessments impacts case planning and service provision and likely contributes to poor case outcomes for these youth.

Chapter 6. Cross-Systems

Systems Collaboration

Collaboration between systems is fundamental to successful service delivery with families involved in foster care. Case-level collaboration encompasses efficient service initiation, ongoing information sharing, and interagency coordination. While this study focuses primarily on collaboration as it relates to the provision of mental health and substance abuse services, other major systems clearly play a significant role in foster care outcomes. Thus, findings related to relationships with the judicial and educational systems will be addressed in this chapter.

Service Initiation

The process of interagency collaboration usually begins with the referral from child welfare. The exceptions are youth who are already receiving services at the time they come into care. As previously explained, mental health intake took a minimum of a few days to more than three months. A foster care supervisor described the challenges in service initiation: “The mental health centers require a packet of information. It is very time intensive. The case manager has to be present at the first mental health intake. Coordination of schedules is hard.” Expressing a similar sentiment regarding time demands to initiate services, an SRS case manager remarked:

I’ve spent a month trying to set up an agreement between the mental health center and SRS to pay for Strategic Family Therapy. I’ve had good luck with these services. It was a struggle to get these services for a family. It took a month and then my family blew up. I finally did get an MOU for these services. It takes lots of effort and time. I don’t know why it was so difficult...partly because I didn’t know who to contact.

A number of workers attributed delays in service initiation to the volume of paperwork required for making a mental health referral. One foster care case manager further pointed out what she sees as unnecessary redundancy between the paperwork required by the mental health center and the paperwork required within her agency to make a referral. In a small number of

cases, the intake process stalled when a worker or parent failed to adequately complete required referral forms such as the Child Behavior Checklist.

Delays in timely service initiation were also ascribed to mental health staffing shortages. According to a foster care supervisor, “Mental health centers cannot timely meet needs of the community. They need more staff. We do not see this in AOD providers.” Missed appointments require re-scheduling that compound these delays for youth and families.

When a child disrupted or purposely changed placements (such as moving to another treatment level or going home) to a new catchment area, the intake process started all over again with a new mental health center or service provider. Workers’ frustrations around these all too frequent occurrences are evident in the following interview comments:

Timeliness is hard with both [service coordination/collaboration], especially with high risk kids. By the time we get them in services, they are running or disrupting. The intake process takes 3-4 weeks to get them in then 3-4 weeks to staff a therapist. By the time they get a therapist and build relationship there are problems...If we could have more timely intake and services, that’s what would prevent disruptions from occurring. (Foster care case manager)

Simple fact is that just to get an intake scheduled would take a ton of paperwork. Then they set the intake for 3 weeks out. Then the kid disrupts in placement. Then we can’t find a placement and the kid goes to a shelter. Then we find a placement and the kid moves again. Kids move so fast and the time to get them in and get mental health services and medication is too long. Kids move in the middle of the night and don’t have medication and then another center in another location would refuse to fill meds. Then the schools will not take them. It’s a huge struggle. (Foster care case manager)

In contrast to mental health service initiation, alcohol and other drug (AOD) assessments and services seemed relatively simpler to access as needed. It should be noted, however, that case files typically contained very little detailed information regarding AOD, putatively due to federal confidentiality regulations. In many cases, it was impossible to ascertain how the referral for a RADAC assessment occurred and how quickly the AOD system responded. Overall, however, there were few case file references or interview comments related to problems with the

RADAC referral process or substance abuse service initiation. A foster care supervisor's statement captures the relative ease of RADAC assessment and AOD treatment: "Typically, trying to get a RADAC assessment happens quickly and getting recommendations back is timely. We're never told by AOD providers that we have a waiting list or we can't serve your kid."

In some areas, mental health centers offered substance abuse education or treatment rather than referring the case to an AOD provider. It is not clear if these cases experienced the same delays in service initiation common with mental health services provided by the CMHCs. There was at least one case in which a youth was not assessed until four months into placement, despite a history with AOD issues and recent arrest for marijuana possession. Unfortunately, there was not enough information provided to ascertain why AOD issues were not assessed earlier in the case. This delayed response was certainly an exception to the timely service response seen in other cases.

Some case managers did question the validity of the RADAC assessments due to their reliance on client self-report. However, RADAC recommendations appear to be faithfully followed by service providers, at least in these 30 cases of youth in care.

Information Sharing

Timely exchange of information is a significant component of collaboration. Ideally, this exchange occurs on a regular, face-to-face basis. Case reviews revealed that workers consistently invited mental health, AOD, and other service providers (such as educators) to case planning meetings. They rarely attended. On the occasions when mental health was represented at a case plan, it was mental health case managers, rather than individual or family therapists who participated.

In lieu of direct participation, workers sought progress reports from therapists and treatment providers. Workers reported mixed success in obtaining timely written reports. If

necessary, they shifted tactics and attempted to get phone or email updates from service providers. When successful, case workers incorporated providers' remarks into court reports and/or case plans. Getting therapist reports in a timely manner was a common challenge repeatedly mentioned by case managers. Not having current updates on services became particularly problematic when courts would not accept a late report and made decisions without pertinent information.

Information sharing and communication between child welfare and service providers varied greatly by provider. Workers reported that communication was facilitated by an existing relationship with a therapist or treatment provider. The following descriptions characterize two cases in which timely, regular information sharing occurred.

- An AOD counselor in one case was described as “willing to do what it takes to support the youth.” The counselor showed high involvement and commitment by providing timely reports, participating in case plan meetings, and communicating regularly with the case manager.
- A private therapist did not participate in case planning meetings but the case manager reported close contact, both formal and informal, with this individual. At a minimum, they spoke every two weeks. In an interview, the worker noted that this therapist was “very involved” and that “this is not typical.”

Case reviews suggest that an accessible, dependable relationship is a key to successful collaboration. This implies, therefore, that cross-systems work might be particularly difficult in cases involving worker instability, placement instability, and placement proximity issues. Frequent changes in caseworkers or therapists, whether due to turnover or child placement change, undermine professionals' abilities to develop trusting working relationships. In addition, professionals are less likely to have established working relationships with colleagues who are located in different areas across the state. A therapist explains the challenges in attempting to coordinate services with unfamiliar professionals from another area: “If kids are placed out of

town, we sometimes try to work with the family therapist in the town where their parents are. But that's hard to coordinate, and it's not billable.”

On the whole, case reviews reflected a lack of consistent, detailed information sharing between professionals. As expressed by a family support worker, “We don't get a lot of documentation from the mental health centers, such as discharge summaries, goals of therapy or case logs. We just don't.” As already described, case information was particularly limited in regard to AOD services. As a caveat, however, overall case documentation was frequently lacking. There is, of course, the possibility that ongoing instructive communication was occurring but that it was not adequately captured in the case files.

At times, information sharing appeared to be little more than information collection by the foster care case manager. Clearly, information sharing needs to occur in both directions. It may be assumed that the phone and e-mail communication described above includes sharing of pertinent child welfare information with mental health and AOD providers, but case records did not provide enough information to judge the adequacy of information exchange. In at least one case, the foster care agency failed to inform mental health of a placement change during aftercare. A mental health case manager reported showing up at school to visit a youth only to learn that he had been withdrawn several days prior in order to begin Level VI treatment.

Aside from updates to child welfare workers, case reviews yielded limited evidence of mental health or substance abuse systems sharing information and communicating with each other. As an example:

- A youth with substance abuse issues started outpatient and then stepped up to inpatient treatment. At the same time he was participating in individual counseling with the CMHC. While the foster care case manager had regular contacts with both the mental health and AOD providers individually, there is no indication that they ever dialogued with each other or as a team. In this case, the youth had a good relationship with the AOD provider while the therapist was struggling to engage him and figure out his diagnosis.

In this case, communication and an exchange of ideas between providers might have produced creative solutions for more effective service provision.

Interagency Collaboration

Truly effective cross-systems work involves ongoing interagency collaboration. This approach to serving children and families involves a profound understanding of other systems, aligned goals and service provision, mechanisms for interdisciplinary meetings, and a sense of shared responsibility and accountability.

Interagency collaboration begins with a heightened understanding of other systems—including respect for their expertise and potential contributions. This awareness is illustrated through the following examples:

- Excerpt from an AOD treatment provider report, “(Youth) would benefit from visiting with a therapist about issues in her personal life.”
- A parent AOD evaluation recommended outpatient treatment as well as “a full mental health screening to further assess her current mental health issues and to reevaluate all the medications she is taking.”

Lack of interagency planning can be particularly problematic for youth who are inundated with professionals and plans from multiple agencies and systems. These youth end up with multiple appointments and sometimes conflicting goals. Youth and families in this situation can be overwhelmed when they are asked to attend so many appointments, accomplish so many goals, and establish so many relationships with professionals as the following excerpt shows:

- Reviews determined that in one case an adolescent was expected to attend psychosocial group 2 nights/week, AA/NA 3 nights/week, individual counseling 1 night every other week, in addition to family therapy, school responsibilities and additional meetings with the foster care case manager. Reviewers speculated that the sheer number of required sessions may be setting up unrealistic expectations. In fact, the youth attended psychosocial groups and school but typically missed AA and therapy. There was no indication in this case that the mental health, AOD, education and child welfare systems were talking to each other to coordinate requirements.

Collaboration facilitates the alignment or sharing of youth and family goals across various agencies. Evidence of reinforcing goals is seen in the example below:

- A specific recommendation from a psych evaluation read, “Psychological evaluation should be shared with the youth’s educational team. Appropriate modifications to the educational plan could improve school behaviors dramatically.”

Effective interagency teams utilize a regular forum for increasing knowledge and communication, collective decision-making, identifying barriers to services, seeking creative solutions, and jointly monitoring outcomes. Sometimes child welfare case planning meetings involve other professional disciplines and have the potential to serve as a place for interagency work. More frequently, however, case plan meetings are short on representation from other systems and therefore fail to serve as an effective mechanism for interagency teamwork.

Case reviews revealed at least three successful mechanisms for multidisciplinary collaboration. Each mechanism is briefly described followed by an example from the case reviews:

- Multidisciplinary Teams include SRS, law enforcement, forensic interviewing agency, CMHC, foster care agency, family preservation agency, AOD, schools, county attorney, court services, and family advocates. Teams meet every other week with specific cases to review. They create a plan with tasks and responsible parties. The team follows up on the case at every meeting until the case is closed.
 - A county *multidisciplinary team* helped in the case of a youth taken into custody when her guardian failed to appear in court. The team quickly recognized that this family’s primary issue was a problem with intergenerational communication that might be more appropriately resolved through family preservation. The youth returned home within a month.
- Wraparound Meetings, typically facilitated by the mental health centers, are a planning process involving a “family team” which includes professionals and family members. The result is an individualized set of community services and natural supports to achieve outcomes. Wraparound was cited in several cases as a valuable means for coordinating services. It should be noted that therapists were more likely to attend Wraparound meetings than case plans or other team meetings.

- In a case that involved a parent with serious mental and physical health problems and a youth with a serious emotional disorder, *wraparound meetings* brought together both the mother and youth's mental health providers. In another case, *wrap around meetings* helped the family and youth with concluding that guardianship should be considered.
- Family Meetings, based on the Family Group Decision-Making model, offer a structured planning process involving relatives, supportive friends, and involved professionals. Meetings start with time for professional information sharing with the family and include a facilitated discussion of family strengths and concerns. Families are then provided private time for the development of a plan addressing how they will care for and protect the child in care.
 - A *family meeting* was conducted in the case of a youth coming into care for the second time for parent-child conflict and running away. The *family meeting* resulted in the discovery of a relative placement resource that had not been considered for the previous year in which the youth was in foster care with a non-relative.

Collaboration, at its best, embodies a spirit of shared responsibility and accountability as reflected in the following vignettes:

- A foster care provider felt it might be difficult to engage a particular set of parents in mental health services so they asked a parent support worker (prior to having an open case on the family) to accompany the family support worker on home visits to try to persuade the parents to participate in family therapy.
- The mental health case manager was used as an intermediary by the provider case manager to advocate within the mental health system to increase the intensity of therapy. At the time of the trial home visit, the youth's therapist inquired about a safety plan and this was done by the family support worker.

Other Major Systems

Two other major systems were considered as key stakeholders for adequately addressing the needs of youth and families involved in the foster care system – courts and schools. This section discusses this study's findings relevant to each of these systems.

Court System

Courts play a potentially powerful role in the child welfare intervention. Case reviews uncovered significant variation in the judicial approach across jurisdictions. In many cases,

researchers perceived the court role as “hands-off” or “perfunctory.” In these cases, courts simply appeared to go along with recommendations made by case workers and/or other professionals. In contrast, one court’s judge was described by a foster care case manager as “micromanaging.” In another jurisdiction, a worker expressed frustration that the judge “doesn’t read court reports and missed the point of many cases.” At the extreme, at least one court was outwardly antagonistic toward child welfare professionals. This judge refused to allow foster care workers to speak in court and, from the case managers’ perspective, blatantly disregards their recommendations.

Researchers commonly found that services or tasks that were court-ordered were done by youth and parents, while those not ordered were more frequently disregarded—typically without consequence. Parents, in particular, did not comply with case plans or participate in services when they were not court-ordered.

- Youth received comprehensive psych evaluation recommending individual and family therapy. The court agreed with recommendations from the mental health center and the foster care provider and ordered that the youth participate in these services. She did.
- Caseworkers tried valiantly to get a father and stepmother to participate in their case. They even contested the father’s claims that his medical condition prevented him from getting involved. The judge in this case did not task father even though a doctor’s note indicated that he could have participated to some degree. The father eventually moved away without informing the foster care provider and the youth aged out of custody.
- A psych evaluation recommended individual psychotherapy for a father and although a task was added to the case plan indicating that the father would follow this recommendation, it was not court ordered and it never occurred.

There was evidence that some courts buy into the myth of “fixing the child” with no regard for the family’s contribution to the youth’s issues. Family therapy was the most frequently ordered service involving parents. Parental need for individual mental health or substance abuse treatment was frequently ignored.

Nearly half of reviewed cases did not make any orders specifically for parents. Without orders, caseworkers lack the court's backing and support in trying to engage families in services. Lack of orders is particularly problematic when, as in many of these cases, the need for treatment or intervention with parents is clearly indicated. The following case vignette demonstrates a court's disinterest in parental need:

- A judge in the case of a youth with two alcoholic parents blatantly ignored the parental substance abuse and neither parent was ordered to do anything, despite family therapy being recommended at least twice. The case manager thought it was because the father was rich and the judge thought he would fight anything he was ordered to do. The judge was more focused on a punitive response to the child's acting out behavior.

In some cases, youth or parents had legal charges pending which might have been utilized as leverage to order counseling or push for services. Often these charges were dropped along with the opportunity to compel services.

A few courts were found to "order everything" for services. As explained by a foster care supervisor, "In this county every youth is referred for mental health and frequently for UA's." Professionals and families respond in these areas by ignoring the orders or services that they do not feel are needed. A family preservation supervisor describes a case handled in this manner: "This is a good example of a cookie-cutter case plan. Referrals were made in the court where the youth was in foster care. When she moved home they were not followed because no one felt services were needed." When workers and families perceive court orders as irrelevant to their situation and the court fails to hold workers and families accountable, the orders in these areas quickly became meaningless.

While the child welfare system strives to embody a more family-centered approach, the courts sometimes thwarted these efforts with what appeared to be a "knee-jerk" reactions or

overly punitive responses. Some examples of court actions that impede relationship building and productive casework with youth and families follow:

- There were a small handful of cases placed prior to SRS involvement. In at least one of these cases, family preservation was determined to be a more appropriate service than foster care.
- A youth at JIAC for stealing twice and fighting once was returned home each time with no services and no referrals. The court then sent the youth to Secure Care to “teach her a lesson.”
- A judge ordered a youth to a foster home in central or western Kansas for telling her friends that “foster care is fun.”

The court role could be characterized as lacking in effective judicial oversight in nearly half of the cases reviewed. This includes cases at two ends of a continuum. In some cases, the judge appeared to simply “rubber-stamp” the case with no questions or concerns. And in the cases described above, a judge clearly failed to respond or responded in an insensitive or inappropriate manner that did not facilitate a positive case outcome. There were also cases where inadequate information seemed to be driving ineffective judicial oversight. Some cases did not have assessment results or therapist reports before the judge ruled on placement or even dismissed the case. Timely, accurate, and comprehensive information puts judges in a better position to make appropriate decisions. Other times, when dismissal seems justified, cases are continued, as exemplified below:

- In two cases, disagreements between workers and county attorneys resulted in cases where families moved out-of-state while youth in care remained in Kansas for intensive mental health treatment. In both cases, families in the other states had indicated a desire to have the youth with them.

In a few cases, researchers observed that when parents had active representation, cases ended more favorably for the parent. In one, a case manager felt that mom having an attorney and agreeing to services were the two factors that led the judge to dismiss the case. In another

case, the plan submitted to the court recommended individual therapy for youth and mother, family therapy and parent education, however, the court decided to release the youth from custody against the recommendation of the foster care provider and SRS.

Educational System

Schools are a major system in the lives of most foster youth as they are typically the place where youth spend the most time outside their homes or placements. The majority of reviewed cases involved some school problems. These difficulties included academic struggles or failure, behavioral problems and/or truancy. Despite the prevalence of school issues, there is not a lot of detailed information in case files regarding education of these youth, even in the cases where truancy was part of what brought a youth to the system's attention. Two examples of the pitfalls of failing to adequately involve education follow:

- A case manager approved home schooling for a truant youth with an un-medicated mentally ill parent.
- A resource parent was not informed that a youth had an IEP in his home community even though the youth's behavior in the educational setting was the precipitating event for placement. When it was discovered, the new school district had difficulty obtaining the IEP and other information from the youth's home school district.

Case files sometimes mentioned the existence of Individualized Education Plans (IEP), but copies of IEPs were rarely, if ever, included in the case files. In general, there was very little information on child welfare involvement with the schools over the course of the case. In a handful of cases, the foster care case manager, sometimes joined by the mental health case manager, participated in an IEP meeting. There did not appear, however, to be any sort of joint case planning (i.e. shared goals or tasks) among the various youth-serving systems.

The lack of attention to education overlooks a potential resource for children in foster care. School can be a safe haven for youth. Case reviews revealed that several adolescents were

referred to specialized or alternative schools. These programs almost always seemed to have a stabilizing and positive effect on the youth's behavior and school performance. The following two cases exemplify this effect:

- A youth with delinquent behavior and truancy transferred to an ESL high school program in Wyandotte County and began to improve markedly.
- Upon entry to foster care, a youth was walking out of class, using profanity and refusing to comply with teachers, which had resulted in multiple suspensions. Transfer to an alternative school resulted in improved school attendance and no subsequent school suspensions. The youth was then reintegrated into regular classes, discontinued case management and began attending therapy at school. He graduated!

Case files noted improved grades, connections with friends, teachers or other professionals at the school and other positive impacts. In one case, a youth even sought out a former teacher to serve as her foster parent.

Key Findings – Cross Systems

Service Initiation

- The time-consuming mental health intake process results in delays in service initiation. The necessity to repeat the process in cases of placement instability becomes particularly problematic.
- AOD assessment and treatment initiation appears relatively unproblematic though some workers question the validity of the RADAC assessment due to its basis in self-report.

Information Sharing

- Information sharing between systems typically occurs through periodic phone calls or e-mail. Regular, well-documented exchange of information is lacking, particularly with AOD providers.

Interagency Collaboration

- Three successful models of collaboration emerged: multidisciplinary teams, wrap around and family meetings. Case planning meetings are too poorly attended by other professionals to serve as an effective mechanism for ongoing interagency collaboration.

Other Major Systems – Courts & Schools

- The court role varied widely by jurisdiction. Court orders facilitated compliance with services by youth and their parents.
- A majority of cases involved educational issues. Schools are an overlooked potential resource for youth in care.

Chapter 7. Major Supports and Barriers

This section summarizes the major supports and barriers that were identified across the 30 cases reviewed in this study. Researchers considered both case documentation and interviews to identify supports and barriers. The interview protocol included questions that specifically asked the respondent to identify major supports and barriers related to the case. Below is a summary of the analysis that identified themes relevant to supports and barriers.

Strengths & Supports

Strengths and supports represent those activities and people that were identified as facilitating positive movement in cases which led to timely permanency, or to the accomplishment of smaller tasks that were important for the safety, stability, and well-being of youth and families. Five strengths and supports emerged in this study. When done well, these variables were identified as the essential things that helped foster youth and their families. These five key factors are described below.

Relationships with Helping Professionals

Relationships with helping professionals were identified as major supports for a number of cases. In general, the type of professional was less important than the relationship they were able to establish with the youth or parent. A variety of professionals from different fields were identified, including foster care case managers, mental health therapists, AOD counselors, parent support workers, family support workers, and mental health case managers. The key to their support can be summarized as building trusting relationships that led to the youth or parent feeling respected and cared for. For example, when asked what made a difference for a youth in foster care, an interview participant responded, “Having a social worker she trusted. Once she trusted me, she stayed in placement and stopped doing drugs...Once she trusted me, she stopped

all the nonsense.” On another case, a case manager explained that the youth was not open to treatment, “... so they could have put her in all the treatment they wanted to and it wouldn’t have made a difference until she felt cared for and respected for who she was.” This theme confirms a long-standing principle of social work that places the worker-client relationship central to effective helping (Biestek, 1957; Perlman, 1979). It also points to the importance of engagement, which will be discussed later in the chapter.

Resource Parents

Resource parents were the next prominent support for youth in foster care. Resource parents helped foster youth in a variety of ways documented in case files and interviews. Supportive resource parents helped with daily tasks and responsibilities like getting to therapist appointments and completing homework. They also assisted youth with bigger goals like learning to drive, finding a job, and exploring career opportunities. Case files and interviews verified that resource parents often provided the structure that had been missing for these youth. They set appropriate limits by having ordered daily routines and house rules with known consequences. The structure and stability provided by resource parents was repeatedly noted as helping youth and leading to improvements in their lives. Case documents indicated that youth improved in ways such as school attendance, academic performance, employment, and peer relationships. Two case examples follow:

- A teen who had serious truancy problems prior to placement was able to attend school and make the honor roll while in her foster placement.
- A resource mother helped the youth figure out how to have a relationship with her loving, but mentally ill and sometimes unstable mother. She also helped the youth with educational planning. The youth graduated from high school and went on to attend college.
- This youth’s reasons for referral to foster care included truancy and lack of parental supervision. When entering care he had an apathetic attitude toward school and was not involved in any extracurricular activities. With structure and support provided by his

resource parents, the youth was able to improve his school attendance, academic performance, and make the football team. He became interested in nutrition and exercise, quit smoking cigarettes, and established a healthy, prosocial focus in his life. This youth went from being expelled from school for behavioral issues to being described as a “role model” for other children in his foster home.

Sometimes resource parents were role models for youth who had no other adult role models in their lives. When one teen became pregnant and did not have a female caregiver in her home, the resource mom stepped in and helped with doctor appointments. Another teen expressed an interest in the military and his resource father took him to a local base to talk firsthand to other men with military experience. These resource parents provided help that was both constructive and emotionally supportive.

Interview participants corroborated the finding that resource parents provide emotional support, nurturing, and guidance for youth. One resource parent was commended for “...sticking with this kid even when he was acting out and being difficult.” Resource parents also supported youth in becoming involved in normal teen activities like athletics and dating. Another interview participant noted the importance of resource parents who created stability, structure, and high expectations for a youth.

Though less common, resource parents were also seen as supports to birth parents, especially during transitions to reintegration. One resource parent was described as “supportive and encouraging” of the biological parent during reintegration. This resource parent lived more than an hour away from the biological parent but made regular phone calls during the initial weeks of reintegration to help support the youth and biological mother. Another example was resource parents who, even after reintegration, continued to have periodic overnight visits as well as regular after school visits to help the youth with homework. Interviews indicated that this ongoing support during the early weeks of reintegration was important in helping these youth transition back home with their biological families.

Services

In identifying strengths, the current study showed that various services were important for addressing the needs of youth and families. While this study did not test the efficacy of any specific intervention, it did provide anecdotal evidence of services contributing to improvements in the lives of youth and families. The following is a description of noteworthy services.

Individual Therapy – While not always seen as the single most important factor for improvements, individual therapy was identified as a helpful intervention in a number of situations. Many of the study’s youth had experienced significant trauma (e.g., sexual abuse, death of a family member, witnessing a murder). Individual therapy was seen as an important adjunct for supporting them. In one case a fourteen year old teen had been sexually assaulted by a paternal uncle. When her father and his extended family did not believe her, and her mother emotionally abandoned her, individual therapy was critical for her support and healing.

Family Therapy – Family therapy was a logical intervention because many cases were characterized by parent-child conflict and other family relationship issues. Research on similar adolescent populations with trauma experiences also suggests that it is important to involve family members in treatment (Mahoney, Ko & Siegfried, 2004).

Level VI Placements – Level VI placements were identified as being central to cases in which the youth’s mental health needs were very serious. These highly structured placements were seen as creating stability that was not being achieved in other placement for teens with serious emotional and behavioral problems. Frequently, when the youth was stepped down to lower level placements, disruptions occurred. It was noted in one case that the agency that provided the Level VI placement was the one placement that seemed to understand this youth’s presentation of mental illness. This facility created a structured, well-designed treatment plan that provided stability for this youth. Interviews brought to light the pressure residential

treatment facilities and case managers are under pressure to limit the number of days in Level VI placement. Unfortunately, this mandate of least restrictive placement seemed, in some severe cases, to erase the gains the youth made in treatment. It was unclear if subsequent placement disruption was the result of the brevity of treatment, lack of discharge planning, or some other reason.

Substance Abuse Services – Cases presented several examples in which inpatient or outpatient substance abuse services were essential for helping teens quit using alcohol and other drugs. Treatment was particularly critical in keeping them safe and eliminating some very risky behaviors. Here are some examples:

- Prior to treatment and foster care, this youth was in a home with an older sibling who had dropped out of high school and was using numerous drugs. This 13 year old's risky behaviors included sexual activity with multiple partners and using highly addictive drugs such as methamphetamine, cocaine, ecstasy, and LSD. When removed from his home environment and with treatment, this youth quit using drugs.
- Another youth had been involved in gang activity and several crimes prior to coming into foster care. With the sobriety she gained through treatment, this youth was able to address her gang involvement in a more rationale manner. She told her resource mom that she had a dream of becoming a youth counselor so she could help other youth stay away from drugs.

Educational Services – Educational services were observed to be important for some teens, especially those with Individual Educational Plans (IEPs). Additionally, school was noted as a “safe haven” for some teens. In one case, an alternative high school was seen as a critical support for a young person who was reintegrated with his family, but who faced continued tensions with his father. Another teen was described as showing marked improvements when he was able to attend an ESL high school. In a third example, a child exhibited many difficult acting out behaviors. The school was a key support in offering multiple services and coordinating with other providers to help this youth. Clearly, schools can play a significant role in helping foster youth since this is where they spend the majority of their time. The case review

showed that some schools are champions in finding strategies for helping youth with very difficult behaviors.

In-Home Aftercare Services – When aftercare services were actually delivered and were delivered in-home, they were seen as a key strength. These in-home services helped families with the transition to reintegration. Importantly, aftercare services sometimes provided an opportunity for either initiating or continuing family-based work. For example, placement location was often a barrier for parents and youth to participate in family therapy together. In one case, a family was provided in-home family therapy while in aftercare. In another case, the aftercare clinician provided in-home parent education. This in-home work was seen as an essential support for a single parent who struggled to create structure for his children. During the study period, the researchers noticed that frequent and intense aftercare services did not appear to be delivered on a widespread basis. In light of the chronic nature of the mental health and AOD needs present, researchers thought that aftercare or some other ongoing services would likely benefit the youth and families.

Collaboration & Coordination

Chapter 8 reviewed system collaboration and coordination, with examples of strengths and weaknesses. The previously noted examples of effective collaboration and coordination are acknowledged as important supports for youth and families.

Exceptional Effort and Best Practices

A miscellaneous category of strengths and supports emerged from the case reviews. This category includes a variety of practices that were seen as exceptional effort or the use of best practices. While these practices were not necessarily implemented on a widespread basis across the 30 cases, researchers wanted to draw attention to exemplary practice. Practitioners working with foster youth and families face considerable and complex situations that they are expected to

address in the most efficient manner possible. In this regard, this study provides anecdotal examples of extraordinary effort, resourcefulness, and innovation. The following is a list of examples of best practices and exceptional effort:

- A mental health therapist challenged a “blame the victim” stance by acknowledging an adolescent’s normal developmental issues and highlighting her strengths and abilities.
- A foster care case manager assisted with arrangements for frequent and consistent home visits that appear to have facilitated timely reunification.
- A parent support worker from a local mental health center accompanied a foster care worker on home visits even when the family did not have an open case with the mental health center. This type of proactive outreach by the mental health center was highly regarded and seen as an extremely valuable strategy for engaging parents. Thus, not only were the actions assisting an individual family, they were also building teamwork and collaboration among the helping systems.
- A foster care provider made the extra effort to provide culturally relevant services. This included a Spanish-speaking case manager and connecting the youth to an educational program for Spanish-speaking teens.
- A foster care case manager skillfully coordinated communications among numerous practitioners who were all serving a youth in a town several hours away. She regularly and consistently phoned and emailed all of the practitioners regarding this youth’s case plan tasks and seemed to help keep everyone focused on the major goals. She also included the resource parent in regular communications. This youth was reintegrated within her family after 8 months of foster care.
- A foster care provider implemented a comprehensive assessment system and made recommendations for services that are evidence-based practices (i.e., Trauma-Focused Cognitive Behavioral Therapy and Parent Management Training) (Hensler, Wilson & Sadler, 2004).
- A foster care provider used master level clinicians to provide in-home aftercare services to coach and support families during a tentative transition time.

Barriers & Service Gaps

This section describes the major barriers and service gaps that were identified in the analysis of case data and interviews. Every family faced its own unique barriers to accomplishing their tasks and goals. Thus, this section specifies the common themes among the unique barriers identified in the 30 cases under review. Barriers and service gaps describe those

things that got in the way of addressing youth and family needs, that impeded progress in their cases, and that complicated the attainment of permanency. Themes related to barriers and service gaps have been organized into two main categories: 1) shortfalls in practice and 2) service gaps.

Shortfalls in Practice

This section identifies the most prominent shortfalls in practice that were identified through case review and interviews. As described in Chapters 3 and 5, the analysis is explicitly based on an assumption that family-centered principles lead to the most effective processes and outcomes.

Addressing Underlying Needs

The data collection instrument used for this study asked for information on the underlying needs of each case. This question is consistent with federal guidelines for Comprehensive Family Assessment. A clear and major finding of this study is that there was a wide range of underlying needs which were not addressed effectively by assessment or services. For example, even when youth experienced significant trauma such as sexual or physical abuse, death of a loved one, or abandonment, it was not always clear that case plans or individual therapy addressed these overarching issues. Moreover, it was often unclear whether a comprehensive assessment had been conducted that considered the entire family system, major life domains, or the etiology of family problems. For example, a history of domestic violence in the family might be mentioned in an intake form but not mentioned again in the case file and not addressed in the case plan. The fact that a youth had recently witnessed a murder or experienced the loss of a sibling did not make its way into a case plan. These cases were marked by example after example of trauma. They were also marked by little indication that family-based or evidence-based interventions were employed to help youth and families deal with the underlying

trauma that was so central to many presenting problems, such as a youth's acting out behavior (Taylor & Siegfried, 2005).

There were numerous examples of case plans and services ignoring underlying needs. In large part, case plans were cursory and perfunctory. Researchers found that case plans were often simply restating the inverse of the presenting problem. If the presenting problem was truancy, then the case plan tasked the youth with 100% school attendance. A presenting problem of school performance led to a case plan that required 100% passing grades. Problems with running away were addressed by a case plan task stating that the youth "will not run away." If the presenting problem was verbal aggression, then the plan mandated that the youth be respectful. These cases showed so little variation in case tasks, and such a dominant pattern of restating the inverse of the problem, that once a presenting problem was known, the task was easily predicted. Thus, there were very few examples of case plans showing an understanding of the complex nature of the underlying needs of these youth and families. Furthermore, there were few examples of case plans that were individualized—that is, case plans that were creative and original in finding unique, customized strategies to *match* the particular needs and strengths of a family and youth.

Although case managers must have the knowledge and skills necessary to conduct comprehensive family assessments, there are also system responsibilities to consider (Taylor & Siegfried, 2005). Agencies are responsible for providing training and tools that facilitate the implementation of comprehensive family assessment. Researchers examined case files in search of examples of family assessment, but found few. Interviews also revealed that addressing underlying needs is not always supported by the responsible agencies and systems. One case manager's quote provides some insight:

We're told that casework needs to be focused on the reason for referral. Our goal is to get them home quickly and safely. In some ways, it's kind of appealing when the system takes that one-sided approach to things because when you look at the case in depth, you find out about all the other family problems.

The most obvious dilemma with only addressing the presenting problem is that youth reintegrate into a home with a family system where the same patterns and unmet needs persist.

Non-Compliant Families and Engagement

One of the most prominent barriers identified was getting parents and youth to complete case plan tasks and actively engage in services. For youth, noncompliance or resistance to change was expressed by canceling and missing appointments, and by adopting an uninterested attitude during therapy sessions. Youth may have attended counseling sessions, but case notes indicated that they sometimes chose to not actively participate. Some youth expressed dissatisfaction with therapy by their repeated absences or by requesting a different therapist. Other modalities or strategies may have been more effective in engaging teens than individual counseling. A case manager explained the importance of getting youth buy-in and finding strategies that work for them:

Kids in foster care: trying to get them services when they don't want it is like flushing money down the toilet. They've got their defenses in place. They're not going to see mental health or drugs as a problem...It really makes a big difference if the social worker respects the kids.

Parents' unwillingness to actively participate in services was also noted as a significant barrier in more than half of the cases reviewed. Commonly, parents neither acknowledged their role in their child's struggles nor their responsibility to support their child with his or her case plan tasks. Some parents simply refused to participate in any services. Others participated on an irregular basis. Their attendance at therapy sessions was erratic and they completed some case plan tasks while ignoring others. Some parents ignored all case plan tasks, particularly if they were not court-ordered to complete them.

There were numerous examples of missed opportunities for engaging parents and youth.

- This parent was consistent in making appointments and wanted to have more say in her son's treatment. The parent's advocacy was viewed as oppositional rather than as interested, involved, and active. She was not actively engaged or helped with getting to family activities at the AOD treatment center where her son was placed out of town.
- This parent denied that his daughter was sexually abused by his brother even though prosecution and incarceration had occurred. Despite the youth's expressed desire for affirmation and connection with her dad, case notes and interviews indicated that no one challenged this father's denial or made serious attempts to engage him in acknowledging the abuse and helping his daughter heal.
- Extended family members expressed concerns with phone calls and letters. These actions were perceived as them "ganging up on mom." No actions were taken to mediate conflict among extended family members or to seek ways to redirect their concerns into positive help for this struggling parent and youth.

Clearly, parents are on the defensive when their child is placed in foster care. Often, practitioners must make extraordinary efforts to build a partnership with families and to get them engaged in services. A commitment to family-centered practice demands strong skills and strategies for engaging even the most resistant parents and youth.

Family-Centered Practice

This research is guided by principles of family-centered practice. For instance, researchers sought examples of comprehensive assessment that included all family members, examples of family-based services, examples of strengths-oriented practice, and examples of the use of community-based, informal supports. The data collection instrument included specific questions on family-centered practice. For example, "How adequate were assessments in covering all relevant areas/family members and in identifying needs?" and "What service barriers were encountered by the youth or family?" It also included separate sections on AOD and mental health services to parents.

The "underlying needs" theme described above pointed to practice weaknesses in terms of assessing the entire family system. While a comprehensive, family-focused assessment would

have been useful in providing a road map in many cases, it was clearly not the practice norm. This lack of acknowledgement of family systems played out in other ways, too. In one of the most common examples, case plans identified a minimal number of tasks for parents to complete, while the number of tasks for youth numbered in the double-digits. A “fix the kid” mentality seemed to dominate, and parent needs and issues were overlooked or disregarded. Youth-focused case plans were the typical approach even when parent mental health and/or AOD needs were obvious and substantial. As mentioned in Chapter 4, parental substance abuse, even when it was a driving factor of the case, was essentially ignored. In another case example, the reviewer noted:

The therapist seems to recognize that issues with step mom are part of the problem, yet all her work is focused on helping G to cope with step mom rather than getting to the root of what is wrong with step mom and how that contributes to the family dynamics.

The exclusion of family members and informal supports in assessments and services was another way that practice lacked a family-centered focus. Stepparents, siblings, and other family members usually were not included in assessments or services. Even when case notes pointed to siblings causing problems, or worse yet, sabotaging the foster youth’s goals, the case plans did not acknowledge or include siblings. Nor were there references in assessments or services to other informal supports in these youths’ lives, such as friends, coaches, neighbors, or church members. Indeed, cases revealed few examples of informal supports used to assist youth with their goals. Although genograms and ecomaps are standard family-centered tools, case files contained only one or two references to their use. Such tools would be valuable for streamlined information-sharing between systems and for case managers new to a case.

Sometimes case plans identified relevant parent tasks, but it was customary for these tasks to be ignored. For example, parent tasks included submitting to urine analysis or attending anger management or parenting education classes. When parents did not follow through with

their tasks, they were seldom consequenced for their noncompliance. As an example, a father was to attend anger management classes as one of his tasks. The family history indicated that anger issues were present for the father, the teen in foster care, and siblings who were either incarcerated or had been placed in foster care in another state. In short, anger and physical aggression were noted as significant issues for this family. Still, the father did not attend anger management classes and the youth was placed back in his care while this task remained incomplete.

In another case, case managers tried to get the father and stepmother to participate in services. The case manager and county attorney contested the father's claim that a medical condition prevented him from participating in family-based services, using a letter from a physician. Still, the judge did not task the father and the result was no family-based services. In these ways, the system inadvertently confirms that parents do not have to recognize their role in a troubled family system.

Gaps in Services

Three major service gaps were identified that are relevant for serving youth in foster care and their families. They are described below.

Continuum of Care

A major finding was an inadequate continuum of care. An adequate continuum of care is characterized by access to a sufficient array of services and by sufficient frequency and intensity of services. This case review indicated that the entire continuum may need replenishing.

Weaknesses were identified in the areas of placement prevention, services offered at the time of reintegration, and aftercare. Following are suggestions that emerged from these data regarding gaps in the continuum of care for youth in foster care.

- In many cases it seemed that additional efforts could have been made to prevent placement. An important consideration would be to include interventions and strategies for addressing parent-child conflict, which was very common among these NAN cases. As was mentioned in last year's study, parent-child mediation services, coupled with brief voluntary respite services, would likely assist families in resolving conflicts that result in out of home placements (Moore, et al., 2006).
- Researchers also noted that a crisis response from mental health was not the practice norm. Youth placement disruptions and other crisis situations (such as suicide threats) would be better managed in collaboration with mental health providers. Procedures for this type of interagency collaboration must be put in place with the appropriate administrative structures (e.g., memoranda of understanding, partnership agreements). In other words, the groundwork must be laid to improve timely, responsive cross-system teamwork.
- During the study period, one third of the youth in the sample experienced more than one placement episode. Researchers questioned whether the intensity of aftercare services was adequate for meeting the needs of these families. Plainly, intensive aftercare services and other services that go beyond aftercare are needed for these youth and families. The mental health and AOD issues faced by these individuals will require ongoing, intermittent support. Additional placements may be prevented by providing families with timely, responsive, and comprehensive services.

Local and Youth-Specific Resources

The availability of local and youth-specific resources was a major service barrier in more than one third of the cases reviewed. Youth-specific services and resources were seen as one of the most prominent gaps in services. This included the need for youth mental health and substance abuse services. Some interview respondents elaborated on needing more high-quality and intensive mental health and substance abuse treatment services geared at youth. Researchers also found few mental health and substance abuse group therapies that were specifically designed and targeted for youth.

Additionally, services and strategies focused on pro-social activities and the use of informal supports were uncommon. In several cases, researchers thought that foster care youth would have benefited from a mentor, role model, or from a connection with one caring adult. Research has demonstrated that when teens have one caring adult who is committed to them,

they fare better academically and emotionally; when a teen is at risk, a caring adult can turn him or her around (Youngblade, Theokas, Schulenberg, Curry, Huang & Novak, 2007). However, case plans did not typically include any recognition of informal supports. Sadly, many of these youth aged out of care without meaningful connections to adults.

Pregnancy emerged from these data as significant and unexpected finding. One third of this study's teen girls became pregnant during their involvement with the child welfare system. The study did not reveal findings on pregnancy rates relevant to the teen boys in the study. Case documents sometimes indicated that the boys were sexually active; however, researchers suspect under reporting of this behavior. Researchers considered the rate of teen pregnancy and the high level of sexual activity among these teens an issue deserving additional attention. Notably, researchers observed that some foster care agencies' routine intake procedures included a consideration of youths' sexual activity and whether medical care was required. For example, youth who reported multiple sexual partners were sent for medical evaluation and screened for sexually transmitted diseases. However, the high rate of teen pregnancy among the study's girls suggests the necessity for foster care agencies to consistently evaluate these needs.

National studies have confirmed that teenage pregnancy and teenage childbearing rates among foster youth are higher than their peers not in foster care. By age 19, nearly half of teen girls in foster care become pregnant, compared to a fifth of their peers not in foster care. Research has also found that teenage pregnancy risk is strongly linked to sexual abuse, especially for males and those who have experienced both incest and nonfamilial abuse. Even more urgent are national data on youth who leave the foster care system. At age 19, foster youth who leave the system are at higher risk for teen pregnancy and birth than their peers who remain in the system *and* youth who have never been in foster care (Bilaver & Courtney, 2006; Saewyc,

Magee, & Pettingell, 2004). These data raise an issue that is relevant to all of the systems serving youth in foster care: Services to youth must address pregnancy prevention and STD screening as a fundamental need for youth in foster care, both girls *and* boys.

Same Language & Culturally Relevant Services

Same-language and culturally relevant services were barriers for several cases to which they pertain. Spanish-speaking families faced gaps in Spanish-speaking services. Only one of three Spanish-speaking families was served by Spanish-speaking professionals or interpreters while their youth was in foster care. The other two families had to rely on relatives to translate for them while their teen was in foster care. One of these families did receive aftercare services from a Spanish-speaking clinician. Importantly, the case of the Spanish-speaking family who was served with Spanish language services also demonstrated a more strengths-based and comprehensive assessment that celebrated the family's journey from Mexico to Kansas as a family strength.

During interviews some providers noted that they are experiencing an increase in Latino youth coming into foster care. Providers also acknowledged the need to have interpreters, same-language services, and other culturally relevant services and strategies. Same-language services are needed in all the systems that serve youth in foster care: mental health, substance abuse, and child welfare agencies.

Culturally relevant services were seen as inadequate for youth of color and sexual minority youth. Race, ethnicity, and sexual orientation issues seemed to be largely unaddressed by assessments and services. Several examples of gaps in culturally competent services follow.

- One example was a bi-racial teen who experienced conflicts with peers and extended family members. Although it seemed pertinent to researchers, this youth's bi-racial identity was never discussed in case documentation or addressed through any specific strategies.

- Placement stability for sexual minority youth was a major issue for two of the 30 cases reviewed. Mental health services did appear to be well prepared to serve these youth either. One parent reported discomfort that the psychiatrist conducting the youth's medication evaluations directly asked the youth if he/she is gay? It was unclear from the case documentation what foundation there might have been for such a question. Another youth's resource parent insisted on a change in therapist because, despite an extensive history of trauma and loss, the youths' therapist insisted that he/she needed to 'fix' the youth's sexual identity 'problems' before any other issues could be addressed in therapy.
- An apparently precipitous termination of parental rights occurred for an African American youth whose family had moved to Kansas from another state seeking support for the youth's behaviors from an extended family member living in Kansas. The court denied the parents' request to return to their home state; when the parents returned to the home state and Kansas workers were not able to reach them, the judge terminated their parental rights.
- Two African American youth with parents from out of state experienced the longest stays in high level placements.
- Although small in number, there were youth with identified Native American heritage. While case managers made note of the Native American heritage of the youths, ICWA reporting requirements were not followed. One worker reported in the interview that the youth was not registered with the tribe so ICWA did not apply. This is inaccurate. Many tribes have considerable resources to support families with child welfare involvement; a resource that could likely be accessed more frequently for Native American foster youth in Kansas.

This lack of evidence that racial and cultural issues were addressed for youth of color and sexual minority youth is disconcerting. Recent reports have noted widespread findings that when compared to white children and families in the child welfare system, children of color and their families have less access to services and suffer poorer outcomes. More deliberate attention must be given to innovative strategies and promising practices that will reduce these disparities (Hill, 2006).

Key Findings – Supports & Barriers

Major Supports

- Helping professionals who built trusting, caring, and respectful relationships
- Resource parents who provided structure and various supports that lead to other improvements for youth in their care
- Various services, including individual and family therapy, Level VI placements, substance abuse services, educational services, and aftercare services
- Exceptional efforts and best practices that demonstrated high commitment, effort, and innovation

Barriers and Service Gaps

- Shortfalls in practice demonstrated the need for:
 - More comprehensive family assessments and services that address underlying needs
 - Practice strategies for engaging noncompliant and resistant parents and youth
 - More family-centered practice, including engagement of all family members and informal supports in assessment and services
- Gaps in services pointed to the need for:
 - A more complete continuum of care, including placement prevention interventions, easily accessible parent-child mediation services, crisis response from mental health, and aftercare services
 - More high quality, youth-specific services at the local level
 - More same-language and culturally relevant services that address the needs of Spanish-speaking families, youth of color, and sexual minority youth

Chapter 8. Major Findings and Recommendations

This chapter summarizes major findings and makes recommendations as a starting point for the development of improvement strategies. This study was an in-depth review of 30 CINC NAN cases drawn from a larger random sample (n=255) of cases analyzed in an FY 2006 study of the CINC NAN population. More specifically, cases for this year's review were selected because researchers speculated that these cases represented a population of youth and families for whom timely mental health, substance abuse, and other service strategies might prove maximally useful and preventive of out-of-home placement. Findings cut across cases and service categories. Policy and practice implications of these findings are also discussed.

Seven Major Findings

Finding #1: Cases were marked by multiple and complex needs, and commonly included youth with histories of abuse and neglect or other trauma.

As mentioned in Chapters 1 and 2, last year's study showed that the group from which the 30 cases were selected had fewer documented instances of prior abuse and neglect, fewer previous placement episodes, and fewer parent problems indicated in SRS case files. However, after conducting a more in-depth review of these cases over a longer period of time, a different picture emerged. Rather than finding a group of youth with 'overwhelmed' parents and less severe problems than their cohorts, researchers instead discovered a group of youth with multiple and complex needs—including parents with significant mental health and substance abuse histories.

The prevalence of both child maltreatment histories and major parenting problems were much higher for this sample than indicated by the cluster analysis performed on last year's SRS intake case files. At least one half of the youth in the study sample had a history of sexual abuse.

Around one third of the youth had physical abuse histories. Often this history was not known to the agency at intake but revealed at some point during the course of the case. In several cases, the abuse and neglect allegations and substantiations occurred in another state. For nearly two thirds of the youth in this sample, the case file included indications of some type of previous trauma. In addition to sexual and physical abuse, grief, loss, and abandonment were common features of these cases.

Additionally, the prevalence and severity of mental health issues were substantial. Of the 30 youth, 19 were determined to have a serious emotional disturbance (SED). These youth also had significant diagnoses. Conduct and other behavior disorders were the most common diagnoses among the youth in the sample. One youth received a psychotic disorder diagnosis. Nine of 30 youth were placed in Level V or VI placements at some point in the life of their case, and many were taking psychotropic medications to manage mood, attention, and behavior diagnoses. More than half the sample (18) youth received assessments for indicated alcohol or drug (AOD) use, while 12 youth received AOD treatment. Case records for nearly all youth included indications of school problems, including behavior problems, academic performance, and truancy. Moreover, these youth substance abuse needs were viewed as complex in terms of severity and co-occurrence with other issues.

Parents of youth in the sample presented with similarly high acuity. At least seven parents were considered to have a serious and persistent mental illness (SPMI). Parental alcohol and drug problems were clearly indicated in many cases. Underlying needs such as significant health conditions, domestic violence, and incarceration also impacted parental capacity and family well-being.

Taken together, this finding suggests that the classification of NAN cases as non abuse and neglect seems to reflect the *precipitating event* that led the case into the child welfare system, not the *level of need* among these youth and families. This study showed that some CINC-NAN youth and family needs would not be accurately defined as *non-abuse* and neglect. As discussed, cases were marked by historical and contemporary abuse and neglect. Some of the abuse/neglect was not reported or confirmed, while some occurred in other states. Interviews conducted with caseworkers in the FY 2006 study revealed that workers sometimes classified cases as CINC NAN because they were unable to substantiate abuse and neglect, despite concerns about a youth's safety and well-being.

The way an agency defines child welfare becomes the fundamental basis for addressing the causes of and interventions for child maltreatment (Morton & Holder, 2000). This study highlights the need to revisit the NAN classification and revise the NAN intake protocol. Currently, it fails to adequately capture the multiple, complex, and significant mental health and substance abuse needs of this population. Using a "NAN" classification may sidetrack the system from fully appreciating the extent of need within this population. Classification based on level of need would attune the system to more appropriate intervention strategies, including more attention to abuse/neglect/trauma histories and parental capacity.

Finding # 2: Across systems, cases overwhelmingly focused on individual youth without sufficient attention to parents and the family system.

Researchers found a systematic lack of family inclusion across cases. On the child welfare side, biological and other family members, particularly stepparents and custodial grandparents were left out of assessments. Few examples of truly comprehensive family assessments were found in case files, and case plan tasks were overwhelmingly focused on the youth alone. Though parents presented with a number of mental health and AOD needs, they

were far less likely than the youth to receive any kind of treatment. On the mental health side, little family therapy took place, and parents did not often participate in the child's mental health treatment. Parents' own mental health needs were not attended to once the child was in care; rather, parents with serious and persistent mental illness (SPMI) were more likely to have received services prior to the removal of their child from the home. None of the parents in the sample received mental health services explicitly due to reunification efforts. On the AOD side, youth were sent for inpatient and outpatient treatment, but parents participated little in this treatment. Parents own avowed AOD problems were essentially overlooked by courts and providers. Only five parents of youth in the sample received any kind of AOD assessment. Furthermore, only one parent in the entire sample was compelled to complete AOD treatment.

Given child welfare's mandate to demonstrate reasonable efforts to reunify the family, the pervasive absence of parent and family inclusion in assessment and service provision is of great concern. Limited funding for parent-specific treatment is a recognized service barrier. However, numerous policy statements underscore the necessity of family-centered assessment and services.

The major child welfare contracts implemented in July 2005 sought to bolster a more family-centered approach. This sample looked at children entering care just before these new contracts were implemented. Researchers saw limited evidence of these philosophical and practice changes in those cases that continued to be in foster care during the new contract period. Researchers acknowledge that changes of the magnitude intended in these contracts will take time.

The pervasive lack of family participation in service provision for youth and the dearth of treatment for the parents themselves reveal a need to explore new strategies for facilitating

family involvement in the child welfare intervention. Family meetings and family group decision making are promising strategies to encourage families' resourcefulness. To better engage parents as partners in the care of their children and youth, the child welfare system must understand the barriers and supports to their involvement. A proposed FY 2008 study of parent MH and AOD treatment will examine from worker and parent perspectives these barriers and supports and identify successful strategies for serving parents.

Given that the engagement and building of worker-client rapport are centrally important in gathering information from families regarding their needs and strengths, organizational and administrative supports are necessary for implementing family assessment techniques. These include allocating staff time for assessment, formal training, clinical supervision, and mentoring in areas such as completing comprehensive assessments in a culturally sensitive manner, engaging families in a change process, and reaching the appropriate conclusions about the meaning of the information gathered.

Given the emphasis on family involvement in the new contracts, it might be useful to consider additional research and enhanced quality assurance activities that measure the extent to which family involvement occurs across all components of the child welfare intervention, including assessment, case planning and service delivery. Measures must be carefully selected to go beyond simply tracking whether a family receives an invitation to the case plan meeting. They must capture, in a meaningful way, the extent to which a family is given the opportunity to participate as well as guide the case toward resolution. These administrative actions would help to keep this issue in the forefront.

Finding #3: The majority of youth received mental health and substance abuse assessments and services as needed. For the most part, services stabilized youth and promoted well-being, but some service gaps exist.

The majority of youth received timely mental health and AOD assessments and service provision. For mental health services, service initiation was considered good to adequate in about half the cases reviewed. In about a quarter of the remaining cases, slow initiation was attributable to non-mental health provider variables. And in the final remaining quarter of cases, timely service initiation appeared problematic. Specific barriers to timely initiation of services could not be ascertained from case file documents.

Treatment adequacy ranged from excellent to fair. The norm among cases was brief (e.g. 6-8 sessions) sporadic treatment. Successful treatment was distinguished by effective engagement of family members, specialized services, and case-specific treatment goals. There was no evidence that mental health professionals were involved in efforts to maintain placements either through crisis intervention or engaging the support of resource parents in supporting treatment goals.

More than half the cases reviewed were referred for AOD assessment. Overall, AOD referrals were timely, with a handful of exceptions. Researchers could not address timeliness of assessments due to lack of information in case files. Of those youth who were assessed, ten received outpatient treatment, two received inpatient treatment, and six were referred for education only or did not have treatment needs. Treatment services, including any change of levels, occurred in a timely way. Adequacy of treatment was difficult to judge due to a lack of detailed information in the case file; however a number of cases showed that substance abuse services were essential for helping youth quit using alcohol and other drugs.

For mental health, service gaps included: lack of family therapy, lack of attention to sexual abuse and trauma, and lack of specialized services other than individual therapy for youth. For youth in need of intensive mental health treatment (inpatient psychiatric or Level VI placement), services sometimes needed to be initiated more quickly. For youth who required highly structured environments, more effective step-down or transition placements to family care are needed. Systemic issues included: lack of compliance (e.g. failing to attend therapy or not taking meds) among youth and parents, insufficient attendance to develop therapeutic alliance, and vague treatment goals.

In regard to treatment for alcohol and other drugs, need remains for local and youth-specific resources to facilitate youth success and parental involvement. Case reviews uncovered the imperative to continually assess and monitor AOD issues. Case reviews also suggested the need for case managers to develop more finely tuned skills in recognizing AOD treatment needs. Attention to AOD treatment discharge planning for youth in custody should be specialized and designed to address the problems youth in custody often encounter, such as returning to a home where AOD abuse is present.

These gaps point to critical areas for the development of new services or new strategies for meeting these unaddressed needs. Across services, including child welfare providers, research uncovered a need for same-language and culturally relevant services that address the needs of Spanish-speaking families, youth of color, and sexual minority youth.

Finding #4: Lack of attention to youth and family underlying needs impeded effective assessment, service planning, and provision.

A major finding of this study is that there was a wide range of underlying needs which were not addressed effectively by assessment or services. It was often unclear whether the entire family system, major life domains, or the etiology of family problems were considered in the

assessment process. Historical trauma was pervasive in this population, yet there was little indication that it was addressed in case planning and service provision. Youth and family strengths, culture, economic status, and existing community-based informal support networks were areas frequently neglected. There were few examples of case plans that showed an understanding of the complex nature of the underlying needs of these youth and families. Case plans appear to commonly be built around available services rather than finding unique, customized strategies to match the needs and strengths of families and youth.

Adherence to the Children's Bureau's comprehensive family assessment model would mitigate many of the problems noted in the case reviews. Comprehensive family assessment strategies necessitate a more culturally competent, family-centered evaluation of a family that focuses broadly on underlying needs rather than narrowly on presenting problems. Moreover, comprehensive family assessment provides ongoing rather than one-time evaluation to guide case planning efforts. Comprehensive family assessment would also encourage the development of more family-centered tasks and services in permanency planning. Case managers should assess and facilitate a family's readiness to change before making a referral. Research suggests that renewed focus on the development of measurable, achievable goals might improve the utility of permanency plans. Guidelines for comprehensive family assessment, as described by the Children's Bureau, are available online at

http://www.acf.dhhs.gov/programs/cb/pubs/family_assessment/index.htm.

Finding #5: Interagency collaboration facilitated service delivery, but this issue needs greater development and widespread implementation.

The case review documented some exemplary cross-system collaborations. Three successful models of collaboration emerged: multidisciplinary teams, wraparound, and family

meetings. However, while these models worked very well, the case review also documented four persistent cross-system issues. First, mental health intake requirements are regarded by foster care providers as inordinately time-consuming. Researchers saw some delays in service initiation and the need to repeat the process in cases where a change in placement necessitated a change in therapist. Second, information sharing between systems typically occurs through periodic phone calls or e-mail. Regular, well-documented exchange of information is lacking, particularly with AOD providers. Case plan meetings are too poorly attended by other professionals to serve as an effective mechanism for ongoing interagency collaboration. Third, the court role varied widely by jurisdiction. Generally, court orders facilitated compliance with services by youth and their parents, but these orders were inconsistent across jurisdictions. Finally, a majority of cases involved educational issues, but schools were an overlooked potential resource for youth in care.

The infrastructure for interagency communication and information sharing needs to be enhanced so that service providers and child welfare workers are in a position to communicate more effectively. Memorandums of understanding and simplified release processes might be considered in order to facilitate information sharing. Regular cross-systems meetings between front-line professionals and administrators would provide an opportunity for building working relationships within local areas. Other strategies for enhancing collaboration which have been successfully implemented in some locations include joint training, co-location of staff, and designated points of contact. In some jurisdictions, partnering more effectively with the courts might take advantage of the judiciary's ability to hold parents accountable for the care of their children. Enhanced connections between professionals, resource parents, biological parents, and school personnel could create a strong, consistent, daily parental presence in the lives of youth in care.

Finding # 6: Cases were marked by missed opportunities for prevention, crisis, and ongoing support.

Researchers were struck by the presence of several “missed opportunities” across the lives of many of these cases. In many ways, this finding reflects how child welfare service providers perceive their role and responsibilities in child welfare intervention. Child welfare agencies can narrowly define their responsibilities as identifying problems, referring to services, and monitoring family participation in order to fulfill their obligations to the court. Conversely, agencies can choose to assume a more encompassing role, characterized by *shared responsibility* for facilitating change and family well-being. In this approach, case managers not only refer to and monitor services but take a proactive approach in broadly supporting youth/families.

Examples of missed opportunities include: few documented efforts to maintain placements; limited use of intensive aftercare services; inadequate attention to the particular developmental needs of youth, age-appropriate including life skills and connections with supportive adults; and the need for ongoing support.

Researchers noted little evidence of attempts to maintain placements on the verge of disruption. There appeared to be limited use of respite care or of mental health centers in the event of foster care crises. Aftercare was another service that did not appear to be delivered on a widespread basis, although it was clearly essential to maintaining family reunification in some cases. In a few cases, the child welfare intervention ended abruptly upon court dismissal. These cases might have benefited from ending in a more planned manner.

In terms of development needs of youth, some cases reflected appropriate adult life preparation while in others there was an abysmal lack of adequate preparation. Too often, workers appeared to ignore the adults in the youth’s life who were not current placement resources, including the other biological parent, older siblings, and others. Instead of

disregarding these individuals, more efforts to work with youth to re-negotiate their relationship with their biological families could be beneficial—whether or not reunification is the planned permanency goal. Most youth return to their families of origin —either through reunification or through re-connection after aging out of care. Facilitating these connections for youth through rebuilding family relationships sends a powerful message to the youth and family.

In several cases, researchers noted that the resource parent played an important role in supporting the youth and less frequently, the biological family. There was not much indication in the case files that resource parents get the preparation and support needed to assume this role, particularly with youth who exhibit challenging behaviors. In one case, resource parents continued after reunification to have a youth visit their home. Finding a way to support resource parents to continue to serve in a supportive role would provide youth with an important resource as they transition to reunification or aging out of care.

In addition to opportunities for prevention and crisis intervention, many of these cases involved family circumstances, such as parental mental illness, that cannot be treated and cured, but only successfully managed. This reality may call for a different model of care than the system currently in place.

In some cases, youth or parents declined offers of services. It was often difficult to tell through the case records if youth who were designated SED were utilizing the full array of services available to them. Future research might examine the mental health case files in addition to child welfare case files to see what additional information might be gleaned.

Finding # 7: Collectively, poor outcomes were achieved with these youth.

While 16 of the 30 youth had achieved reunification at the end of the study period, only eight achieved timely reunification with no re-entry (i.e., reunification within 12 months of entering care). More than one third of the youth were in care for 12 months, some in excess of 3

years. Eleven of the thirty youth aged out of care. In all, about a third of the youth re-entered foster care at some time during the study period. Many of the foster youth in this sample aged out of care. This was consistent with the finding that children were often sent back home without achieving the case plan goals or evidence of readiness for reunification. Of those aging out of care or reunifying shortly before their 18th birthdays, they appeared to be poorly prepared for transition to adulthood as evidenced by: a lack of firmly established family or other adult connections, lack of high school education, lack of employment experience, and no savings. Finally, another concern that emerged was that one third of the teen girls became pregnant while in foster care.

Policy Implications/Recommendations

The researchers conducting this study formulated ideas about strategies to address some of the service gaps and shortfalls noted in the findings. The action steps offered below are provided from an outside perspective. Admittedly, they were formulated while reviewing cases that preceded the current realities of service provision. Researchers acknowledge that some suggestions may have already been addressed through new child welfare contracts. Likewise, major changes currently underway in the delivery of mental health services may provide additional opportunities to address needs in ways not previously conceived.

It is the hope of the researchers that the following recommendations represent a starting point for discussion. Researchers also made an attempt to suggest multi-pronged improvement strategies. These may include changes in policies or procedures, staff development, resource development, quality assurance enhancements, interagency collaboration, or any combination of these system changes. Clearly, the people best positioned to develop improvement strategies are

those doing the work. We look forward to partnering with key stakeholders to adapt these recommendations into realistic and workable solutions.

NAN Assessment at Intake

- **Revise NAN assessment protocol at the point of intake to more adequately address past abuse and neglect or other trauma.** Research conducted over the last two years on the NAN population in Kansas has found more similarities than differences between the dynamics of abuse/neglect and NAN cases. These studies have concluded that NAN cases consistently present with significant levels of historical trauma or past maltreatment, whether or not maltreatment or trauma was reported, investigated, or known to officials in this state. This is true for both parents and children; a good number of NAN cases involve intergenerational transmission of physical, emotional, and sexual abuse. Moreover, many cases are characterized by lack of education, poverty or unemployment, and domestic violence. Accordingly, NAN cases in both years of study have been characterized by significant levels of unmet needs for mental health and substance abuse treatment among both youth and parents.

Findings from the two studies cast doubt on the need for a separate NAN classification. The sole use of classifying cases as NAN at intake is to determine whether a finding of abuse or neglect is warranted. That is, cases could be assigned as either requiring a finding or not requiring a finding, depending on the presenting problem. Obviously, while a report could be classified as not requiring a finding, it would still be important to reassign a case and make a finding if more recent abuse or neglect were uncovered in the course of the assessment. Little is accomplished by making findings on historical maltreatment, aside from elevating awareness for treatment needs subsequent to trauma.

The NAN research conducted last year also found that the current NAN assessment is too narrow in scope for the wide range of cases classified as NAN. The in-depth case reviews conducted this year revealed that more attention needs to be paid to the aftereffects of *historical* trauma and to the multiple, complex, and significant mental health and substance abuse needs of these children and their caregivers—not just to ongoing maltreatment. It is therefore suggested that the assessment tools and protocols to determine the level of service needs not differ from the assessment undertaken for abuse/neglect cases. It is further suggested that training field staff is critical to making such changes.

Comprehensive Family Assessment and Engagement Strategies

- **Conduct comprehensive family assessments.** Perhaps the most important finding of this study was the lack of routine comprehensive family assessments. Without conducting comprehensive family assessments, underlying needs go unmet and possible resources go overlooked, with potentially traumatic and expensive consequences. Use of comprehensive family assessment would also promote a family-focus, individualization of case planning and service provision, cultural competence, use of family strengths, and use of families' informal supports and natural resources. Additionally, use of family assessment at multiple points in the life of each case would be beneficial, especially for determining reunification readiness.

Findings of this case review reveal that compliance-based tasks such as timely case planning were accomplished with remarkable consistency. The institutional expectation that case plans be completed in a certain manner is clearly responsible for this consistency. Comprehensive family assessments should be conducted and monitored with the same institutional commitment. As the new child welfare contracts specify greater family involvement, implementation of the Children's Bureau National Resource Center's Comprehensive Family Assessment model is timely and could improve permanency

outcomes for the State of Kansas. Guidelines may be accessed online at:

http://www.acf.dhhs.gov/programs/cb/pubs/family_assessment/index.htm

Additionally, a recent analysis of seven different family assessment tools was conducted by the Center for Social Services Research (Johnson, et al., 2006). This review is available at http://cssr.berkeley.edu/bassc/public/BASSC_FamilyAssessment_FULL_REPORT091406.pdf.

- **Improve parent and youth engagement in the case management process.** Engaging fearful or hostile parents and youth requires considerable effort. Implementing the Comprehensive Family Assessment model mentioned above could aid case managers in this difficult process and could improve permanency outcomes measurably. By involving children, youth, and families in the development of the service plan, case managers increase the family's understanding of expectations and raise family members' level of commitment to make the necessary changes. Case managers will require specialized training and ongoing supervision to maximally engage parents and youth.
- **Provide culturally relevant, competent services.** Our small sample was reflective of a national problem in out of home care: the overrepresentation of youth of color, particularly African American and Native American youth. While some cases in our sample appeared to receive culturally relevant, linguistically matched services, other case files contained little evidence that race/ethnicity and cultural needs were considered. In three cases in which there were more than five placement moves, youth were African American or Hispanic. Additionally, all sexual minority youth in the sample (e.g. transgender, bisexual, or gay or lesbian) experienced either multiple placement moves or precipitous reunifications without evidence of readiness for reunification. Case reviews reveal that greater attention needs to be

paid to: the geographic isolation of youth of color placed in predominantly white communities; homophobia or lack of education regarding transgender identity vs. sexual orientation; homophobia or lack of education regarding the difference between traumatic sexual re-enactments vs. sexual orientation vs. sexual minority identity development. Many resources exist online to help with training needs in these areas.

Mental Health and AOD Service Enhancements

- **Provide family therapy.** Cases in which family therapy was provided (and attended with consistency) had better outcomes. However, little family therapy was actually delivered to families in this review. Issues precipitating removal from the home are clearly family-based, despite the presence of an SED diagnosis for the youth. If anything, an SED diagnosis should raise rather than lower clinical suspicion of family issues. While Medicaid requires an identified client for service receipt, this should not preclude family therapy from being included in case plan tasks, ordered by courts, or delivered by child welfare agencies or community mental health centers.

Furthermore, a recent Kansas-based study of the costs of treating conduct disordered Medicaid youth with or without family therapy (Crane, Hillin, & Jakubowski, 2005) found that there was no increase in healthcare costs when family therapy was included in the treatment of a sample of youth with conduct disorder diagnoses. Many CINC NAN youth in this study presented with serious mental health diagnoses, the most prevalent of which was conduct disorder. Family therapy was clearly the most appropriate modality in many cases reviewed. It should be routinely delivered.

- **Improve service response for youth with trauma histories, particularly sexual abuse.** Case reviews and interviews with child welfare and mental health administrators revealed an inadequate service response to historical trauma. While clinically-oriented child welfare

agencies have implemented specialized service response for youth with histories of trauma, in interviews, administrators from these agencies noted a dearth of qualified mental health professionals statewide who can provide evidence-based interventions for trauma, particularly sexual abuse. Trauma is pervasive among youth (and parents of youth) in foster care. Capacity development in this area is crucial if the behavioral sequelae of trauma are to be effectively extinguished and if the intergenerational transmission of trauma is to be interrupted.

- **Provide specialized mental health and AOD services for youth.** Case reviews indicated a need for more developmentally specialized mental health and alcohol and drug services. This was particularly true for youth with AOD needs. In some areas of the state, youth-specific programs were not available and teens had to attend programs designed for adults. Given the vulnerabilities of youth in foster care, attendance at adult AOD treatment or meetings is clearly undesirable and inappropriate. On the mental health side, youth who attended a youth-specific mental health intervention through Pawnee Mental Health Center, Survivor University, appeared to have better attendance than most youth in individual therapy. Moreover, youth reported to case managers that they liked this mental health intervention. Group therapy appears to be a developmentally appropriate but underutilized modality for youth in care.
- **Provide mental health and AOD services to parents of youth in foster care.** While funding constraints often prevent delivery of MH and AOD services to parents of youth in foster care (unless they qualify for the medical card through another mechanism), this still remains a profound unmet need. Parental mental illness or substance addiction is a consistent, remediable barrier to reunification if parents can be engaged and provided

services. This issue will be explored further in an FY2008 study of services to parents of youth in care. The study will pay particular attention to service factors which promoted successful reunification.

Foster Care/Placement Enhancements

- **Monitor cases which have more than three placement moves within a specified period of time.** A number of cases were marked by more than ten placement moves. Often, moves were the result of severe behavioral or emotional disturbances. Some youth appeared to need earlier Level VI screening or placement in a more restrictive setting from initiation of out of home placement.
- **Extended stays in Level VI or similar settings may be necessary for some youth.** Some youth exhibited such extreme behavioral disturbances (e.g. urinating or defecating on people, attacking staff members in secure care settings, sexual aggression toward peers) that they may require longer stays than are now routinely allowed in inpatient psychiatric or psychiatric residential settings. As evidenced by placement disruptions subsequent to their release from these settings, youth may also require more effective step-down or transitional placements from Level VI (now PRTF) to family care.
- **Provide more training and mental health support for resource parents.** In several cases, resource parents were the crucial factor in a youth's improved school attendance, academic performance, employment, and life preparation. In a few cases, resource parents were also supportive of biological or birth parents. Despite their centrally important role, and with a few important exceptions, there was not much indication in case files that resource parents received the preparation and support needed to assume this role, particularly with youth who exhibited challenging behaviors. Training and ongoing support from clinically trained professionals might have mitigated some placement disruptions among youth in the sample.

- **Improve adult preparation of foster youth by maintaining family connections.** At least 11 youth in the sample aged out of care. While some cases reflected appropriate adult life preparation, others were profoundly lacking in adequate preparation. Too often, adults in the youth’s life who were not current placement resources were ignored in the case planning process. These included the other biological parent, older siblings, and others. Instead of disregarding these individuals, more efforts to work with youth to re-negotiate their relationship with their biological families could be beneficial—whether or not reunification is the planned permanency goal. Most youth return to their families of origin, either through reunification or through re-connection after aging out of care. Facilitating these connections for youth prior to the end of custody sends a powerful message to the youth and family.
- **Use mental health services or respite to maintain placements.** Researchers noted little evidence of attempts to maintain placements on the verge of disruption. There appeared to be limited use of respite care or of mental health centers in the event of foster care crises. It is unclear why mental health services are not sought out by case managers, and researchers concluded from interviews that case managers experienced considerable frustration scheduling therapy appointments for youth. In most parts of the state, child welfare and mental health have negotiated an intake process which satisfies the requirements of the CMHCs, even though these requirements are seen as cumbersome by child welfare case managers. Perhaps continued collaboration between the two systems could increase child welfare’s willingness to consider mental health a resource in “routine” (non psychiatric) crises, and could increase mental health’s capacity to respond to such crises. This collaboration could play an important role in preventing placement disruptions.

- **Provide aftercare.** Aftercare did not appear to be delivered on a consistent basis, although it was clearly essential to maintaining family reunification in some cases. Because aftercare is voluntary, it clearly requires considerable effort on the part of child welfare workers to engage parents and youth and demonstrate the desirability of their continued involvement with the agency. Also, in a few cases, the child welfare intervention ended abruptly upon court dismissal. These cases might have benefited from ending in a more planned manner.

Cross-Systems Collaboration

- **Develop placement prevention alternatives for cases characterized by parent or child refusal to return home.** While the majority of the cases in this study presented with very serious concerns, researchers estimated that state custody and foster care placement could have been prevented in six to nine of the cases reviewed. These were cases in which the youth or parent initially refused the youth's return home. In these cases, after the heat of the crisis subsided, parents often tried undo the decision made (e.g. by hiring an attorney or requesting that the child be returned home). Once the child was removed from the home, an irreversible process began—sometimes despite the wishes of the youth, the parent, or the case managers.

Some factors which precipitated removal could have been addressed through services such as voluntary short-term placements (e.g. respite), and intensive case management. Intensive case management by child welfare should involve such strategies as securing immediate mental health services, mediation, and a more comprehensive assessment to identify family strengths, resources, and underlying issues. The need for mental health services has been clearly identified for these cases in this research. This would be an ideal place for child welfare and mental health systems to collaborate in developing a rapid response to these situations. While this kind of emergency response exists in some parts of

the state, it has not been implemented statewide. Future research should seek to determine what barriers are preventing full implementation of this service response. Possible barriers include: lack of funding, unavailability of emergency homes, lack of mediation services, or need for capacity development to establish such a service response.

- **Increase the use of wraparound services.** Nineteen of the 30 youth in this review were determined to have a serious emotional disturbance (SED). While case documentation of wraparound services was uneven, in interviews, case managers were consistently positive about the support provided by wraparound teams and meetings. Case managers reported that wraparound services promoted greater service coordination, a solid foundation for child welfare decision making, and more support for parents through parent support specialists. This is an effective, collaborative effort which should continue.
- **Implement multidisciplinary group supervision.** Group supervision provides a powerful venue for training, improving practice skills, sharing knowledge among case managers, supporting workers, retaining workers, and promoting better outcomes for children and youth. Case management staff would benefit from access to clinical specialists to help assess parent AOD indicators; to help assess sexual abuse and physical abuse histories—especially when there are suspicions but no substantiated allegations; to help identify effective interventions, including natural milieu interventions known to be effective with youth; and to help recognize signs of psychotic and other mental health issues among parents and youth.
- **Courts and child welfare could partner more effectively to improve child welfare outcomes and to hold parents accountable for the care of their youth.** Some areas of the state have created effective cross-system collaborations to improve permanency outcomes and parent accountability. One example is Sedgwick County’s Permanency Council. The

Council comprises representatives from child welfare agencies, dependency judges, and county representatives. Moreover, a pilot project in Ohio uses interdisciplinary county teams, including judges and child service providers, to monitor CFSR permanency outcomes. The teams are given a group of ten closed cases which did not meet CFSR permanency outcomes; they jointly analyze what occurred over the course of the case. These reviews help teams to gain critical insight as to how cases are handled by child welfare and how court actions impact case outcomes.

- **Improve information sharing between child welfare and AOD providers.** Case reviews identified some barriers to information sharing between child welfare and AOD providers. The study suggests the need to clarify federal and state statutes, agency regulations, and professional mandates around confidentiality and information sharing so that all professionals are aware of the opportunities and constraints around communication. Also, the two systems should work to remove barriers establishing MOU's and simplified release processes.
- **Hold joint trainings and create ongoing professional development and networking opportunities across the mental health, substance abuse, and child welfare systems.** Systems collaboration is built on a foundation of personal relationships forged by individuals across systems. Relationships at all levels—from front line to administrative—need to be intentionally fostered for systems to function harmoniously, collaboratively, or even minimally. Some areas of the state currently hold multidisciplinary trainings to foster relationships across systems. Trainings are held once a month or less frequently, and costs are reasonable as trainers are drawn from local resources, including universities, hospitals and mental health clinics.

- **Consider integrated models of care such as co-location of mental health and substance abuse staff in child welfare agencies or multi-service centers.** Some foster care agencies have adopted this model, with good results. Additionally, RADAC has co-located in SRS offices in four regions. Evidence from this case review suggests that service coordination is increased by co-locating services.

Appendix A

CINC NAN Year Two Study – Data Collection Tool

Case Reviewer:		Date of Review:	
<i>Identifying Information</i>			
Child's Name:	Client Id:	Case Id:	
DOB:	Home County:		
Head of House:	SSN:	Relationship:	
Other Parent:	SSN:	Relationship:	
Other info about household:			
<i>Case Contact Information</i> (add rows as needed to record different workers)			
Provider case manager(s):	Phone:	Email:	
Provider supervisor:	Phone:	Email:	
	Phone:	Email:	
<i>Significant Stakeholders</i> (add rows as needed)			<i>Date of Interview</i>
Name:	Phone:	Relationship:	
<i>Key Dates</i> (Record dates from database file prior to site visit.)			
Removal date:	Trial home visit date:	Discharge date:	
<i>Other History</i> (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

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.)			

Comments on Assessments:

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.

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

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

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

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

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

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

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.

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

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
Was a RADAC assessment documented in the case file? <i>Include dates referred or completed and note if date was not clear.</i> <i>Also indicate findings of RADAC screen below:</i> <input type="checkbox"/> No treatment <input type="checkbox"/> Education <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient			

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.

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

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

Provide any other comments on youth AOD needs.

Item 4. Service Provision – Child AOD

Core Questions

What AOD services does the case file indicate the youth received?

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.

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

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

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.)			

Comments on Assessments:

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.

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

List available DSM diagnoses.

Axis I:

Axis II:

Axis III:

Axis IV: Axis V (GAF score):			
What were underlying needs that were not identified and/or addressed, if any?			
Among parties, were there discernible disagreements about the mental health needs of the adult(s)?			
How adequate were assessments in covering all relevant areas/family members and in identifying needs?			
How would you describe the timeliness of MH assessments?			
Item 6. Service Provision – Adult Mental Health & Other Social Services			
Core Questions			
What mental health and other social services, if any, does the case file indicate the adult(s) received?			
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.			
How would you describe the timeliness of MH service initiation? Include discussion of MH response to emergencies and crises.			
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
Was a RADAC assessment documented in the case file? <i>Include dates referred or completed and note if date was not clear. Also indicate findings of RADAC screen below:</i> ____ No treatment ____ Education ____ Outpatient ____ Inpatient			
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.

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

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

Provide any other comments on AOD needs of adult.

Item 8. Service Provision – Adult AOD

Core Questions

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

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.

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

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

Item 9. Case Planning (entire case)

Core Questions

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

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

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.

What events, services or people were important in supporting 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

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

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

Were services timely?

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

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

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

What events, services or people were important in supporting 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).

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 B

Administrator/Key Informant Interview Guide

CINC NAN Year Two: Mental Health and AOD 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?

References

Administration for Children and Families (2002). *General findings from the federal Child and Family Services Review*. [On-line]. Available:

<http://www.acf.hhs.gov/programs/cb/cwitoring/results/genfindings04/ch1.htm>.

Administration on Children and Families (2002). *Summary results of the 2001 and 2002 child and family services reviews*. [On-line]. Available:

<http://www.acf.hhs.gov/programs/cb/cwmonitoring/results/2002cfsrresults.pdf>.

Altshuler, S.J. (2003). From barriers to successful collaboration: Public schools and child welfare working together. *Social Work*, 48, 52-63.

American Academy of Child and Adolescent Psychiatry & Child Welfare League of America (2003). AACAP/CWLA policy statement on mental health and use of alcohol and other drugs, screening and assessment of children in foster care. [On-line]. Available:

<http://www.aacap.org/page.wv?section=Policy+Statements&name=AACAP%2FCWLA+Policy+Statement+on+Mental+Health+and+Use+of+Alcohol+and+Other+Drugs%2C+Screening+and+Assessment+of+Children+in+Foster+Care>

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders, 4th edition, text revision (DSM-IV-TR)*. Washington, DC: American Psychiatric Press, Inc.

Banks, H. & Boehm, S. (2001). Substance abuse and child abuse. *Children's Voice*. Child Welfare League of America, Washington D.C. Available:

www.cwla.org/articles/cv0109sacm.htm.

Barth, R.P. (1990). On their own: The experiences of youth after foster care. *Child and Adolescent Social Work*, 7(5), 419-40.

Biestek, F. (1957). *The casework relationship*. Chicago: Loyola University Press.

Bilaver, L. M. & Courtney, M. E. (2006). Science says: Foster care youth. Chapin Hall, Center for Children. University of Chicago. [On-line]. Available:

http://www.chapinhall.org/article_abstract.aspx?ar=1434

Brittain, C.R. & Hunt, D.E. (2004). *Helping in child protective services: A competency-based casework handbook* (2nd ed.). Oxford: Oxford University Press.

Burns, B.J., Phillips, S.D., Wagner, H.R., Barth, R.P., Kolko, D.J., Campbell, Y. & Landsverk, J. (2004). Mental health need and access to mental health services by youths involved with child welfare: A national study. *Journal of American Academy of Child and Adolescent Psychiatry*, 43(8), 960-970.

Cash, S.J. & Berry, M. (2002). Family characteristics and child welfare services: Does the assessment drive service provision? *Families in Society: The Journal of Contemporary Human Services*, 83(5/6), 499-507.

Child Welfare League of America (1998). *Alcohol and other drug survey of state child welfare agencies*. Washington, D.C.: Author.

Children and Family Research Center. Best Practice Research: Initial assessment. [Online]. Available at:
http://cfrcwww.social.uiuc.edu/respract/toolpages/research.pgs/Frame_initial/fr_initial.htm

Children's Defense Fund. The barriers: Why is it so difficult for children to get mental health screens and assessments? *Children's Mental Health Resource Kit*. Washington, D.C.: Author. [On-line]. Available at
www.childrensdefense.org/childwelfare/mentlahealth/resourcekit/barriers.pdf.

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.

Courtney, M., Piliavin, I., Grogan-Kaylor, A., & Nesmith, A. (2001). Foster youth transitions to adulthood: A longitudinal view of youth leaving care. *Child Welfare*, 80, 685-717.

DePanfilis, D. & Salus, M.K. (2003). *Child protective services: A guide for caseworkers*. U.S. Department of Health and Human Services.

Drabble, L. (2007). Pathways to collaboration: Exploring values and collaborative practices between child welfare and substance abuse treatment fields. *Child Maltreatment*, 12(1), 31-42.

Drake, B., Jonson-Reid, M., & Sapokaite, L. (2006). Re-reporting of child maltreatment: Does participation in other public sector services moderate the likelihood of a second maltreatment report? *Child Abuse & Neglect*, 30(11), 1201-1226.

Faller, K. & Bellamy, C. (2000). Mental health problems and child maltreatment. University of Michigan Interdisciplinary Child Welfare Training Program. [On-line]. Available:
<http://www.ssw.umich.edu/icwtp/mentalhealth/d-mhpar.pdf>

Flango, V.E. (2001). Measuring progress in improving court processing of child abuse and neglect cases. *Family Court Review*, 39(2) 158-169.

Flower, C., McDonald, J., & Sumski, M. (2005). *Review of turnover in Milwaukee County private agency child welfare ongoing case management staff*.

Frankel, R. M. & Devers, K. (2000). Qualitative research: A consumer's guide. *Education for Health*, 13(1), 113-123.

Fuller, T. & Wells, S.J. (Eds). (1998). *Child endangerment risk assessment protocol: A technical report concerning the implementation and validation of the protocol*. Urbana, Illinois: Children and Family Research Center, School of Social Work at the University of Illinois at Urbana-Champaign.

Garland, A.F., Hough, R.L., Landsverk, J.A., McCabe, K.A., Yeh, M., Ganger, W.C. & Reynolds, B. (2000). Racial and ethnic variations in mental health care utilization among children in foster care. *Children's Services: Social Policy, Research & Practice*, 3(3), 133-146.

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). *Child welfare and juvenile justice: Federal agencies could play a stronger role in helping states reduce the number of children placed solely to obtain mental health services* (GAO-03-397). Washington DC: Author.

General Accounting Office (GAO) (2002). *Foster care: Recent legislation helps state focus on finding permanent homes for children, but longstanding barriers remain*. (GAO-02-585). Washington DC: Author.

Green, B. L., Rockhill, A. & Furrer, C. Does substance abuse treatment make a difference for child welfare case outcomes? A statewide longitudinal analysis. *Children and Youth Services Review*, 29(4), 460-473.

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

Guion, L. A. (2002). *Triangulation: Establishing the validity of qualitative studies*. Department of Family, Youth and Community Sciences, Florida Cooperative Extension Service, Institute of Food and Agricultural Sciences, University of Florida. [On-line]. Available: <http://edis.ifas.ufl.edu/pdffiles/FY/FY39400.pdf>

Guo, S., Barth, R. P., & Gibbons, C. (in press). Propensity score matching strategies for evaluating substance abuse services for child welfare clients. *Children and Youth Services Review*.

Halfon, N., Zepeda, A., & Inkelas, M. (2002). Mental health services for children in foster care. *Health Services for Children in Foster Care*. Los Angeles, CA: University of California, Los Angeles, Center for Healthier Children, Families and Communities.

Hammond, M. (2006). How Kansas stacks up: A regional and national comparison of mental health care services. [On-line]. Available: <http://www.acmhck.org/common/modules/documentcenter2/documentview.asp?DID=244>.

- Hartnett, M., Falconnier, L., Leathers, S. & Testa, M. (1999). *Placement stability study: Final report*. University of Chicago, School of Social Service Administration.
- Henggeler, S., Schoenwald, S., Rowland, M., & Cunningham, P. (2002). *Serious emotional disturbance in children and adolescents: Multisystemic family therapy*. New York: Guilford Press.
- Hensler, D., Wilson, C., & Sadler, B. (2004). Closing the quality chasm in child abuse treatment: Identifying and disseminating best practices. *The findings of the Kauffman best practices project to help children heal from child abuse*.
- Hill, R. (2006). *Synthesis of research on disproportionality in child welfare: An update*. Casey-CSSP Alliance for Racial Equity in the Child Welfare System.
- James, S., Landverk, J., Slymen, D.J. & Leslie, L.K. (2004). Predictors of outpatient mental health service use – the role of foster care placement change. *Mental Health Services Research*, 6(3), 127-141.
- Johnson, M. A., Stone, S., Lou, C., Vu, C., Ling, J., Mizrahi, P. & Austin, M. J. (2006). Family assessment in child welfare services: Instrument comparisons. Center for Social Services Research, University of California at Berkeley, School of Social Welfare. [On-line] Available: http://cssr.berkeley.edu/bassc/public/BASSC_FamilyAssessment_FULL_REPORT091406.pdf
- Kamerman, S.B. & Kahn, A. J. (1990). Social services for children, youth and families. *Children and Youth Services Review*, 12, 1-184.
- Kansas Health Solutions (2007). Provider manual. [On-line]. Available: http://www.kansashealthsolutions.org/web_docs/Provider_Manual_vii_v_30.pdf.
- Kerker, B.D. & Dore, M.M. (2006). Mental health needs and treatment of foster youth: Barriers and opportunities. *American Journal of Orthopsychiatry*, 76(1), 138-147.
- Kirk S. & Hutchins H. (1999). *Making us crazy: DSM – The psychiatric bible and the creation of mental disorder*. Constable and Robinson, London.
- Kortenkamp, K., & Ehrle, J. (2002). *The well-being of children involved with the child welfare system: A national overview*. Washington, D.C.: Urban Institute.
- Landsverk, J.A., Burns, B.J., Stambaugh, L.F., & Reutz, J.A. (2006). *Mental health care for children and adolescents in foster care: Review of research literature*. Seattle, WA: Casey Family Programs.
- Leslie, L.K., Landsverk, J., Ezzet-Lofstrom, R., Tschann, J.M., Slymen, D.J. & Garland, A.F. (2000). Children in foster care: Factors influencing outpatient mental health service use. *Child Abuse and Neglect*, 24(4), 465-476.

Lindblad-Goldberg, M., Dore, M., & Stern, L. (1998). *Creating competence from chaos: A comprehensive guide to home based services for children with serious emotional disturbances and their families*. New York: Norton.

Mahoney, K., Ko, S. J., & Siegfried, C. B. (2004). Trauma-focused interventions for youth in the juvenile justice system. National Child Traumatic Stress Network, Juvenile Justice Working Group. [On-line]. Available: http://www.nctsn.org/nctsn_assets/pdfs/edu_materials/trauma_focused_interventions_youth_jjs.pdf

Marsenich, L. (2002). *Evidence-based practices in mental health services for foster youth*. Sacramento, CA: California Institute for Mental Health.

McMillen, J.C., Scott, L.D, Zima, B.T., Ollie, M.T., Munson, M.R., & Spitznagel, E. (2004). Use of mental health services among youths in foster care. *Psychiatric Services*, 55(7), 811-817.

Milner, J., Mitchell, L. & Hornsby, W. (2001). The Child and Family Service Review: A framework for changing practice. *Journal of Family Social Work*, 6(4), 5-18.

Moore, T., Brook, J., Bryson, S., Holmes, C., McDonald, T., & Taylor, P. (2006). Final report: Children in need of care, non-abuse and neglect. [On-line]. Available: <http://www.socwel.ku.edu/occ/projects/childwelfare/CINC-NAN%20Final%20Report.pdf>.

Morton, T. D. & Holder, W. Eds. (2000). Issues and strategies for assessment approaches to child maltreatment. National Resource Center on Child Maltreatment. [On-line]. Available: <http://www.nrccps.org/PDF/IssuesandStrategiesforAssessment.pdf>.

National Center on Addiction and Substance Abuse (1999). *No safe haven: Children of substance abusing parents*. New York: Columbia University: Author.

National Council on Crime and Delinquency (2006). Relationship between staff turnover, child welfare system functioning and recurrent child abuse. Houston, TX: Cornerstones for Kids.

Office of Applied Studies (2005). *Substance use and need for treatment among youth who have been in foster care. (The National Survey on Drug Use and Health)*. Substance Abuse and Mental Health Services Administration.

Outley, A. (2006). Overcoming barriers to permanency: Recommendations for juvenile and family courts. *Family Court Review*, 44(2), 244-257.

Pecora, P.J., Whittaker, J.K., Maluccio, A.N., Barth, R.P. & Plotnick, R.D. (2000). *The child welfare challenge: Policy, practice, and research*. New York: Aldine de Gruyter.

Perlman, H. (1979). *Relationship: The heart of helping people*. Chicago: University of Chicago Press.

Pilowsky, D. (1995). Psychopathology among children placed in family foster care. *Psychiatric Services*, 46, 906-910.

Pilowsky, D.J. & Wu, L. (2006). Psychiatric symptoms and substance use disorders in a nationally representative sample of American adolescents involved with foster care. *Journal of Adolescent Health*, 38(4), 351-358.

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.

Ragin, Charles C. (1987). *The Comparative Method: Moving Beyond Qualitative and Quantitative Strategies*. Berkeley/Los Angeles/London: University of California Press.

Ryan, J.R., Garnier, P., Zyphur, M. & Zhai, F. (2006). Investigating the effects of case worker characteristics in child welfare. *Children and Youth Services Review*, 28(9), 993-1006.

Saewyc, E. M., Magee, L. L., & Pettingell, S. E. (2004). Teenage pregnancy and associated risk behaviors among sexually abused adolescents. *Perspectives on Sexual and Reproductive Health* 36(3), 98-105. [On-line]. Available: http://findarticles.com/p/articles/mi_m0NNR/is_3_36/ai_n6121836/pg_1

Schene, P. (2005). *Comprehensive family assessment guidelines for child welfare*. National Resource Center for Family-Centered Practice.

Simms, M.D., Dubowitz, H. & Szilagyi, M.A. (2000). Health care needs of children in the foster care system. *Pediatrics*, 106): 909-918.

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

Stroul, B.A., Pires, S.A., Armstrong, M.I. & Meyers, J.C. (1998). The impact of managed care on mental health services for children and their families. *Future Child*, 8, 119-133.

Taylor, N. & Siegfried, C. B. (2005). *Helping children in the child welfare system heal from trauma: A systems integration approach*. National Child Traumatic Stress Network, Systems Integration Working Group. [On-line]. Available: http://www.nctsnet.org/nctsn_assets/pdfs/promising_practices/A_Systems_Integration_Approach.pdf

Tibrewal, S. & Poertner, J. *Confidence and uncertainty in casework decisions: The supervisor's role*. Urbana, IL: Children and Family Research Center, School of Social Work at the University of Illinois at Urbana-Champaign.

Trupin, E.W., Tarico, V.S., Low, B.P., Jemelka, R. & McClellan, J. (1993). Children on child protective services caseloads: Prevalence and nature of serious emotional disturbance. *Child Abuse and Neglect*, 3, 345-355.

U.S. Department of Health and Human Services Administration for Children and Families. (2005). *National Survey of Child and Adolescent Well-being: CPS sample component wave 1 data analysis report*. Washington D.C.: Author.

Washington State Department of Social and Health Services (2002). *Alcohol and substance use among adolescents in foster care in Washington State. Results from the 1998-1999 Adolescent Foster Care Survey*. Available: <http://www1.dshs.wa.gov/rda/research/4/38.shtm>.

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.

Williams, R.J., Chang, S.Y. & Addiction Centre Adolescent Research Group. (2000). A comprehensive and comparative review of adolescent substance abuse treatment. *Clinical Psychology: Outcomes and Practice*, 7, 138-166.

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

Youngblad, L. M., Theokas, C., Shulenberg, J., Curry, L., Huang, I., & Novak, M. (2007). Risk and promotive factors in families, schools, and communities: A contextual model of positive youth development in adolescence. *Pediatrics*, 119 (Supplement February 2007), S47-S53.

Zetlin, A.G., Weinberg, L.A., & Shea, N.M. (2006). Seeing the whole picture: Views from diverse participants on barriers to educating foster youths. *Children & Schools*, 28 (3): 165-173.