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Mental health service utilization and time to care: A comparison of children in traditional foster care and children in kinship care

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ABSTRACT

Existing research indicates that children who are involved with the child welfare system and placed in various forms of out-of-home care experience emotional and behavioral problems. It is also suggested that children placed in kinship care are less likely to receive mental health services than children placed in non-kinship foster homes. This study sought to compare children in non-kinship foster homes to children in kinship care to determine their receipt of mental health services and the time it took for children in kinship care to receive mental health services compared to children in non-kinship foster homes. Using a Cox regression, researchers determined that children in kinship care had a 14% lower likelihood of receipt of mental health services compared to their counterparts in non-kinship foster placements.

1. Introduction

Children who come to the attention of the child welfare system often experienced severe maltreatment and/or neglect and therefore are at risk for an array of mental health problems. Some of the most common problems experienced by children involved in the child welfare system include depression, attachment disorders, low self-esteem, conduct disorder, learning disorders, and other external behavior problems (Shipman & Taussig, 2009). The child welfare system in the United States has been considered an extension of the mental health system due to the vast number of children with documented mental health problems (Burns et al., 2004). Over the past several years there has been an increasing trend in child protection agencies to place children with kinship caregivers. In 2014, Child Welfare Information Gateway estimated 415,129 children were placed in out-of home care settings. Approximately 46% ($n = 190{,}959$) of those children were placed in non-kinship foster homes, while 29% ($n = 120{,}387$) were placed in kinship care. Research shows that children involved with the child welfare system do better when they are placed with family members (Kelley, Whitley, & Campos, 2011). Kinship foster placement offers greater family, culture and community continuity, an increased likelihood of being placed with siblings, and continued contact with biological parents than occurs in non-kinship placements (O'Brien, 2013).

Although there are positive aspects of kinship care there are also challenges to this form of out-of-home care placement. First, kinship caregivers often step into the role of foster parent in the midst of a crisis situation. There is little time for the caregiver to become familiar with the child welfare system or to become a licensed foster parent prior to taking custody of the child (Hunt, Waterhouse, & Lutman, 2008). Unlike kinship caregivers, non-kinship foster parents must be licensed to provide care to children. There are no federal guidelines for kinship licensing, so states develop individualized standards and many caregivers do not become licensed (Bratteli, Bjelde, & Pigatti, 2008) This is unfortunate for kinship caregivers because licensure provides increased financial benefits (Bratteli et al., 2008).

Kinship caregivers must also balance the delicate relationship between the child welfare system and the biological parents (O'Brien, 2012b). Additionally, kinship caregivers are more likely to be single parent households, headed by older adults that are typically poorer, have less formal education, have poorer health, are more likely to be working outside the home (National Survey of Child and Adolescent Well-Being, 2007). Kinship caregivers also often find themselves becoming isolated from formal and informal supports as they take on the role of caregiver. The caregiver may lack a reliable form of transportation to access formal support services such as healthcare services, school, tutoring, and counseling. This sense of isolation and lack of support may increase stress for the caregiver and translate to increased stress experienced by the child, thus resulting in mental health problems (National Survey of Child and Adolescent Well-Being, 2007; Kelley et al., 2011; O'Brien, 2012a).

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2. Prevalence and treatment of mental health problems among children in out-of-home care

Over the last two decades multiple studies have been conducted to measure the prevalence of mental health problems among children living in out-of-home care placements. A majority of these studies indicate that children in non-kinship foster placements have a higher rate of mental health problems compared to children in kinship care (Burns et al., 2004; Holtan, Ronning, Handegard, & Sourander, 2005; Tarren-Sweeney & Hazell, 2006; Vanschoonlandt, Vanderfaeillie, Van Holen, De Maeyer, & Andries, 2012). However, children in kinship care have higher rates of emotional and behavioral problems when compared to children in the general population (O'Brien, 2013; Smith & Palmieri, 2007).

Given that children in both kinship and non-kinship foster placements experience emotional and behavioral problems, it is not surprising that many of these children qualify for professional mental health services. According to the National Survey of Child and Adolescent Well-Being (2012), high levels of unmet mental health service needs exist among children living in out-of-home care. The NSCAW reports that approximately 33–50% of children living in out-of-home care that met the clinical criteria for a mental health problem did not receive services in the previous 18-month period (2012). Research indicates that children placed in kinship care experienced a delay in mental health service utilization, as well as have mental health needs go unmet compared to their counterparts in non-kinship placements (Villagrana, 2010).

Previous research indicates that children in kinship and non-kinship out of home care placements experience varying degrees of emotional and behavioral challenges. However, children in kinship placements are less likely to utilize mental health services than children in non-kinship placements. This study furthers the existing research by comparing children in non-kinship foster placements to children in kinship placements regarding their receipt of mental health services. In addition, the study builds upon the existing research by using a large administrative data set to examine the time it took for children in kinship care to receive mental health services compared to children in non-kinship foster placements.

3. Method

3.1. Study design and sample

The study design consisted of a longitudinal analysis of administrative data with an entry cohort. The entry cohort ($N = 36{,}543$) included all children, from birth to 17 years of age, who were placed in out-of-home care and spent at least 12 months in either kinship care or non-kinship foster placements during FY 2007–2008 through FY 2009–2010 ($N = 36{,}543$). Of these children, 50% were male and their average age was 5 years ($M = 4.79$, $SD = 5.21$). Race/ethnicity of this sample consisted of 48% Non-Hispanic White, 38% African-American, 13% Hispanic, with the remaining 1% from other racial and ethnic groups. Almost 58% of youth were in kinship care.

3.2. Data sources

The data was collected from the Florida Child Welfare Information System (FSFN) and Medicaid administrative databases. FSFN contains information collected from numerous sources by child protective investigators and case workers about all children in the state of Florida reported as being maltreated, including data related to demographics, maltreatment history, children's placement status, dates of children's entry into and exit from different placements, parental substance abuse, and family domestic violence history. The Florida Medicaid claims administrative database includes information about physical and mental health diagnoses, the types of mental health services received, and the dates these services were provided by all Medicaid-eligible individuals in the state of Florida.

3.3. Outcomes measures

3.3.1. Time to receipt of any outpatient mental health service

Outpatient mental health service was defined as any office-based visits from any type of provider (e.g., general family practitioners, pediatricians or other medical professionals) for any behavioral health issues. In this study, receipt of mental health services was tracked for 12 months after the child was first removed from home. If the child received any outpatient mental health service during the study period, then the number of months between the date the child was placed in out-of-home care and the child's first mental health service received was calculated.

3.3.2. Time to receipt of specific categories of outpatient services

These categories were developed and grouped into relevant categories based on procedure codes used in the Medicaid claims data and included: (a) *basic outpatient* services such as individual, family, and group therapy/intervention; (b) *targeted case management* services including case management for children with chronic mental health issues and (c) *specialized mental health* services (e.g., problem(s) requiring admission to "observation status" of high severity). If the child received a mental health service classified as either of the categories mentioned above, then the number of months between the date the child was placed in out-of-home care and the date that mental health service received was calculated.

3.4. Predictor variables

3.4.1. Demographics

Demographic characteristics examined as potential predictors of outpatient mental health services receipt included (a) gender, (b) age at the time the first (i.e., in fiscal year 2007–2008) out-of-home care placement, and (c) race/ethnicity including Caucasian, African American, Hispanic, and Other.

3.4.2. Parental substance abuse problems

The definition of substance abuse problems was based on guidelines developed and described in the Child Allegation Matrix (Yampolskaya, Mowery, & Sharrock, 2012). Based on this matrix, the following criteria are used to determine whether the caregiver experienced substance abuse problems: (a) the parent either had a substance abuse-related diagnosis or received substance abuse services, (b) positive drug screens, (c) the caregiver's admitted or observed history of drug or alcohol use, (d) positive toxicology when the child was born, or (e) documentation from interviewing witnesses to the incident or persons who know the family well. A dichotomized variable was constructed that indicated whether the child's parent(s) had substance abuse problems (1 = yes) or not (0 = no).

3.4.3. Domestic violence in the family

Information about domestic violence was recorded by the child protection investigator. A dichotomized variable was constructed that indicated the presence of domestic violence problems in the family (1 = yes) or not (0 = no).

3.4.4. Child maltreatment history

Child maltreatment measures consisted of five types of maltreatment recorded in FSFN. They included (a) physical abuse, (b) sexual abuse, (c) emotional abuse (d) neglect, and (e) threatened harm. Each type of maltreatment was coded as a dichotomous variable indicating whether the child had (1) or had not (0) experienced a specific type of maltreatment.