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Context-specific mental health services for children in foster care ☆

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ABSTRACT

Although a high proportion of foster children receive mental health services, existing research suggests limited accessibility and effectiveness of these services. This paper discusses strategies to develop a model to deliver evidence-based services using the unique opportunities apparent within publicly funded child welfare systems. An ecologically-focused model providing enhanced services in children's homes and schools could capitalize on these opportunities and radically improve access and effectiveness of mental health services for foster children. We present data from four focus groups conducted with foster parents, caseworkers, and therapists to understand the feasibility of implementing this type of service model. Results support the need for services focused on enhancing interactions in children's foster homes and schools, but also suggest that issues related to priorities and primary roles could limit the extent that caseworkers and agency-based mental health providers would follow through with the proposed service model.

1. Introduction

Over the past two decades, child welfare advocates and researchers have increasingly recognized the need to address foster children's mental health problems (Leslie, Hurlburt, Landsverk, Barth, & Slymen, 2004; Vandivere, Chalk, & Moore, 2003). Consistent with this trend, recent data suggest that child welfare involvement facilitates identification and treatment of children's mental health needs, with a greater chance of mental health service use occurring with increased child welfare involvement. In the general population, 21% of children who need mental health treatment receive services (Kataoka, Zhang, & Wells, 2002). Similarly, among children who come into contact with any type of child protection service, 24% with significant needs have received services in the past 12 months (Burns et al., 2004). Among children who are in foster care for a year or longer, however, the majority with significant needs receive services, with 76% receiving at least one inpatient or outpatient service (Leslie et al., 2004). These data suggest that involvement in foster care systems exerts a strong, positive effect on children's service use.

Given these high levels of service use, the frequent criticisms and even lawsuits alleging substandard mental health service provision to foster children (Dore, 1999; Lyons & Rogers, 2004; Klee & Halfon, 1987; Schneiderman, Connors, Fribourg, Gries, & Gonzales, 1998) might seem perplexing. However, examination of the content, effectiveness, and allocation of the services provided to foster children clarifies this contradiction; the services provided are fragmented, untested, and at best highly variable in quality (Dore, 1999; Leslie et al., 2004; McMillen et al., 2004; Zima, Bussing, Yang, & Belin, 2000). In this paper, we first discuss the need for mental health services reform in child welfare systems. We then propose that the unique characteristics of the child welfare system create an opportunity to develop an accessible, effective mental health service system for foster children. This ecologically-focused model would capitalize on the resources and strengths of the child welfare system and integrate empirically supported mental health prevention and treatment interventions into the core functions of child welfare to create self-sustaining services based in children's homes and schools.

Finally, we present data from four focus groups that were conducted to understand more about the feasibility of shifting service provision to this type of context-specific service model. The focus groups included caseworkers, foster parents, and therapists working in a specialized foster care program that had agreed to participate in a pilot project focused on service development. Our findings support the need for mental health services reform and the relevance of context-specific services for foster children. In addition, however, our findings highlight the challenges for the implementation of this type of service model.

2. Effectiveness of mental health services in child welfare systems

Until recently, little was known about how mental health services are provided to foster children. The National Survey of Child and Adolescent Wellbeing (NSCAW), a representative, longitudinal study of children served by child welfare systems, has begun to address this gap. NSCAW results indicate that about three-quarters of foster children with significant mental health needs receive specialty mental

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health services on an outpatient basis (Leslie et al., 2004). A substantial percentage also enter an inpatient facility (9.3%) or see a medical doctor for emotional, behavioral, or learning difficulties (19.1%), with nearly all of these children also receiving outpatient services. Unfortunately, findings from this study do not clarify the extent that foster children receive services from non-mental health specialty settings such as schools, which are the most common route for entry and provider of services in the general population (Farmer, Burns, Phillips, Angold, & Costello, 2003). Additionally, these findings might underestimate the number of foster children receiving treatment, since interventions provided by child welfare placements (e.g., mileu-oriented treatment foster care homes and residential treatment centers) were not counted as mental health services.

The effectiveness of the mental health services provided to foster children is also largely unknown, but findings from available studies have generally not been positive. In a study involving 68 maltreated children, Kolko, Baumann, and Caldwell (2003) reported no association between receipt of community-based services and lessened emotional and behavioral problems over time. This is not surprising given that findings from studies in the general population have been mixed, with several studies reporting no effectiveness for children's mental health services, including traditional child psychotherapy as generally practiced (Weiss, Catron, Harris, & Phung, 1999) and systems of care initiatives (Bickman, 1996, 1997; Bickman, Noser, & Summerfelt, 1999). This apparent lack of effectiveness might be related to the fact that empirically supported treatments are used infrequently in the general population (Weisz, 2000) as well as in child welfare settings. For example, foster or biological parents rarely participate in the treatment (Leathers, Testa, & Falconnier, 1998), despite evidence that parental involvement is essential for many of the most commonly diagnosed childhood disorders, such as externalizing behavior disorders (Farmer, Compton, Burns, & Robertson, 2002). Most foster children who are referred to outpatient services receive only a few sessions (Leslie et al., 2000), and almost two-thirds of foster children diagnosed with ADHD have not visited a physician for evaluation for psychotropic medication in the last year (Leathers et al., 1998; Zima et al., 2000).

Outcome studies of residential treatment have also failed to demonstrate consistent positive outcomes. Residential treatment services might help stabilize the behavior of children and youth with serious emotional or behavioral disturbance while they are in the residential setting, but children experience no long-term benefits in comparison to community-based care (Epstein, 2004; Chamberlain & Reid, 1998). Additionally, intensive, highly structured treatment foster care models are effective in treating emotional and behavioral problems, but the intensity of training and support that is required to implement effective models is not provided to most foster parents (Chamberlain, 2002). Overall, existing data provide little evidence for the effectiveness of the majority of the mental health services provided to foster children.

Problems also occur in the allocation of mental health services within child welfare systems. Although a significant correlation exists between severity of emotional and behavioral problems and intensity of service use (Burns et al., 2004; Leslie et al., 2004), factors unrelated to need for services also appear to determine referral and service use patterns. African American children, children entering care due to physical abuse or neglect, and preschoolers are less likely to receive services than other children (Burns et al., 2004; Garland, Landsverk, Hough, & Ellis-Macleod, 1996; Glisson, 1996; Leslie et al., 2004). Racial differences in the allocation of residential treatment and community-based services also occur, with non-white foster youth more likely than white youth to receive more restrictive, residential services rather than community-based treatment (Berrick, Courtney, & Barth, 1993; McMillen et al., 2004), again replicating service patterns in the general population (Sheppard & Benjamin-Coleman, 2001).

Taken together, these findings support the need to develop, test, and disseminate effective service models for foster children. At present, services are provided to a large proportion of children at a high cost, but it appears that these services are largely ineffective and inequitably allocated. Given the large proportion of child welfare budgets allocated to clinical services (Naylor, Anderson, & Morris, 2003) and the number of foster children with significant mental health needs, an important question is how to develop effective mental health services for foster children.

3. Mental health services development: an ecological approach

Efficacy studies have established evidence-based treatments for the most common childhood mental health disorders and, in the general population, evidence-based treatments lead to better outcomes than treatment as usual (Weisz, Jensen-Doss, & Hawley, 2006). Unfortunately, less is known about how to adapt these interventions to the realities of routine clinical practice with children (Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001). Similarly, effective treatment models with implications for model development in child welfare systems have been developed (Chaffin & Friedrich, 2004; Chamberlain, 2002; Kolko et al., 2003; Timmer, Urquiza, & Zebell, 2006), but these models have not yet been systematically tested and disseminated within child welfare systems.

We suggest that the child welfare system has the resources and potential to promote a context-specific mental health service model in which mental health services are integrated into child welfare services and provided in children's schools and homes, instead of office settings. This type of service system is based on an ecological perspective of child and family functioning. From an ecological perspective, child mental health problems occur in the context of complex embedded systems. Factors from multiple levels, including individual child physiology, family interaction, school and community environments, family transactions with outside systems, and social and cultural variables, affect child mental health both directly and indirectly (Belsky, 1980; Bronfenbrenner, 1979). The context-specific model we propose would focus on modifying the contingencies within the environments directly experienced by the child (e.g., foster homes and schools) to reduce emotional and behavioral problems. An essential aspect of the model is that it restructures transactions between the child welfare service system and the child's environment to support context-specific treatment. This approach follows from an emerging body of research that focuses on delivering the clinical practices developed in traditional outpatient efficacy trials in innovative ways that depart from a clinic-based service model (Cappella, Frazier, Atkins, Schoenwald, & Glisson, 2008; Chamberlain, 2003; Henggeler, Schoenwald, Rowland, & Cunningham, 2002). These models propose a new definition of mental health that moves away from symptom reduction in the individual and towards enhanced functioning within the contexts in which children live.

A context-specific service model departs from existing service models in several key ways. To begin, a context-specific service model would shift the primary treatment focus from individual child treatment to training and support of the child's parents, foster parents, and teachers. Although service systems vary by region, available data indicate that individual outpatient therapy is still the primary mental health service provided to foster children (Leslie et al., 2004). Children who require more intensive services might enter treatment foster care or residential treatment. In this paper, we examine the feasibility of training caseworkers and mental health providers to provide the majority of mental health services in the child's environment, to reduce problems such as low caregiver involvement, poor follow-up with services, and inequities in service provision. By integrating mental health functions into ongoing child welfare services, services could reach a higher percentage of foster children and mental health needs could be met proactively. In this model, time-limited individual treatment would still be provided to children to address issues related to disorders with an empirical basis for individual treatment (i.e., depression, anxiety, and trauma related