For Better or Worse? Change in Service Use by Children Investigated by Child Welfare Over a Decade

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ABSTRACT

BACKGROUND: Children, particularly minority children, referred to child welfare because of suspected maltreatment are vulnerable and need many services. We sought to assess whether service use has improved over the past decade and whether racial-ethnic disparities in service use have decreased.

METHODS: We used 2 national data sets (the National Survey of Child and Adolescent Well-Being [NSCAW] I and II) collected a decade apart to assess changes over time in health, education, mental health (MH), and dental services and overall service use.

RESULTS: In NSCAW II more children were young, had lower Child Behavior Checklist (CBCL) scores, and were Hispanic. We found significant increases in dental services, a decrease in special education services, and a decrease in MH services on the bivariate level (all $P < .01$). A large proportion of the change in MH services occurred in school settings, but the pattern continued when examining only those services delivered outside of school. The greatest decrease occurred for children with CBCL scores <64. However, in multivariate analyses, older children, white non-Hispanic children, and children placed out of the home were significantly more likely to receive MH services. Rates of MH services controlling for CBCL scores showed no improvement over the decade, nor was there a decrease in racial and ethnic disparities.

CONCLUSIONS: These data showed no change in MH services over time for children referred for child welfare evaluation, but improvement in dental services was noted. Racial and ethnic disparities persist. Decrease in MH services occurred predominantly among children whose MH symptoms were below the clinical range.

KEYWORDS: child welfare; dental services; disparities; health; mental health; NSCAW; special education

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WHAT'S NEW

Children in contact with child welfare have high service needs and often fail to get needed services. In an analysis of 2 national data sets, dental services increased, but mental health services decreased, especially in schools. When we controlled for need, racial and ethnic disparities have not decreased.

CHILDREN IN FOSTER care have significant physical and mental health (MH) needs that impair their functioning and require services across multiple sectors.[1,2] This well-established need for multiple services prompted calls for comprehensive evaluations to identify needs of individual children at or shortly after the time of the child welfare (CW) investigation.[3,4]

While it is well recognized that children placed in out-of-home settings have extensive needs, most children referred to CW remain at home. Of the approximately 6 million children who are reported to CW agencies in the United States annually, only about 700,000 have substantiated abuse and neglect.[5] A small subset are placed in foster care, and this is the subset that has most often been the center of research and discussion. However, we recently documented that children who are placed with kin[6] and those who remain in their own homes also have health and MH concerns nearly commensurate with those placed out of home,[7,8] a need also documented by Burns et al.[9] Awareness of the heightened needs of this group of children prompted increased mandates for comprehensive assessments and services to all children who are investigated by CW.[10–12] Class-action lawsuits against CW systems in >32 states have resulted in settlements requiring states to provide a range of services, including services to address MH needs.[13] Professional groups and experts also advocated for quality standards for screening, assessment, and treatment to increase access to services for all children who come into contact with CW services.[14]

Beyond closing the gap between the need for and the use of services for children investigated by CW, attention has also addressed consistent disparities in service use among minority children.[15] For example, even after controlling for need, African American children are less likely to receive services, including developmental, school-related, and health-related services.[16,17] However, system-level coordination between CW and MH has been associated with reduction of disparities.[18] The emphasis on closing disparities in services across race and ethnicity has been a priority for a number of professional groups, including the American Academy of Pediatrics.[19] System-wide emphasis on increasing access has been paired with attention to understanding and addressing disparities in service utilization.[20] Improved awareness of the need to treat physical and MH conditions should increase provision of services to children involved with CW services and, we hope, place greater emphasis on consistent screening for all youth. A direct focus on disparities should also result in reduction of disparities in service use.

However, important countervailing events occurred that might reduce availability of services to these children. The first was passage of Temporary Assistance for Needy Families (TANF),[21] which limited the time that families could depend on public support. In many states, parents were required to be employed at least part time by 1999, potentially limiting their availability to attend their children's appointments.[22] Additionally, the number of individuals on Medicaid decreased as a consequence of this legislation, reducing families' ability to pay for services.[23] These changes undoubtedly affected some families referred to CW.

Second, the deep economic recession decreased publicly funded services. Since 2008, >45 states have reduced services, including Medicaid (31 states) and other health care programs and services to the disabled (29 states).[24] Many MH agencies and school systems also experienced significant cutbacks.[25] Both these factors would be expected to reduce the services provided to vulnerable children.

Thus, although research and policy provide evidence to support an increase in services and additional attention to persistent disparities in service use, it is unclear whether changes in patterns of service use have occurred. Two national surveys of children and adolescents investigated by CW agencies, conducted a decade apart, present an opportunity to examine changes in services delivered to these high-need children. We hypothesized that 1) more youth would be identified with MH problems, but 2) services would remain static or decrease, and 3) racial disparities would have decreased. We based these hypotheses on the increased focus on earlier identification of needs and on reduction of racial disparities in services, coupled with concern that overall services were likely to be adversely affected by economic pressures during the period of data collection.

METHODS

DESIGN AND SAMPLE

Data come from the first and second National Surveys of Child and Adolescent Well-being (NSCAW I and II, respectively), 2 nationally representative, longitudinal surveys tracking experiences of children whose families were investigated by CW. The surveys involved interviews with caregivers, case workers, and youths, and they contained similar measurement tools to facilitate cross-time comparisons.

NSCAW I and II used the same general procedures. A national probability sampling strategy was used to select primary sampling units (PSUs), typically counties, from which a sample of families was drawn. Enrollment for NSCAW I occurred from October 1999 to December 2000, and for NSCAW II from March 2008 to September 2009. In NSCAW I, cases were selected using stratified random sampling within 92 PSUs. Whenever possible, the same PSUs were included in NSCAW II: Of the 92 original PSUs, 71 were eligible and agreed to participate. Ten additional PSUs were added to replace nonparticipating PSUs. Both surveys excluded agencies in 8 states in which laws required first contact of a caregiver by the agency rather than study staff.[26]

Current analyses utilize caseworker and caregiver interviews to assess children's health and their MH, educational, and dental service use from just before the index CW investigation to 18 months thereafter. Initial NSCAW interviews typically occurred approximately 4 to 5 months after the index CW investigation. Follow-up interviews occurred at 12 and 18 months in NSCAW I and at 18 months in NSCAW II, but both surveys included questions asking about service use across the same cumulative time period.

Data on children aged 2 to 14 years were analyzed because this is the age span common to both surveys for which MH needs assessments were available. All procedures were approved by the Research Triangle Institute's institutional review board. All analytic work on deidentified data was approved by Rady Children's Hospital's institutional review board.

MEASURES

BACKGROUND CHARACTERISTICS

Questions about demographics, health, behavior, and child placement were asked in initial parent and caregiver interviews. Age is the age of the child at the time of the investigation. Caregivers were asked to report on the child's overall health using a standardized question and to complete the Child Behavior Checklist (CBCL). There were some minor wording differences in the versions used in the 2 surveys.[27,28]

SERVICES

Caregivers answered questions about children's use of services. Time frames differed slightly for different service types, but we included only variables that were comparable between NSCAW I and II.