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Mental health referrals and treatment in a sample of youth in foster care

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1. Introduction

Children in foster care have elevated rates of mental health problems (e.g., Bramlett & Radel, 2014; Child Trends Databank, 2015; dosReis, Zito, Safer, & Soeken, 2001; Landsverk, Burns, Stambaugh, & Rolls Reutz, 2006; Pilowsky, 1995; Polihronakis, 2008). Anywhere from 50% to 75% of children entering foster care have behavioral difficulties that rise to the level of requiring mental health services (Burns et al., 2004; Fanshel, Finch, & Grundy, 1989; Leslie, Hurlburt, Landsverk, Barth, & Slymen, 2004). Compared to youth in the general population, youth in foster care are significantly more likely to have at least one lifetime diagnosis of a mental illness (Pecora, Jensen, Romanelli, Jackson, & Ortiz, 2009). Elevated rates of depression, anxiety, aggression, and PTSD have all been found in foster care youth (Clausen, Landsverk, Ganger, Chadwick, & Litrownik, 1998; Handwerk, Friman, Mott, & Stairs, 1998; Heiger, 2012).

These high rates of mental health problems are understood in the context of the multiple risk factors associated with foster care placement. The vast majority of youth served in the United States foster care system have been removed from their homes due to abuse or neglect, a significant risk factor for poor outcomes (Barlow, Smailagic, Ferriter, Bennett, & Jones, 2010; Goldman et al., 2007; Perry, 2002, 2006). Compounding the maltreatment is the trauma from separation from their primary caregivers, resulting in emotional problems that can interfere with the parent-child attachment bond and placing them at high risk for establishing insecure and dysfunctional relationships (e.g., Bernard et al., 2012). Other risk factors that contribute to the development of serious emotional and behavioral problems for youth in foster care include environmental, social, biological and psychological influences (Kolko & Swenson, 2002).

Despite this overwhelming need, there are many gaps in the provision of services to youth in the foster care system (Halfon, Mendonca, & Berkowitz, 1995; Halfon, Zepeda, & Inkelas, 2002; Kerker & Dore, 2010; Landsverk et al., 2006). According to Burns et al. (2004) fewer than half of the children in foster care who need mental health services will receive them. Also absent from the literature is information about the youth in foster care who do receive mental health services. Surprisingly little is known about the pathways of foster children through the mental health service delivery process. As noted by Levitt (2009), "Little research is available to describe current practices for mental health screening and assessment in child welfare settings" (p. 32). In fact, there are no published studies about the reasons for mental health referrals, the sources of referrals, and predictors of length of mental health treatment. The current study was designed to begin to fill that gap in the knowledge base by analyzing existing routine service delivery data.

Specifically, the study was conducted to examine four variables of interest: source of referral, reason for referral, adverse childhood experiences, and length of treatment. For each of these four variables we examined associations with age and gender. Age and gender were selected because information about youth age and gender are readily available at the onset of treatment and – if found to be related to youth trajectory in treatment – could be the focus of targeted interventions.

2. Methods

The study was conducted at a single foster care agency located in a large metropolitan area. As per federal and state law, all children entering a foster placement were screened within 30 days of admission to the agency for mental health service need. In addition, at any point in the child's placement at the agency, any number of individuals could make a referral for the child to receive mental health services including, for example, the child, the child's caregiver, the case planner, and so forth. At this agency, virtually all children referred to mental health treatment were seen by one of the agency's own staff clinicians. These clinicians were hired by the agency and located within the agency's own offices throughout the city. This is one of several service delivery models employed by foster care agencies.

2.1. Sample

Children receiving mental health services within the foster care agency comprised the sample for this study. All children at the foster care agency referred for mental health treatment to an agency clinician during calendar year 2014 (n = 156) were included in the study. Fifty-Nine (37.8%) of the youth were male and 97 (62.2%) were female. Of the 156 cases, 138 received some agency-based mental health services and 18 did not. Of those 18, four youth declined treatment, three were discharged prior to treatment starting, two were referred to community services, one youth had a change in permanency to adoption and the work with the birth parent – the reason for the referral – was no longer needed, two youth were AWOL, one youth was waitlisted for treatment,

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and for five youth the reason for the lack of treatment was unknown. There was no difference between genders in terms of who got treatment and who did not, but there was an effect for age at the time of referral. Those in treatment were younger (mean age = 11.8 years, SD = 5.0) than those not in treatment (Mean age = 15.9 years, SD = 3.2), t (29.6) = 3.4, $p < 0.001$.

2.2. Data collection forms

As part of their ongoing work responsibilities, all agency clinicians completed a series of paper and pencil case planning and record keeping forms to help the agency monitor the provision of mental health treatment to the child clients. These routinely completed forms provided the data for the study. Copies of the forms were sent to the research department for ongoing data extraction and data entry in order to facilitate the provision of feedback to the clinicians and administrators about the provision of mental health services. Data were entered into an SPSS data file on an ongoing basis. Because de-identified routinely collected data were used, IRB approval was not necessary.

2.2.1. Referral form

This three-page form was completed whenever a child was referred for therapy. Six variables were extracted from this form for the current study: (1) the date of the referral, (2) the source of the referral (recoded as mandated screening or other source); (3) the reasons for referral (17 options were listed and the person completing the referral form could check off as many as applicable including problems with birth family, school attendance, and the like), (4) the date of the first session if the youth actually attended treatment, (5) the child's birthdate from which the child's age at the time of the referral could be calculated, and (6) the child's gender.

2.2.2. Dates of clinical

This one-page form was completed on a monthly basis by the mental health clinician to indicate the number of sessions scheduled and attended for each client. By reviewing the chronology of these forms it was possible to ascertain the number of months of treatment each youth obtained, with each month counting as long as the child had at least one session per month. Nine months was the maximum in order to include everyone in the sample and was perceived to be a reasonable amount of time for a youth to be in treatment.

2.2.3. Initial treatment plan

This four-page form was completed by the clinician after each youth client had been in treatment three months. It contained both qualitative and quantitative data summarizing the clinician's understanding of the client's history, presenting problems, and initial treatment goals. Included on the form was a list of adverse childhood experiences which the clinician checked off, reflecting the clinician's understanding of the child's history. That understanding was based on discussions with both the youth and his or her family, discussions with the family's case planner, as well as review of any documents that might be available. Eight adverse childhood experiences could be indicated: physical abuse, sexual abuse, emotional abuse/neglect, physical neglect, loss/separation from attachment figure(s), parental substance abuse, witnessing/experiencing domestic violence, and parental mental illness.

2.2.4. Closing treatment plan

This four-page form is completed by the clinician upon termination of the youth's mental health treatment. From this form a single item was extracted: reason for termination of treatment. This was comprised of a checklist of seven possible reasons (more than one could be checked) such as reunification, youth stopped attending, AWOL, and so forth.

Table 1
Proportion of youth with each reason for referral (n = 156).

	N	%
Birth family issues	90	58.4
Depression/anxiety	61	39.1
Behavior problems	57	36.5
Trauma	54	35.1
Poor adjustment in foster home	30	19.2
School attendance	12	07.7
School achievement	31	19.9
Low self esteem	28	18.1
Attachment issues	28	18.1
Relationship problems	24	15.6
School behavior	24	15.4
ADHD	25	16.0
Self harm	12	07.8
Sexual behavior problems	12	07.8
AWOL	09	05.9
Suicidal	08	05.1
Psychiatric hospitalization	07	04.5

3. Results

3.1. Referrals for treatment

We began by examining the referral source for the sample of 156 children. We examined what proportion of referrals came from the routine mandated screening as opposed to some other source (such as the child, the caregiver, the courts, the case planner, and so forth). We found that 28% of the referrals came from the mandated screenings while the remaining 72% came from other sources. Next we asked what proportion of the youth referred for mental health treatment actually began treatment, by referral source. We found that close to 88% of all youth who were referred for mental health services actually received those services, regardless of whether the referral was from a routine screening or other source.

Next, we examined the reasons indicated on the referral form for the referral. Seventeen possible reasons could be checked off, with more than one reason being checked per child. The frequency of each reason is presented in Table 1.

The most commonly indicated reasons for treatment were birth family issues, depression/anxiety, behavior problems, and trauma. No other reason was indicated for more than 20% of the cases. Next, we calculated the total number of reasons per youth. These data are presented in Table 2.

As can be seen, about one fifth of the sample had only one reason for referral, about one fourth had two reasons, and the remaining roughly half of the sample, had three or more different reasons for being referred to mental health treatment.

Associations between and age and gender and number of reasons for referral revealed a statistically significant association with age (R = 0.25, $p < 0.001$) but not gender. Older youth were referred for treatment for a greater number of reasons. We also conducted a t-test comparing source of referral (routine screening or other) on number of

Table 2
Number of reasons for the referral.

	N	%
1	30	19.5
2	38	24.7
3	27	17.5
4	22	14.3
5	14	09.1
6	05	03.2
7	13	08.4
8 or more	05	03.2