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Longitudinal trends in substance use and mental health service needs in child welfare☆

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ABSTRACT

Caregiver substance use and mental health problems have long been discussed as concerns in promoting positive child welfare outcomes. Yet the absence of longitudinal data focused on racial/ethnic differences in service needs and substance use has limited child welfare systems in their ability to address potential disparities. This study examines racial/ethnic trends in service needs and patterns of substances used among child welfare-involved caregivers over a 15-year period (2000–2015) from a large, urban county located in the Midwestern United States. Substance use service needs showed an increase over time among White non-Hispanic individuals, and declined over time for all racial/ethnic minority groups. Mental health service needs increased over time, with White non-Hispanic individuals experiencing the largest increase. Co-occurring service needs showed a moderate increase for all groups. Trends associated with service needs across the lifespan were relatively similar across racial and ethnic groups, with needs peaking between ages 30 and 35. When examining specific substances used, cocaine use decreased over time for all individuals. However, marijuana use increased substantially for Black/African American individuals, while opioid use increased substantially for White non-Hispanic individuals. These results highlight key areas where trends among child welfare-involved caregivers differ from population-based trends and suggest that improved coordination between child welfare agencies, mental health and substance use treatment providers may be a key step in reducing the disparities observed.

1. Introduction

Child welfare agencies are responsible for providing a range of services to families in pursuit of enhancing child safety, establishing permanency, and facilitating healthy child development. These responsibilities require internal expertise to identify needs and ongoing partnerships with external service providers to offer specialized care when needed. One such support includes meeting caregiver needs for substance use and mental health services. Child welfare agencies must maintain the capacity to screen for substance use and mental health service needs and make referrals to treatment specialists when necessary. However, given the breadth and depth of services needed, matching caregivers with the requisite support services is an ongoing challenge for child welfare agencies (Courtney, Barth, Berrick, Brooks, et al., 1996). The task is further complicated by population level shifts in the popularity of particular substances, along with racial/ethnic variations in use. Because different substances require different treatment approaches, child welfare agencies must monitor trends in substance use in order to provide the necessary training to their staff when the use of new substances becomes prevalent among their clientele, and to ensure that referrals to appropriate external service providers are available.

Historical trends of racial/ethnic disparities in matching services to caregiver needs (Courtney et al., 1996), further support that identifying disparities in substance use and mental health service needs among child welfare-involved caregivers remain an area in need of attention (Hill, 2006). In order to identify racial/ethnic differences in substance use and mental health, we examine trends in child welfare-involved caregivers' needs for substance use and mental health services, as well as patterns of substances they use over a 15-year period, in a large, urban county located in the Midwestern United States.

1.1. Substance use and mental health among child welfare-involved caregivers

Substance use and mental health problems are common issues that child welfare-involved families experience (Brook & McDonald, 2009; Kemp, Marcenko, Hoagwood, & Vesneski, 2009; Libby, Orton, Barth,

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Webb, et al., 2006; Staudt & Cherry, 2015). About 75% of foster care placements are attributable directly or indirectly to caregiver substance use (Young, Gardner, & Dennis, 1998). Also, up to 60% of child welfare-involved caregivers have problems related to substance use, and 30–35% experience mental health-related problems (Barth, Wildfire, & Green, 2006; Staudt & Cherry, 2015).

Substance use and mental health problems have been documented as key barriers to reunification and child development for child welfare-involved families (Connell, Bergeron, Katz, Saunders, et al., 2007; Rinehart, Becker, Buckley, Dailey, et al., 2005), and precipitate an increased need for effective intervention and treatment (Burns, Phillips, Wagner, Barth, et al., 2004; Keller, Salazar, & Courtney, 2010; Keller, Wetherbee, Le Prohn, Payne, et al., 2001). While innovative practices focused on mental health and substance use service delivery for child welfare-involved caregivers have shown success (Marsh, Ryan, Choi, & Testa, 2006; McComish, Greenberg, Ager, Essenmacher, et al., 2003; Ryan, Marsh, Testa, & Louderman, 2006), a challenge for child welfare agencies is that population trends and shifts in substance use and mental health service needs often go unobserved or undocumented, which can prevent the development of needed partnerships with external service providers, and influence whether individuals needs are met.

1.2. Substance use and mental health trends in the United States

1.2.1. Services needs

Nationwide population trends suggest that approximately 6–10% of adults in the United States have substance use-related service needs, and 12–20% have mental health-related service needs; While treatment needs for substance use has remained relatively stable (Ilgen, Price, Burnett-Zeigler, Perron, et al., 2011) or has slightly decreased (Havassy, Alvidrez, & Mericle, 2015) over the past 15 years, mental health service needs have likely been increasing over time (Olfson, Marcus, Druss, Elinson, et al., 2002; Kessler et al., 2005). When examining service needs associated with co-occurring substance use and mental health problems, trends suggests an overall slight increase in need (Case, Olfson, Marcus, & Siegel, 2007; Larkin, Claassen, Emond, Pelletier, et al., 2005), with gaps between Black/African American, Hispanic, and White non-Hispanic individuals' mental health service needs widening over time (Cook, McGuire, & Miranda, 2007). However, child welfare-involved caregivers represent a group with a higher-than-average level of risk for substance use and mental health problems (Connell et al., 2007; Rinehart et al., 2005), and this group tends to have a higher proportions of racial/ethnic minority individuals than the broader United States population (Boyd, 2014), leaving doubt as to whether national population trends in service needs best capture or reflect the needs of this group.

1.2.2. Substances used

While child welfare-involved caregivers are a distinct group, U.S. population-level trends can offer insight into what types of substances are currently being used. These trends suggest that while alcohol and cocaine use have decreased steadily over the past decade, use of other drugs including marijuana and opioids have consistently increased (SAMHSA, 2013). Understanding these trends is important in the successful treatment of substance use behaviors, as different substances used require different forms of treatment. However, many caregivers who experience substance use problems, mental health problems, or both tend to be younger in age compared to caregivers with no substance use, mental health, or co-occurring problems (Besinger, Garland, Litrownik, & Landsverk, 1999). Thus, an understanding of how different substances used vary both over time and across the lifespans of child welfare-involved caregivers in particular may assist in identifying current substance-specific treatment needs.

Yet, to date there has been no examination of trends in the types of substances used and how they vary across the lifespan among child welfare-involved caregivers. This is a critical gap in the literature, because child welfare agencies must monitor the specific needs of their clients at intake and be prepared to adapt both in terms of internal diagnostic expertise and the maintenance of appropriate external partnerships so that clients can be linked to the proper set of treatment services in a timely manner.

1.3. Racial/Ethnic differences in substances used

Racial/Ethnic variations in substances used suggest that while alcohol and cocaine use are relatively similar among racial/ethnic groups (Evans-Polce, Vasilenko, & Lanza, 2015; Palamar, Davies, Ompad, Cleland, et al., 2015), there is some evidence to suggest that the prevalence of marijuana use among Black/African American adults is higher than that of White non-Hispanic adults (Chen & Jacobson, 2012; Evans-Polce et al., 2015). However, the prevalence of prescription opioid use is higher among White non-Hispanic adults compared to other racial/ethnic minority adults (Sullivan, Edlund, Zhang, Unützer, et al., 2006; Chen, Kurz, Pasanen, Faselis, et al., 2005; Kelly, Cook, Kaufman, Anderson, et al., 2008). Yet given the higher proportions of racial/ethnic minority individuals involved in child welfare compared to the broader United States population (Boyd, 2014), it is again unclear whether national trends in substances used best capture or reflect the behaviors of this group.

1.4. Current study

In the absence of empirical data concerning trends in services needs and substances used, we begin by examining trends over time concerning service needs of caregivers at intake (i.e., when a foster child is placed in their care) to determine whether any differences exist among specific racial/ethnic groups, and whether these needs vary across the lifespan. We then examine the specific substances used over time among different racial/ethnic groups. Using child welfare data from the state of Illinois, we examine these trends between the years 2000 and 2015.

2. Methods

2.1. Data source

Data for the present study are drawn from the administrative records of the Illinois Title IV-E Alcohol and Other Drug Abuse (AODA) Demonstration Waiver. Initiated on April 28, 2000, the AODA demonstration allows for innovation in the child welfare system's delivery of parental substance abuse services. To be eligible for the demonstration project, parents must be classified as being in need of referral to substance abuse treatment according to the criteria established by the American Society of Addiction Medicine (ASAM). These criteria specify four levels of care: outpatient, intensive outpatient and partial hospitalization, medically monitored inpatient (residential treatment), and medically managed intensive inpatient treatment (O'Toole et al., 2004). Parents are referred to the county's Juvenile Court Assessment Program (JCAP) for such assessments at the time of their temporary custody hearing or at any time within 90 days subsequent to the hearing if substance use is suspected by a child welfare worker or if families report a substance use service need. Masters level certified and/or licensed counselors provide alcohol and drug assessments for adults 18 years and older, and the findings from these assessments are presented to the parents along with their child welfare caseworker.

JCAP is located on site at the Juvenile Court Building in order to provide convenience and easy accessibility for caregivers who have lost custody of their children and who are in need of an assessment to determine if a referral to drug treatment is appropriate and necessary. On average, JCAP conducts approximately 550 assessments within the court building each year. This study's total sample consisted of 11,570