

**An Analysis of Mental Health Issues  
in States' Child and Family Service Reviews and  
Program Improvement Plans**

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## INTRODUCTION

The Child and Family Service Reviews (CFSR) conducted by the U.S. Department of Health and Human Services, in partnership with state governments, are designed to help states improve child welfare services and the outcomes for families and children who receive services by identifying strengths and needs within state programs, as well as areas where technical assistance can lead to program improvements.<sup>1</sup> The CFSR process is managed at the federal level by the Children's Bureau in the Administration for Children and Families; however, findings from the Reviews are important for the work of other federal agencies. In 2003, a workgroup of staff from the Administration for Children and Families and from the Substance Abuse and Mental Health Services Administration was formed to identify common concerns among the two federal agencies, share information, and work on strategies to improve access to quality mental health and substance abuse services for children and families in the child welfare system. This workgroup asked the National Technical Assistance Center for Children's Mental Health at Georgetown University and the Technical Assistance Partnership for Child and Family Mental Health at the American Institutes for Research to conduct a mental health analysis of the CFSR findings. This analysis is based upon findings from Final Reports in 38 States and Program Improvement Plans (PIPs) from 28 States.<sup>2</sup> It will be updated as additional Final Reports and PIPs are available and reviewed.<sup>3</sup>

The concerns about mental health services, confirmed in the State level data cited below,<sup>4</sup> demonstrate why it is important to conduct an analysis of specific mental health issues in the Final Reports and the PIPs, and to work collaboratively across child-serving systems and with families to transform and build relevant, effective service systems to meet the mental health needs of children and families in child welfare.

Mental health related findings from 2001– 2002 Reviews of 32 States show that<sup>5</sup>:

- ◆ **Thirty-one (31)** States did not achieve substantial conformity with *Well-Being Outcome 3 – children receive adequate services to meet their physical and mental health needs*.<sup>6</sup>

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<sup>1</sup> Source: summary description of Child and Family Service Reviews distributed by the Administration for Children and Families and used in a national teleconference call sponsored by the National TA Center for Children's Mental Health at Georgetown University, February 26, 2004.

<sup>2</sup> **FINAL REPORTS:** AL, AK, AZ, AR, CA, CO, CT, DE, DC, FL, GA, ID, IN, IA, KS, KY, MA, MI, MN, MT, NE, NH, NM, NY, NC, ND, OH, OK, OR, PA, SC, SD, TN, TX, UT, VT, WV, WY

**PIPs:** AL, AK, AZ, AR, CA, CT, DE, DC, FL, GA, IN, KS, MA, MN, MT, NE, NM, NY, NC, ND, OH, OR, PA,, SD, TN, TX, VT, WV

<sup>3</sup> For an explanation of the CFSR process, final reports, and program improvement plans, see Appendix A.

<sup>4</sup> Data cited in this introduction are taken from *Preliminary Findings of the Child and Family Services Reviews in Fiscal Years 2001 and 2002 (DRAFT – 2/04, James Bell Associates)* and from presentations offered on the Web site of the Children's Bureau.

<sup>5</sup> The reviews examine 7 outcomes, 23 indicators, and 7 systemic factors. See Appendix B for a complete list.

<sup>6</sup> To achieve substantial conformity in this outcome, a state has to achieve the outcome for 90% of the children in the sample of cases reviewed.

- ◆ For **two (2)** States, Item 23 – *Mental Health of the Child* – was rated as a strength. For **30** States, it was rated as an area needing improvement.

A content analysis was conducted by the Administration for Children and Families on the Final Reports for the FY 2002 States. It identified common concerns across States for all 23 indicators. Common concerns<sup>7</sup> related to mental health issues and family participation in planning included:

- ◆ Scarcity of mental health services for children and concern about the quality of those services that are available (**11** States), and inconsistency in conducting mental health assessments for children when an assessment is warranted (**6** States) – *Item 23*<sup>8</sup>
- ◆ Inconsistency in providing appropriate services to meet the identified needs of children and parents (**15** states) - *Item 17*<sup>9</sup>
- ◆ Fathers, mothers, and children are not routinely involved in case planning (**15** States) - *Item 18*<sup>10</sup>
- ◆ Scarcity of appropriate placement options for children with developmental disabilities or with behavioral problems (**9** States) – *Item 6*<sup>11</sup>

Case level data relevant to the 747 individual children who made up the sample of cases<sup>12</sup> that were reviewed in 2002 showed that states did not perform as well on mental health indicators as they did on many other indicators.

- For 15 of the 23 items that were rated, at least three-fourths of the children’s cases were rated as a strength. However, Item 23 (mental health of the child), was rated as a strength for only **72.3%** of the children reviewed in 2002. This item also was rated as a strength more often for children in foster care (**77.3%**) than for children in their own homes (**64.3%**).
- ◆ *Well-Being Outcome 3* (child’s physical and mental health needs) was substantially achieved for **69.4%** of the children reviewed. This outcome was achieved more often for children in foster care (**72.2%**) than for children in their own homes (**65.2%**). The range of substantial achievement for this outcome among all the States in 2001 and 2002 was **55.1%** to **92.1%**.

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<sup>7</sup> A concern was “common” if it was relevant to 6 of the 15 States reviewed in FY2002. Concerns were identified either by case reviewers or by stakeholders interviewed during the onsite CF SR.

<sup>8</sup> Item 23 – mental health of the child

<sup>9</sup> Item 17 – needs and services of child, parents, foster parents

<sup>10</sup> Item 18 – child and family involvement in case planning

<sup>11</sup> Item 6 – stability of foster care placement

<sup>12</sup> The sample of cases reviewed during 2001 and 2002 included 1,584 children in 32 States. Fifty (50) children were selected for review in each State, although in a few instances the number was less than 50 if the child did not meet the criteria for inclusion in the review. This case-level data analysis provided by the Children’s Bureau includes only the 747 children from the 2002 reviews (in 15 States) because a standard database was not developed for entering case level data until the FY 2002 reviews.

## METHODOLOGY AND FORMAT FOR THE REPORT

To complete this analysis, findings related to Well-Being Outcome 3 (*children receive adequate services to meet their physical and mental health needs*) and Item 23 (*mental health of the child*) were studied. We also reviewed Well-Being Outcome 1 (*families have enhanced capacity to provide for their children's needs*), and Item 17 (*needs and services*). We reviewed two Systemic Factors: #5 - Service Array (Items 35 - 37)<sup>13</sup> and #6 – Agency Responsiveness to the Community (Item 38 – 40).<sup>14</sup> A word search was conducted to locate other sections of the Final Reports and PIPs that discuss mental health issues. The words used in the search were *mental health, behavioral health, behavior, emotional, psychological, counseling, wraparound, and therapy*.

As we reviewed the findings from the Final Reports and the PIPs, we sought answers to 10 specific questions about mental health screening and assessment, mental health services, and the extent to which mental health issues are addressed in the PIPs. The information in this report summarizes the responses to the 10 questions and identifies the trends that emerged from the Final Reports and from the PIPs.

- ◆ **Section 1** describes trends related to mental health issues found in the 38 State Final Reports.
- ◆ **Section 2** describes trends related to mental health issues found in the 28 State Program Improvement Plans.
- ◆ **Section 3** provides a summary of the challenges and solutions related to mental health needs and services that are described in the Final Reports and PIPs.

We label the issues presented in this analysis as *trends* because each of them was described in several State Final Reports or PIPs. For most trends, we include the number of States that mentioned them. We believe that many of the trends are true for a greater number of States than indicated in this analysis; however, we only counted States that mentioned the issues in their Final Reports or PIPs. It is important to note that sometimes the Reports and PIPs describe inconsistent trends, both across different States and within each individual State.

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<sup>13</sup> Item 35 – service array in place, Item 36 – accessibility, Item 37 - individualized services

<sup>14</sup> Item 38 - engaging other stakeholders, Item 39 - annual progress reports, and Item 40 - coordinated with other federal programs

## SECTION 1 – TRENDS IN FINAL REPORTS

The four questions posed during our review of the 38 Final Reports included:

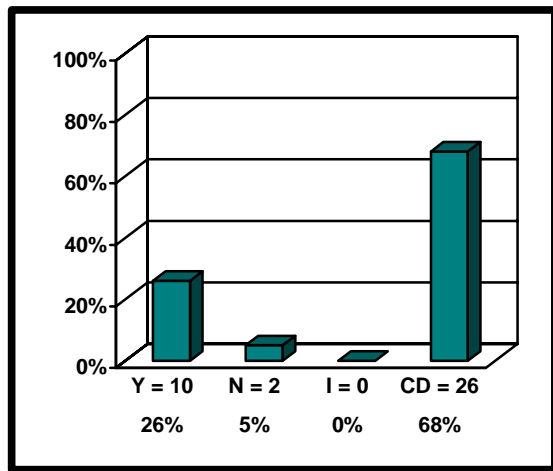
1. Does state policy *require* mental health screening or assessment of children in foster care?
2. Do children in foster care *receive* an initial formal mental health screening or assessment?
3. Are adequate services provided to meet the identified mental health needs of children in the case sample?
4. Is there a scarcity or lack of MH services to meet the needs of children in the case sample?

When a Final Report provided consistent information about any of these four questions, we counted it as a *Yes* or *No* response. When a Report provided inconsistent information, e.g., stakeholder perceptions varied, or individual children's experiences were so different that a conclusion could not be drawn, we categorized this as demonstrating *Inconsistent Practice*, i.e., both good and bad practices were noted in the Final Report. It is possible that many States categorized as *Cannot Determine* actually should be a *Yes*, *No*, or *Inconsistent Practice* response; however, if we were unable to find reference to the question in the Final Report, we categorized the response as *Cannot Determine*.

### **Mental Health Assessments**

#### **1. Does state policy require mental health screening or assessment of children in foster care?**

Final Reports were reviewed to determine whether State policies require that children in foster care receive a mental health screening or assessment. The Reports indicated that **10** States require mental health screening or assessment at or near entry into foster care, and **two (2)** do not. However, as the graph following shows, in the majority of State Final Reports (**26**), it was not possible to determine whether the States required such mental health screening or assessment. In the states requiring screening and/or assessment, they differed in which children are assessed, in who conducts the assessments, and in the timeframes for providing screening and assessment.



N=38

Y = Yes  
N = No

I = Inconsistent Practice  
CD = Cannot Determine

**Four states** required that *certain groups of children* be assessed, e.g., children in certain age groups (3 and older, 5 and older, 6 and older); or children whose parental rights have been terminated and who have suffered from sexual abuse, serious physical abuse, or mental illness. In **one (1)** State, a developmental assessment met the requirement for very young children.

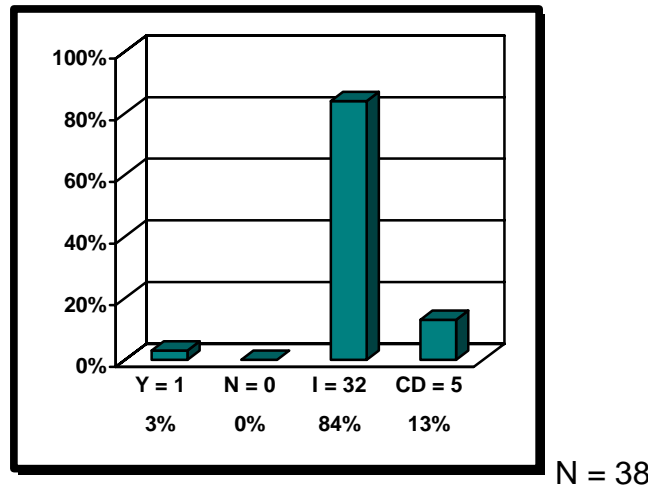
States differed in *who conducted the assessments*, from the child's social worker to a licensed mental health professional trained in children's assessments. **One (1)** State was using an Initial Family Assessment (IFA) to replace its current investigation and assessment process. The IFA requires social workers to assess children's cognitive, developmental, and emotional functioning. The state anticipated that this would strengthen the social worker's attention to children's mental health issues.

The *timeframes* within which assessments must be conducted also differed among States. **One** State required an initial mental health screening within 24 to 48 hours of entry into foster care and continuing assessment of mental health needs during monthly contacts with the child and foster parents. Another State required a 30-day mental health assessment for children entering care, with an annual mental health assessment as long as the child remains in custody. **Two** other States require assessments within 60 days of entering care.

## 2. Do children in foster care receive initial formal mental health screenings or assessments?

Only **one (1)** State's Final Report indicated clearly that children entering foster care receive an initial formal mental health screening or assessment; however, none of the Reports stated that children do *not* receive such screening or assessment. Instead, information from almost all of the States (**31**) shows that practice is inconsistent. Some children receive mental health assessments and others do not. In **five (5)** of the States, it could not be determined from the Final Reports whether children are screened and assessed for mental health issues or not. **Five (5)** States described positive results from the screening and assessments. Multiple problems that resulted from not conducting

assessments were cited by **15** of the States that did not consistently provide mental health assessments.



Y = Yes  
N = No

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CD = Cannot Determine

*Positive comments about assessments included the following:* individualized mental health needs of children and families are being met; needs were identified as soon as the child came into custody, and services were provided; and mental health evaluations occurring prior to placement are effective in identifying physical, educational, and mental health issues that affect placing children in the least restrictive environments to meet their needs. **One (1)** State incorporates mental health assessments in each child and family plan, monitors the appropriateness of the treatment received, and adapts the child and family plan as needed to address a child's mental health needs.

*Problems cited among 15 States included:* the lack of initial assessment resulted in mental health needs not being met or children being hospitalized; agencies lacked a thorough assessment to guide treatment and placement decisions; assessments needed to enhance placement stability were not available; some children were discharged from care without having their mental health needs identified and addressed; the mental health needs of some family members were met, but not others; case plans for children in juvenile justice did not address their mental health needs; and children did not receive timely mental health treatment. In several States, it was noted that assessments were not conducted consistently. Even children who had been exposed to traumatic events and those who showed evidence of potential mental health issues did not receive assessments consistently. **Two (2)** States noted that the agency's risk assessments, conducted as part of the maltreatment investigation, were not sufficiently comprehensive to capture underlying problems in the family, such as mental health needs and domestic violence.

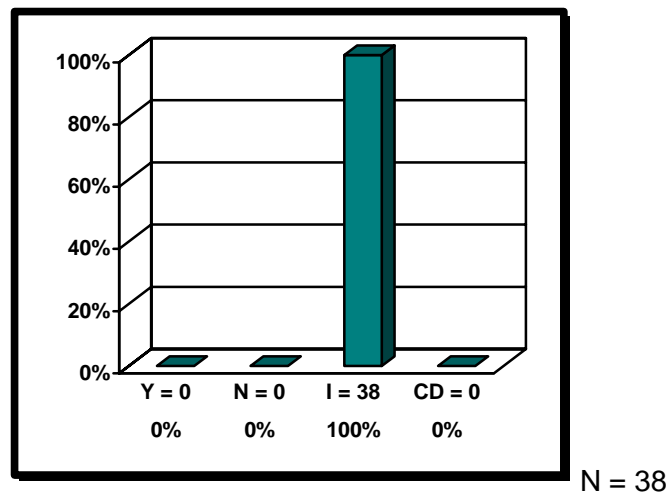
Reasons cited for not providing assessments included the child's age, the availability of mental health resources, difficulty in getting assessments done, and delays in assessment and treatment. **Eleven (11)** States indicated that even when mental health

needs were assessed, needed services were not provided, were ended prematurely, or no follow-up monitoring was provided.

### **Ongoing Mental Health Services**

#### **3. Are services provided to meet the mental health needs of children in the case sample (in home and in foster care)?**

The services provided to meet the mental health needs of children in the case sample varied within every state. The graph below reflects inconsistent practice within each state. None of the Final Reports stated clearly that all children receive or do not receive mental health services to meet their mental health needs. Many States (**12**) listed a range of available mental health services, but no State reported that these services are available to all of the families and children who require them; and even when states report the general availability of services, some report long waiting lists to access them. Many of the services that are more commonly available are those that are most traditionally part of community systems and do not reflect the more complex needs that children and families in the child welfare system present.



Y = Yes            I = Inconsistent Practice  
N = No            CD = Cannot Determine

**Twelve (12)** States reported a range of available services to meet the mental health needs of children and families:

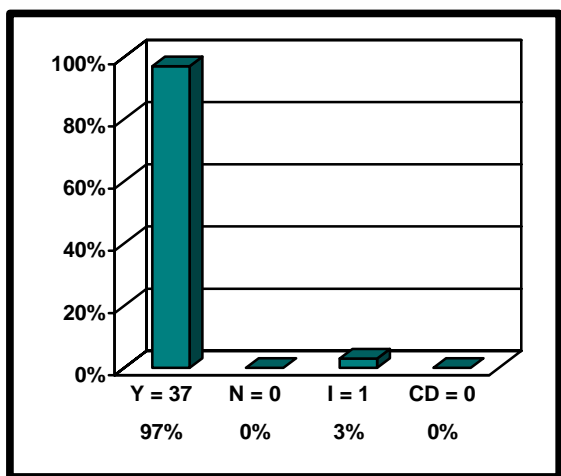
- ◆ Inpatient and outpatient services
- ◆ Psychological testing
- ◆ Individual, family, and group counseling
- ◆ Parent and child therapy
- ◆ Medication monitoring
- ◆ Residential care
- ◆ Therapeutic foster homes
- ◆ Substance abuse services
- ◆ Services for children who have been sexually abused

- ◆ Psychiatric services evaluations (for all family members)
- ◆ Mental health services for uninsured families
- ◆ Mental health information distributed in Spanish

**Five (5)** States report waiting lists from four weeks to six months for certain mental health services including: services ordered by the court, mental health evaluations, in-home counseling, parent aid services, psychiatric services, psychological evaluations, and in one state, Medicaid cards. **One (1)** State reported that it often takes up to four weeks to obtain a child sexual abuse forensic examination.

#### 4. Is there a scarcity or lack of Mental Health services to meet needs of children in the case sample?

The chart below provides evidence of the scarcity of mental health services to meet the needs of children and families in the child welfare system. All but one State Final Report described a lack of mental health services. The Reports noted some services that are consistently scarce.



N=38

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States described a dearth of services for families whose children were removed due to parental substance abuse (**10 states**), as well as for adolescents in care who abuse substances. **One (1)** State reported that this affected its ability to reunify families. In addition, **18** States reported a lack of specialized mental health services for children in both foster care and child protective services. There was a specific reference to services or interventions that address the trauma resulting from maltreatment and separation of children from their families. **Twenty-seven (27)** States (not always the same ones) mentioned that one or more of the following services are in insufficient supply:

- ◆ Substance abuse services for children and families (**12 States**)
- ◆ Treatment foster homes (**11 States**)
- ◆ Treatment for youth who have been sexually abused or have sexually offended (**7 States**)

- ◆ Treatment of adolescents with seriously emotional disorders who cannot live at home (4 States)
- ◆ Placement resources for children with developmental disabilities – MR/DD (4 States)
- ◆ Day treatment, after school programs and other home based services (3 States)
- ◆ Local residential treatment facilities – precipitating out of state placements (3 States)
- ◆ Culturally relevant services for a growing immigrant population (2 States)
- ◆ Placement options for medically fragile children and youth (2 States)
- ◆ Mental health services for youth transitioning from residential care to community based placements (2 States)
- ◆ Crisis intervention services for foster parents to prevent placement disruptions (2 States)
- ◆ Respite care services (2 States)
- ◆ Medication management for children in their own homes (1 State)

### **Provider Issues**

There is a widespread shortage of mental health providers who are skilled in treatment of the special issues presented by children and youth who have experienced the trauma associated with abuse, neglect, sexual abuse, multiple out-of-home placements, parental substance use, and domestic violence. **Four (4) States** describe factors contributing to this shortage as: low reimbursement rates paid by Medicaid that limit the number of providers doing evaluations and therapy; and a high turnover rate among counselors, social workers, and therapists. This presents a major challenge to the provision of services. States report that they have insufficient:

- ◆ Providers to address the issues related to child abuse, neglect, and adoption, (6 States)
- ◆ Providers to address issues of sexual abuse, both youthful offenders and victims (5 States)
- ◆ Child psychiatrists (4 States)
- ◆ Providers who have the expertise to, or choose to serve children (4 States)
- ◆ Providers who accept Medicaid (3 States)
- ◆ Caseworkers who have the experience or training to accurately assess the need for mental health services (3 States)
- ◆ Providers to monitor medication (1 State)

### **Rural Issues**

Rural areas (**10 States**) face many of the same challenges as urban and suburban areas, but distance introduces yet another hurdle. States report that the majority of mental health providers are clustered in and around urban areas. The distance factor for rural areas reduces access to mental health services for children and families and contributes to long waiting lists. Many providers are unwilling to relocate to rural areas. A half-day of driving to and from a services site is not uncommon in many rural areas. It is also very difficult to keep families engaged in family therapy when children are placed at great distances from their families of origin. Of particular concern to states is the lack of the following specialized services in rural areas:

- ◆ Psychological evaluations
- ◆ Psychiatric evaluations

- ◆ Crisis shelters
- ◆ Residential treatment facilities
- ◆ Therapeutic foster care
- ◆ Substance abuse treatment
- ◆ Sexual abuse treatment

## **Funding Issues**

Funding issues mentioned in several Final Reports focused on three trends: 1) the impact of budget deficits; 2) managed care; and 3) creative funding strategies.

### The Impact of Budget Deficits (9 States)

The current economic climate in the country and state budget deficits have impacted the availability of mental health services in a number of states. Measures taken to address budget deficits include a narrowing of the population of children who can access services to those with a diagnosis of serious emotional disturbance, or those who are overtly acting out; a lack of funding for services for children who are moderately unstable; reduction in community contracts; and reduced ability to support interagency initiatives. On the other hand, **one (1)** State legislature requires that the public mental health system serve both children at risk and children who are diagnosed as emotionally disturbed.

Additional effects of budget cuts include: longer waiting lists and shortened treatment sessions; limited funds for psychological exams; limited funding for services for children who live with relatives in unlicensed homes and whose parental rights have not been terminated; mental health providers not reimbursed for participation in court hearings, case staffings, or multidisciplinary team meetings; decrease in the availability of mental health services; low reimbursement rates for Medicaid providers; and limits on the types of services that can be reimbursed by Medicaid.

### Managed Care (7 States)

Final reports that mentioned managed care generally were not positive and indicated that managed care has limited the number of therapy sessions, restricted treatment, created barriers, not covered preventive services, eroded the available service array, and presented problems in obtaining services for family members, e.g., substance abuse services (**6 States**). However, **one (1)** State that included children's mental health care in a managed care waiver requires primary care physicians to incorporate child mental health and substance abuse screening for all children and youth (birth to age 20) in Early and Periodic Screening Diagnosis and Treatment exams.

### Funding Strategies (5 States)

Funding strategies included expanded coverage for children of parents who have no health insurance through the State Child Health Insurance Program (SCHIP); flexible funding available for some mental health services; and the integration of financial resources across departments and child-serving agencies to develop systems of care in local communities for children with serious mental health needs. **One (1)** state noted that having different funding sources (e.g., Title IV-E and Medicaid) for different child-serving agencies created barriers to coordination and collaboration.

## **Coordination and Collaboration**

Coordination and collaboration related to mental health issues depicted in the Final Reports focused on several trends: while collaboration occurs in many states, it continues to be a challenge; strong state level collaboration does not necessarily ensure collaboration and service coordination at the local level; certain barriers to collaboration continue to exist; and states use a variety of strategies to overcome barriers and strengthen cross-system collaboration.

### Signs of Strong Cross-system Collaboration Exist and Challenges Remain

Many State Final Reports **(26)** described efforts of child welfare agencies to collaborate at the system level with other child-serving systems, including mental health, and also attempts to coordinate services across systems at the individual child and family level. In spite of the extent, significance, and value of such collaborative efforts, many of the same States find successful service coordination to be difficult, and problems persist in accessing certain services. The Final Reports demonstrate that while promising, these efforts (e.g., collaborative teams, special initiatives, shared funding, Memoranda of Agreement) have not been enough to resolve ongoing service coordination issues. The Reports emphasize how important it is for collaboration to be an ongoing process in order to resolve problems and issues as they arise.

For example, **one (1)** State has several promising initiatives underway to improve and expand service coordination; however, the impact of these initiatives has not been enough to allay concerns about ongoing coordination issues between social services, mental health, mental retardation, and the school systems that negatively affect families' access to services. In another state, even though mental health, child welfare, and substance abuse engage in joint treatment planning to bring together all parties, identify needs, and develop a comprehensive plan, there are considerable communication barriers among the same agencies.

### Impact of State Level Collaboration

**Four (4)** Final Reports that described strong cross-system collaboration at the State level, also portrayed the difficulties in ensuring the same level of collaboration at the local/county level for a number of possible reasons – the autonomy/independence of county departments, lack of involvement of the counties in the state level collaboration, the challenges of getting local child welfare and mental health agencies to work together, and the inability of social workers to follow through due to high caseloads. An additional State indicated that systemic issues among agencies at the state level created barriers for families trying to access services at the local level.

### Barriers to Collaboration

Additional barriers to collaboration cited by **six (6)** States in the Final Reports include:

- ◆ Children's mental health services are delivered by multiple agencies and providers, and it is challenging to coordinate them
- ◆ Child welfare and mental health agencies are administered differently, one at the state level, the other at the county level

- ◆ Turnover of personnel in leadership positions
- ◆ Different funding sources, different structures, and different mandates for child welfare, mental health, and alcohol and drug services
- ◆ Complex and problematic relationships between agencies
- ◆ Lack of cooperation from mental retardation/developmental disabilities
- ◆ Weak relationship between local human service agencies and the mental health authority

### Collaborative Strategies

While barriers exist, the Final Reports described many strategies for collaboration and service coordination including:

- ◆ Interagency teams and task forces (**13** States)
- ◆ Collaborative efforts to build the service array and increase service capacity (**9** States)
- ◆ Regular interagency meetings (**6** States)
- ◆ Working together across systems to prevent parents from having to relinquish custody of their children to obtain mental health treatment services (**6** States)
- ◆ Policy development and implementation (**5** States)
- ◆ Efforts to offer a single plan of care for each child and family (**3** States)
- ◆ Co-location of staff (**2** States)

Accomplishments resulting from each of these strategies are identified below.

#### *– Interagency Teams and Task Forces*

**Thirteen (13)** States reported that child welfare, mental health, and other agencies are involved in interagency teams that function for specific purposes, e.g., multidisciplinary child protection teams and multidisciplinary teams to coordinate services; treatment teams; child and family teams that ensure individualized service plans; state interagency teams that oversee development of systems of care; early intervention teams; mental health collaboratives; policymaking teams; teams to implement community-based initiatives; care coordination units; stakeholder groups to develop recommendations about system reform; and teams that arrange services for children with the most serious mental health needs.

These teams are described as productive, with achievements such as development of resources, increased support from Medicaid for children needing more than acute care hospitalization, statewide system redesign, creation of integrated care coordination units, review of reports of abuse of children in out-of-home care, coordinated child welfare and mental health service delivery, timely mental health assessments of children entering foster care, and adapting systems of care to meet the more challenging behaviors of children/youth in state custody.

#### *– Building Services Array and Service Capacity*

The Final Reports of **nine (9)** States described a number of services that were developed through interagency collaboration: statewide implementation of the wraparound process; new residential service models to permit children and youth who have no community placement to leave psychiatric settings when they are ready for

discharge; programs for children with assaultive behavior; Medicaid reimbursement for provider travel in order to serve rural areas; behavioral health services; and mental health services specifically for children in foster care.

– *Regular Interagency Meetings*

**Six (6)** States described regular ongoing meetings (some monthly, some weekly) between mental health, social services and Medicaid to do such things as address waiting lists, discuss clinically complex child/family cases, plan for services for families served by several agencies, address mental health services for children/youth in custody, and develop policies and guidelines for serving children with significant mental health needs.

– *Preventing Unnecessary Custody Relinquishment*

**Two (2)** States described an increase in the use of out-of-home care that could be due to the lack of community-based mental health resources, causing children to enter the child welfare system in order to access needed care. **Three (3)** States mentioned initiatives to reduce this practice; however, no Final Report fully described how such initiatives work. **Two (2)** States described policies to have review hearings for children who are voluntarily placed by their parents solely due to developmental disability, severe emotional disorders, or delinquency.

– *Policy Development and Implementation*

Memoranda of Understanding and Memoranda of Agreement (MOUs and MOAs) were the primary policy strategy used by **five (5)** States in developing and implementing policy to ensure mental health services for children and families in the child welfare system. **One (1)** state issued Management Practice Standards recommending that county agencies establish agreements and protocols with all major service systems. In another State the children's services department entered into annual contracts with regional community service agencies.

MOUs and MOAs addressed issues such as each agency's area of responsibility and accountability and how services are obtained from the managed care organization for children in state custody.

– *Single Plans of Care*

**Three (3)** States described efforts to create a single plan of care for children and families who are involved with multiple agencies. Child welfare, mental health, juvenile justice, education, and private providers are involved in implementing single plans of care. In another State, four regions have implemented the single plan of care. **One (1)** State credited interagency collaboration as one of the primary reasons for the agency's effectiveness in being able to individualize services and increase placement stability for children in foster homes. In another State, however, the Final Report indicated that mental health providers often have no knowledge of the child welfare "case plan," reducing the effectiveness of the case plan because services are not coordinated.

– *Co-location of Staff*

**Two (2)** State Reports described the value of housing mental health therapists and nurses in the child welfare agency. In **one (1)** State, mental health therapists are co-

located in social services offices in twelve counties to provide family preservation and reunification services. Children involved with the child welfare system in these 12 counties have better access to mental health services than children in other counties where overloaded community mental health centers are not as timely in their response. In another State, the child welfare agency contracted with the Department of Health to provide registered nurses and health program representatives to work in child welfare agencies to manage the physical, dental, and mental health needs of all children entering foster care.

### **Family Involvement and Services for Families**

Findings from the **15** State reviews in 2002 indicate that the lack of family involvement and participation is one of the greatest concerns. In **all 15** States reviewed in 2002, a common concern was that fathers, mothers, and children are not routinely involved in case planning.<sup>15</sup>

In our review of 38 Final Reports, we found minimal discussion of mental health services being developed and provided for birth families. **Four (4)** States described inconsistency in identifying and providing for the service needs of families; a lack of involvement of families in case planning; and a focus on services for the child, rather than other family members. **One (1)** State indicated that mothers with developmental disabilities were not able to receive the services and support they needed to resolve child abuse and neglect issues. Another State surveyed parents whose children were in foster care and learned that **26%** felt their service needs were not met by the agency, particularly their need for counseling.

The individual child/case data from 2002 support these findings. *Well-Being Outcome 1 – families have enhanced capacity to provide for their children’s needs* – was achieved for only **53.9%** of the 747 children reviewed in 2002. The range of scores on all of the other CFSR outcomes was **49.8% to 84.3%**.<sup>16</sup> Only one other outcome<sup>17</sup> was achieved for a fewer number of children than Well-Being 1. In addition, none of the 32 States reviewed in 2001 or 2002 were in substantial conformity with Well-Being Outcome 1.<sup>18</sup>

On a more positive note, **five (5)** States described early identification of families’ mental health needs, linking families to a wide array of services, including family group therapy.

There was some discussion of mental health services and supports needed or provided for foster families. **Four (4)** States noted that more training was needed to assist foster parents in working with children who have significant emotional and behavior problems. **One (1)** State described how it was increasing the training required for foster parent licensure and providing additional training for foster parents who care for children with special emotional/behavioral health needs. Another State described placement stability services to assist foster families when crises occur.

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<sup>15</sup> DRAFT - CFSR Findings Report, James Bell Associates, Section 1, Table 6, p.7, March 2004.

<sup>16</sup> DRAFT - CFSR Findings Report, James Bell Associates, Section 2, Table 3, p.11, March 2004

<sup>17</sup> *Permanency Outcome 1 – Children have permanency and stability in their living situations* - was achieved in 49.8% of the children reviewed.

<sup>18</sup> From presentations offered on the Web site of the Children’s Bureau.

## **Permanency and Stability**

**Twenty (20)** State Final Reports demonstrated that many system challenges coalesce around the goals of permanency and stability for children. The complex behavioral health needs of children, along with the lack of early diagnosis; specialized providers to address need; and well- trained and supported foster parents and social workers lead to placement disruptions, instability, and difficulty in establishing and reaching a permanent goal. According to several States, children with emotional and behavioral challenges often were not considered ready for adoption, placement resources were few, and efforts were not made to identify adoptive homes for them. Reunification is limited by the availability of mental health and substance abuse services for parents and reentries of their children into care are attributed to the same services deficits. States attributed instability and the lack of permanency to the following:

- ◆ Lack of specialized placements for children with severe medical, psychiatric, or substance abuse needs (**10** States)
- ◆ Few adoption resources for older children with behavioral challenges (**4** States)
- ◆ Lack of mental health services for children and substance abuse services for their families that hinder reunification (**3** States)
- ◆ Lack of effective transitional services for older youth with mental health needs (**3** States)
- ◆ Inadequate training and support for foster parents who care for children with serious emotional disorders (**2** States)
- ◆ Lack of specialized placements for children in their own communities (**2** States)
- ◆ Need for more mental health counseling available to keep children in their own homes (**1** State)

## **Training**

**Fifteen (15)** State Final Reports identified training as a major part of their plans to prepare staff, providers, foster parents, and parents to meet the mental health needs of children and families in the child welfare system. Cross-system training with law enforcement, mental health, primary health, and the courts was reported. In addition, the need for the specific training of families, staff, and providers on mental health issues including specifically how to read a psychological and identification of underlying family mental health issues was reported. **One (1)** State reported the need for specific training of child welfare workers regarding recognition of both mental health and substance use issues. Another proposed cross-systems training of mental health workers, school counselors, law enforcement officers, and social workers *with* foster and adoptive parents.

**Five (5)** States recognized and reported a range of their training needs:

- ◆ Forty hours of specialized training annually for therapeutic foster care providers
- ◆ Mental health and substance use training for staff who work with adolescents with behavioral health issues
- ◆ A statewide conference on infant mental health
- ◆ Specialized units, such as mental health assessment and treatment and sexual abuse treatment, need additional training

- ◆ Ongoing training addressing substance abuse dynamics, child management, sexual abuse, children on medications, and mental health issues
- ◆ Foster parents training on grief and loss, independent living preparation, mental health issues, sexual abuse, and accessing local services
- ◆ Expand annual training to include the individual needs of children and their families and psychotropic drugs and their side effects

### **Data Collection**

**Six (6)** Final Reports mentioned a lack of aggregate data to identify the mental health needs of children in the child welfare system. **One (1)** State described difficulty in obtaining reports on individual children from mental health providers, and another indicated that they do not know how many children move from the foster care system into the adult mental health system. **One (1)** State indicated that it will be able to collect more data on children's mental health needs and services as its FACIS system is implemented statewide. It will track mental health treatment, psychological and psychiatric evaluations, and diagnoses.

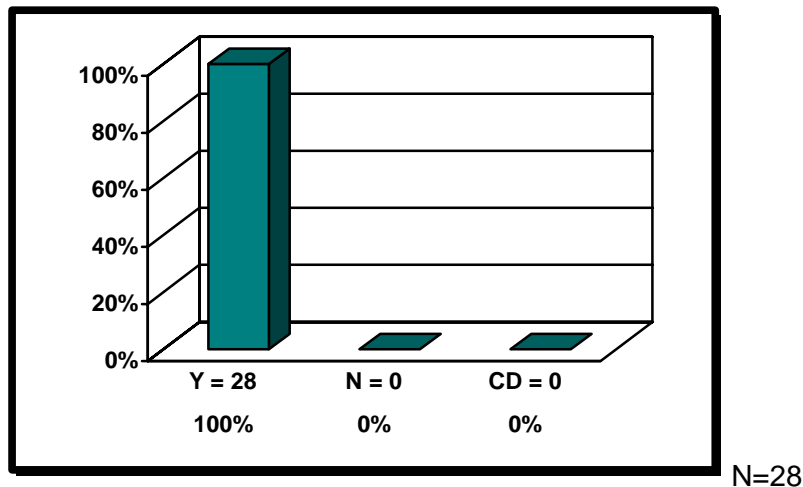
## SECTION 2 – TRENDS IN PROGRAM IMPROVEMENT PLANS<sup>19</sup>

This section describes a number of trends that emerged from the PIPs and strategies states are pursuing to better address the mental health needs of children and families. In addition to summarizing mental health related trends in the 28 PIPs reviewed, we sought answers to the following six questions;

1. Are *mental health* issues mentioned in the PIP?
2. If mental health issues are mentioned, do the *goals* of the PIP address the mental health issues?
3. If mental health issues are mentioned, are there *action steps* related to the mental health issues?
4. Are *mental health stakeholders* listed as PIP team members or obviously involved in the action steps?
5. Are *parents* listed as PIP team members?
6. Does the State identify in its PIP a need for technical assistance regarding mental health issues?

When a PIP provided information about any of the six questions, we counted them as a Yes or No response. We categorized PIPs that did not include any information related to a question as *Cannot Determine*. It is possible that many states categorized as *Cannot Determine* might actually fall within a Yes or No response, but because we were unable to find reference to the question in the PIP, they are counted as *Cannot Determine*. (Y = Yes; N = No; CD = Cannot be determined from the PIP.)

### 1. Are mental health issues mentioned in the PIP?

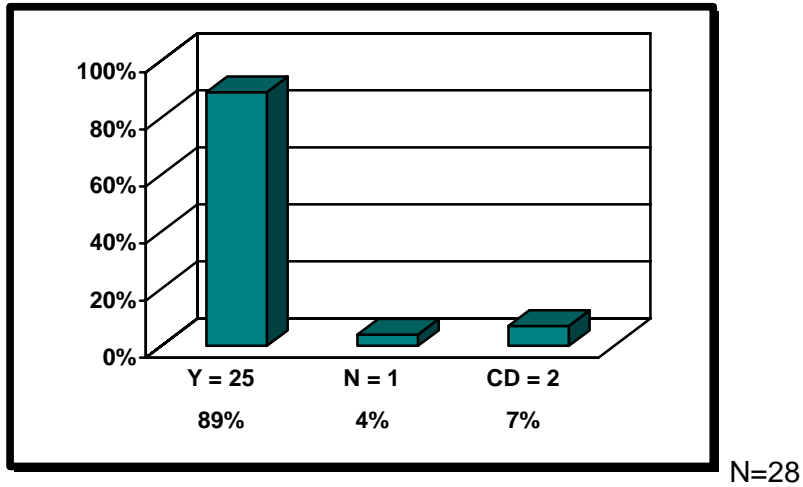


All of the **28** PIPs reviewed included a discussion of mental health issues.

<sup>19</sup>

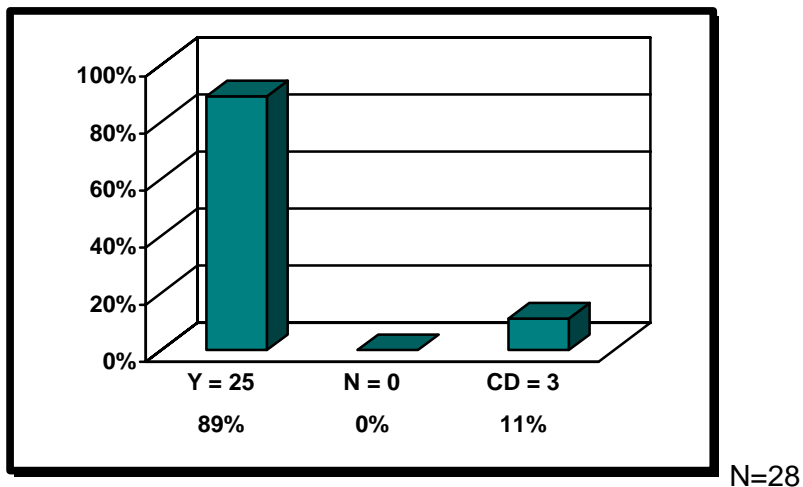
See Appendix A for further explanation about Program Improvement Plans.

**2. If mental health issues are mentioned in the PIP, do the goals of the PIP address the mental health issues?**



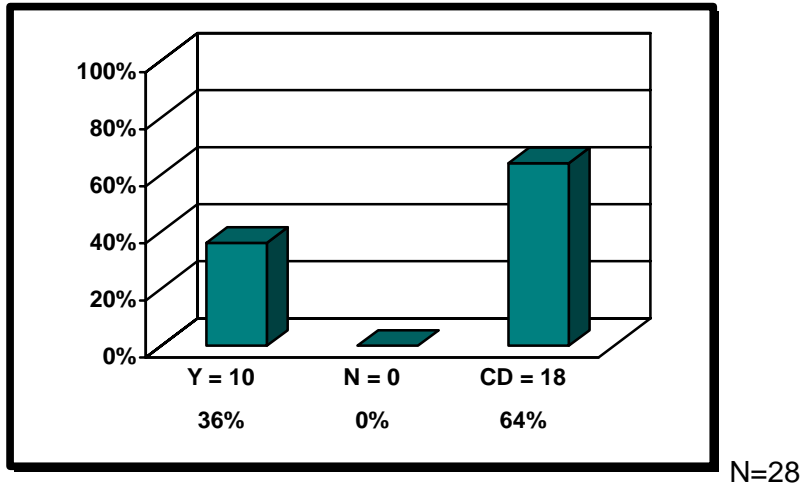
Almost all of the PIPs (**89%**) included goals related to mental health issues. One PIP did not.

**3. If mental health issues are mentioned in the PIP, are there action steps related to the mental health issues?**



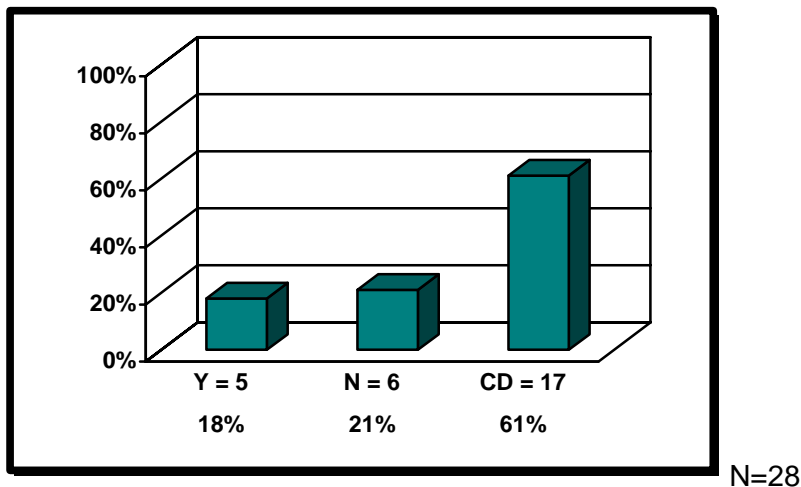
Almost all of the PIPs (**89%**) included action steps related to mental health issues.

**4. Are mental health stakeholders listed as PIP team members or obviously involved in the action steps?**



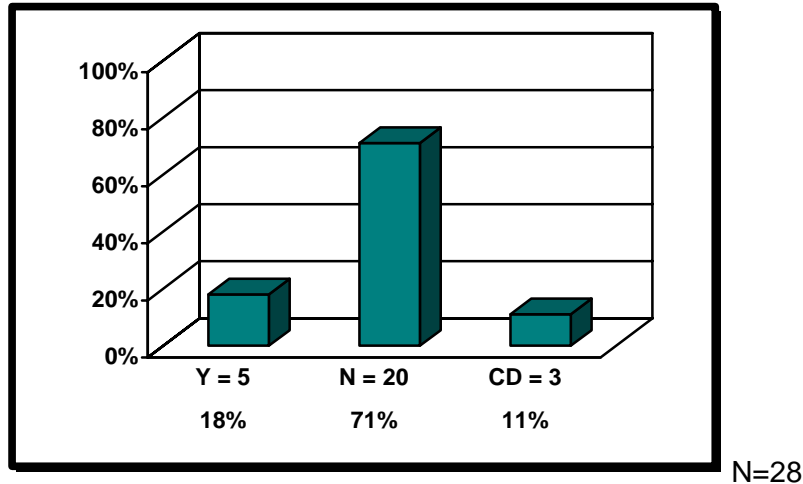
To determine whether mental health stakeholders were involved in addressing the mental health issues, we reviewed the lists of PIP team members in each state and the assignment of leadership regarding specific steps in the PIP. It was difficult to form a valid answer to this question because many of the PIPs (**64%**) did not clearly identify team members; however, **36%** of the PIPs do include mental health stakeholders.

**5. Are parents listed as PIP team members?**



As in question 4, it was difficult to form a valid answer to this question because many of the PIPs did not clearly identify team members. The analysis did show that **five (5) States (18%)** are involving family members in the PIPs and **six (6) States (21%)** are not. We could not determine the role of parents in the other **61%** of the States.

## 6. Does the state identify in its PIP a need for technical assistance regarding mental health issues?



Even though every State mentioned mental health issues in their PIPs, only **five (5) States (18%)** clearly indicated that they need or will request technical assistance to address the mental health issues.

### **Assessing Child and Family Mental Health Needs**

As mentioned previously, **15** State Final Reports described problems that occurred when mental health screening and assessments were not conducted. Consistent with this, in the PIPs, **18** States identified strategies for improving the assessment of child and family mental health needs. The most commonly mentioned strategy focused on developing or reviewing screening and assessment tools (**11 States**). **Six (6)** States indicated that they would increase the number of children entering foster care who receive mental health assessments. **Six (6)** States are strengthening their existing comprehensive family assessment processes to include assessment of child and family mental health needs. **Five (5)** States proposed pilot projects before moving to statewide mental health screening and assessment of all children in the child welfare system. **Three (3)** States are focusing on documentation of behavioral health assessment results — in electronic records or in the child's case plan.

Additional examples of how States focused on screening and assessment in their PIPs include the following:

- ◆ Created a tool to help foster parents and child welfare staff identify behaviors that indicate a child may need a comprehensive evaluation.
- ◆ Began screening for the mental health needs of children in need of services (CHINS) and youth who have been adjudicated.
- ◆ Requested funding from the state legislature to increase behavioral health assessments of children entering care statewide.
- ◆ Distributed information about assessment tools to local mental health providers.

- ♦ Initiated a comprehensive approach to assessment that included technical assistance and training, policy changes, changes in the state information system, certification of staff, and evaluation of the effort.

Screening and assessing the mental health needs of children in the child welfare system is at least a two-step process. An initial and immediate mental health screen is used to identify problems that require immediate attention and further evaluation. A comprehensive mental health assessment is more extensive and addresses a child's mental/emotional and developmental strengths and needs. It focuses on the child, the family, and the environment in which they live. Most of the PIPs that mentioned screening and assessment did not address it as a two-step process with different timeframes and purposes.

### **Identifying Service Gaps and Building Services Array and Service Capacity**

The Final Reports identified a number of mental health services that were consistently in limited supply (e.g., mental health services for children in foster care and child protective services, substance abuse treatment, therapeutic foster care, sexual abuse treatment services, and domestic violence services; services for children whose parents are addicted; and intensive home based services). The PIPs reflect the same deficits, and **19** States have approached the task of building services array and capacity in several ways.

**Eleven (11)** States have implemented assessment or screening tools in order to ensure a more expeditious discovery of the mental health needs of children and families. These assessments will also assist the States to identify the required array of services needed by children in foster care and in their own homes. **One (1)** State proposed a specialized services continuum that includes early intervention services, intensive home based services, multi-systemic therapy (MST), family therapy, substance abuse treatment, mobile crisis services, and supported housing for 144 families with behavioral health needs.

**Eight (8)** States have approached the task of building a service array by implementing a statewide needs assessment to identify strengths and service gaps. States propose to use the data to support legislative requests, market a family drug court, gain the advocacy of a children's cabinet, negotiate with Medicaid or mental health authorities, modify procurement regulations, support demonstration/pilot programs, justify in-home services for children in child protective services, support the hiring of six mental health therapists who will facilitate earlier discharge planning from in-patient facilities, and to support a plan for foster parent recruitment and support.

Consistent with the top five deficits in the service array found in the Final Reports, **six (6)** States have proposed to develop all, or combinations of the following services: addiction services, therapeutic foster care, sexual abuse services, intensive in home services, and behavioral health services for children and youth in foster care. In an effort to promote stability, foster homes for medically fragile children and policies to support recruitment and retention of foster parents, including pre-adoptive homes, are planned. Many of these services will be developed through interagency collaborations.

**Four (4)** States propose to expand the continuum of mental health services by monitoring and appealing Title XIX (Medicaid) denials of mental health claims or by

negotiating for expanded Medicaid coverage of sexual abuse treatment, attachment and bonding, grief and loss therapies, intensive home based treatment, and assertive community treatment. In addition, another State will closely monitor timely and accurate eligibility for Medicaid and Title IV-E for children in out-of-home care.

**Two (2)** States did not address their acknowledged services deficit by proposing new services. **One (1)** proposed to reduce caseloads by hiring additional staff. Another proposed increasing electronic documentation, monitoring of case reviews, and supervision of staff.

## **Training**

**Twenty-two (22)** States proposed to train child welfare staff, mental health clinicians, and foster parents on topics such as: mental health practice guidelines, assessment protocols, service planning, wraparound, domestic violence, Medicaid eligibility, access to mental health services, and recognition of underlying issues such as developmental disabilities and substance abuse needs of children and families.

**Twelve (12)** States will be training or retraining staff in the use of one or more of the following: new or existing mental health assessment protocols; preparation of clinicians to diagnose children from 0-3; and preparation of social workers, clinicians, and foster parents to meet the behavioral health needs of children in foster care and adoption. One state offered training for staff in the recruitment and retention of foster homes for children who are African American.

**Ten (10)** States propose training to raise competency levels in the areas of substance abuse, mental health, sexual abuse, the wraparound process, and domestic violence.

**Six (6)** States propose training of foster parents on behavioral health issues; medical passports and documenting medical and mental health information; grief and loss; mental health issues and sexual abuse; and how to obtain mental health services and challenge recommendations.

Remaining training proposals included: training mental health providers on Medicaid federal confidentiality laws, and how to support adoptive families.

## **Monitoring Services Received and Child and Family Outcomes Achieved**

Documentation was the most frequently proposed strategy in the PIPs for monitoring whether or not a child receives mental health services. **Seven (7)** States described goals or policies instructing localities to document how identified mental health needs are met in case plans. Each of the following additional strategies was mentioned by **two (2)** States:

- ◆ Evaluate residential care models for children who have extraordinary needs. Track, monitor, and assess outcomes for the children placed in these facilities.
- ◆ Use existing electronic case plan reporting process to document child mental health needs and date of psychological assessment. Supervisors will review the case manager's reports to ensure that they address mental health issues.

- ◆ Improve standards for purchasing services and develop tools to match the level of care needed by each child with the services offered.

### **Collaborative Efforts**

The PIPs reflect very closely the extensive list of collaboration and coordination issues mentioned in the Final Reports. In the PIPs, **19** States propose collaborative strategies to address issues such as mental health service gaps, increasing the service array and service capacity, managing referrals, integrating service plans, reducing mental health denials, addressing system level barriers, improving communication, offering cross-system training, pooling funds, sharing information and data across systems, and prioritizing children and families in the child welfare system as service recipients.

**Ten (10)** States noted the involvement of mental health representatives on the PIP team or in workgroups. **Three (3)** of those States described mental health in a leadership role on specific aspects of the PIP.

### **Replicating Systems of Care**

**Eleven (11)** States describe that they have been involved in interagency teams and task forces with goals of coordinating services across systems, developing integrated interagency policy ensuring access to appropriate treatment, and overseeing the development and implementation of community based mental systems of care for children and families.

There are currently **63** active systems of care in **41** states and **2** territories funded by the Center for Mental Health Services, and **9** systems of care grants funded by the Administration for Children and Families. However, in the review of the PIPs, we found that just **eight (8)** States described the expansion of system of care values/framework to obtain a seamless statewide mental health system, across systems, to improve all outcomes for children and families in child welfare. These **eight (8)** States are already engaged in extensive collaboration and partnering across systems in the interest of meeting the mental health needs of children in child welfare.

- ◆ **Three (3)** States have already begun the integration of financial resources across child serving agencies to develop systems of care for children with serious mental health needs.
- ◆ **One (1)** State joined in a collaborative initiative with the Department of Mental Health and the Department of Youth Services to commit funding to develop new family, school, and community services to meet the special needs of children.
- ◆ **One (1)** State is designing long-term goals to focus on designing a seamless multi-system response to its self-described “overwhelming need for mental health services for children in the state’s care.”
- ◆ **One (1)** State entered into a collaboration with health, justice, probation, education, welfare, developmental disabilities, and child welfare (State Commission) to ensure that the children and families in the state child welfare system receive appropriate priority for services across systems.
- ◆ **One (1)** State indicated that they have a goal of developing of a system of care for children with mental health needs and their families..

- ♦ **One (1)** State will use existing system of care managers to focus on the development maintaining and evaluating of their local and regional systems of care.

### **Service Planning**

**Three (3)** State PIPs described service planning processes such as:

- ♦ Training for staff on case planning
- ♦ Implementing the wraparound process in child welfare and combining these child welfare system efforts with the mental health system wraparound process so that wraparound becomes the case management model for the child welfare system. The ultimate goal is to implement a single plan of care for each child that will support the wraparound process.
- ♦ Implementing a care management system to coordinate care across systems.

### **Data Collection**

Only **one (1)** State PIP described efforts to improve access to data about child and family mental health needs and services. This State is developing its capacity to match data between child welfare, Medicaid, and mental health payment records. This will require a data plan proposal, determination of costs to share data, and identification of a funding source.

### **Policy Development and Implementation**

Our review of the policy development within the PIPs revealed a cluster of changes around developing comprehensive assessments of the behavioral health needs of children and families; introducing new, or revision of existing, mental health policies; collaborating across systems to coordinate policies; monitoring of mental health providers or revisiting procurement regulations; retraining of staff and providers on behavioral health issues; and redefining entry point to behavioral health services.

- ♦ **Twelve (12)** States propose strengthening policy related to assessment of mental health needs of children and families by developing new assessment instruments and training staff in to use them.
- ♦ **Seven (7)** States have introduced new or revised existing policies, e.g., instituting family centered practice; revising administrative regulations to ensure that mental health and substance abuse treatment are provided; developing educational and mental health specialists to serve as regional experts; and developing wraparound certification program.
- ♦ **Five (5)** States have proposed collaboration across systems to coordinate policies and develop uniform intake and referral between child welfare and mental health.
- ♦ **Four (4)** States proposed retraining staff and providers on behavioral health issues, separate from assessment training.
- ♦ **Three (3)** States proposed monitoring internal agency practices.
- ♦ **Three (3)** States proposed monitoring of mental health providers or revising procurement regulations and certification guidelines.
- ♦ **One (1)** State will pilot home-based services for families receiving child protective serves.
- ♦ **One (1)** State will enroll all nonexempt children into managed care plans.

- ◆ **One (1)** State proposed implementing a new single point of entry process to improve communication between counselors, caregivers, families, and services providers.

### **Comprehensive Strategies to Develop Mental Health Service Systems**

When a PIP described three or more statewide strategies or action steps that focused on improving mental health services, we categorized this as a comprehensive strategy. **Ten (10)** of the **28** PIPs reviewed were taking a comprehensive approach. These States were engaged in many of the strategies described previously in this report, including:

- ◆ Assessment
- ◆ Building/expanding the service array and availability
- ◆ Expanding Medicaid services
- ◆ Requesting additional funds from the legislature and/or pooling funds across systems
- ◆ Better documentation of mental health needs and follow-up services
- ◆ Monitoring by supervisory staff to ensure that services are provided
- ◆ Cross-system collaboration
- ◆ Sharing information and data across systems
- ◆ Developing mental health practice guidelines
- ◆ Enhancing training for social workers, foster parents, clinicians/providers on topics such as: clinical assessment and treatment modalities, diagnosing children ages 0 to 3, adoption issues, how to access mental health services, wraparound service process and individualized care, behavioral health needs of children in child welfare, and evidence based practices
- ◆ Making services for children and families in the child welfare system a priority of the mental health system
- ◆ Community and/or statewide needs assessment to determine gaps in or barriers to mental health service availability
- ◆ Evaluating and transforming residential care services
- ◆ Additional support for foster parents to prevent placement disruptions
- ◆ Determining the effectiveness of certain services and providers
- ◆ Certification of providers

## SECTION 3 – SUMMARY AND CONCLUSION

As confirmed by the findings cited in this report, States recognize the need to address collaboratively the mental health needs of, and mental health services for, children and families in the child welfare system. Attention is being focused on both system level improvements and service coordination for individual children and families. Each of the 28 PIPs that were reviewed mentioned mental health issues; almost all of them (89%) included goals and action steps related to mental health; and although many of the PIPs did not list their PIP team members, all of those that did (10) included mental health stakeholders on the teams.

### **Continuing Challenges**

Both the Final Reports and the PIPs described continuing challenges to adequately meet the mental health needs of children and families.

#### Service Accessibility

States consistently described the lack of appropriate mental health services, with some services being more available than others. Services most frequently cited as unavailable included specialized services for children in the child welfare system such as treatment for children who have been sexually abused and/or for children who have sexually offended. Treatment foster care was another service frequently mentioned. For families, substance abuse treatment (for youth and adults) and domestic violence services were most needed.

States described many challenges to providing comprehensive mental health assessments for children in the child welfare system; and in some States, even when assessments were done, there was no assurance that a child would be referred for or receive recommended follow-up services. States also noted the lack of documentation of children's mental health care.

#### Providers/Rural Areas

States described a widespread shortage of mental health providers who are skilled in treatment of the special issues presented by children and youth who have experienced the trauma associated with abuse, neglect, sexual abuse, multiple out-of-home placements, parental substance use, and domestic violence. States often reported that the majority of mental health providers are clustered in and around urban areas and that many providers are unwilling to relocate to rural areas.

#### Budget Deficits

Several States described the significant impact that budget deficits are having on the availability of appropriate mental health services, citing especially a narrowing of the population of children served by the public mental health system to those with the most serious emotional disorders.

#### Collaboration

Even though more than two-thirds of the State Final Reports described cross-system collaborative efforts to build service capacity and meet the mental health needs of children and families in the child welfare system, many states continue to find service

coordination problematic and difficulty in accessing certain services. The Reports emphasize how important it is for collaboration to be an ongoing process in order to resolve problems and issues as they arise.

### Family Involvement and Participation

Findings from the 15 State reviews in 2002 indicate that the lack of family involvement and participation is one of the greatest concerns. In all of the 2002 reviews, a common concern was that fathers, mothers, and children are not routinely involved in case planning. Our review of 38 Final Reports and 28 PIPs confirms this finding. We found some discussion of the need for more accessible mental health services for family members, and five (5) States described early identification of families' mental health needs and linking families to a wide array of services. However, there was very little focus on the participation of families in their own mental health services, in the services of their children, or in system level planning. A few states that described a wraparound service model or improved service planning processes were the only ones that directly addressed family involvement in mental health services. Where States described training as a strategy for improving mental health services, foster parents were often a target audience for training, but birth parents usually were not included.

### Permanency and Stability

The majority of States indicated that when the complex behavioral health needs of children are not met; when there is no early diagnosis or specialized providers to address needs; and when foster parents and social workers are not well-trained and supported in understanding behavioral health issues, children experience placement disruptions, instability, and difficulty in establishing and reaching a permanent goal.

## **Solutions**

Strategies for addressing these challenges and other mental health issues were mentioned in every State's PIP.

### Assessment and Services

Approximately two-thirds of the State PIPs identified strategies for improving the assessment of child and family mental health needs and for building/expanding the array and accessibility of mental health services. *Assessment strategies* that were proposed included: developing or reviewing screening and assessment instruments; increasing the number of children who enter foster care who receive mental health assessments; and strengthening existing comprehensive family assessment processes to include child and family mental health needs. *Strategies for expanding the service array* and making these services accessible to children and families included: conducting Statewide needs assessments to identify service strengths and service gaps. Several States plan to use this information to obtain necessary resources, modify regulations, hire mental health therapists, and negotiate expanded Medicaid coverage. Services being developed or expanded by States included: addiction services, treatment foster care, sexual abuse treatment, intensive in home services, and behavioral health services targeted for children and youth in foster care.

### Training

More than three-fourths of the PIPs proposed training as one strategy for improving mental health services. States proposed to train child welfare staff, mental health

clinicians, and foster parents on topics such as mental health practice guidelines, assessment protocols, service planning, the wraparound process, domestic violence, Medicaid eligibility, access to mental health services, and recognition of underlying issues such as developmental disabilities and substance abuse needs of children and families.

#### Collaboration

Where cross-system problems exist, many communities and States are using cross-system strategies to address them, rather than having the child welfare system attempt solutions on its own. At least two-thirds of the State PIPs proposed collaborative strategies to address issues such as: integrating service plans, managing referrals, reducing denials by the mental health or managed care system, pooling funds, implementing systems of care, developing a certification process for mental health providers, creating a single point of access to mental health services for children in the child welfare system and a uniform intake/referral process, training for mental health therapists on adoption issues, offering statewide substance abuse training, merging efforts of the child welfare and mental health systems to implement a wraparound service model, and requesting federal approval of Medicaid expansion.

#### Comprehensive Strategies

As stated previously, when a PIP described three or more statewide strategies or action steps that focused on improving mental health services, we categorized this as a comprehensive strategy. More than one-third of the PIPs reviewed were taking a comprehensive approach to strengthening mental health services for children and families in the child welfare system. These States were engaged in many of the strategies described above.

### **Issues for Further Consideration and Study**

The process used in this analysis included a word search focused on behavioral health terms, as well as close examination of certain sections of the Final Reports and the PIPs (see Methodology on p. 6). Acknowledging the limitations of the word search methodology, there were several issues that we anticipated addressing in this analysis, but our search of the Final Reports and PIPs did not provide information about them. For example,

- We had expected to address the issue of cultural competence in providing mental health services for children and families, but very few Reports and PIPs described challenges or solutions related to cultural issues. This is of concern due to the disproportionate presence of children of color, especially African American children, in the child welfare system. The absence of an effort to provide culturally competent mental health and substance abuse services for children and their families can contribute to the disproportionality of children of color in out-of-home placements. It is possible, however, that further study of other sections of the Final Reports and the PIPs that were not reviewed would provide more information on both the problems and strategies for offering culturally appropriate services.
- Both the mental health system and the child welfare system have focused attention recently on providing services that are effective and that achieve the outcomes children and families desire. There is a movement toward “evidence based

practices”, a desire to disseminate information about such practices, and an attempt to implement evidence based practices in states and communities. While the Final Reports and the PIPs that we reviewed mentioned services that have an evidence base, e.g., treatment foster care, multi-systemic therapy, and the wraparound process, we found very little information to indicate that states are making a concerted effort to implement evidence based practices that work for children in the child welfare system.

## **APPENDICES**

## APPENDIX A

### APPENDIX A CHILD AND FAMILY SERVICE REVIEWS

#### **PROCESS AND STRUCTURE**

##### **VALUES AND PRINCIPLES**

The reviews promote practice principles that support improved outcomes for children and families, such as family-centered practice, community-based services, strengthening parental capacity to protect and provide for their children, and individualizing services that respond to the unique needs of children and families.

##### **STRUCTURE**

Each child and family service review is a two-stage process that comprises a statewide self-assessment and an onsite review of child and family service outcomes and program systems. (See Appendix B for specific outcomes, indicators, and systemic factors)

##### **Statewide Self-Assessment**

The statewide assessment is completed during the six-month period prior to the onsite review by a team of State agency staff and other State representatives who are not staff of the State agency. It includes an analysis of data indicators that address safety and permanency issues for children served by the agency, and helps to guide certain decisions about the onsite review, such as the locations in the State where onsite review activities will occur and the composition of the sample of cases to be reviewed onsite. States are encouraged to include a wide range of stakeholders in the Statewide Assessment.

##### **Onsite Review**

After the statewide assessment has been completed, an onsite review of the State child welfare system is conducted by a joint Federal-State team. The review takes place in three political subdivisions in the state, one of which includes the city with the largest population. The onsite portion of the review includes the following: (1) case record reviews (30 to 50 per State); (2) interviews with children and families engaged in services; and (3) interviews with community stakeholders, such as the courts, other child-serving agencies and community organizations, foster families, social workers, and service providers.

The Administration for Children and Families (ACF) makes a separate determination about the State's conformity with each of the seven outcomes and seven systemic factors following the onsite review, and confirms the determination of conformity to the State in a written report issued within 30 days of the onsite review.

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\* Information in this description was adapted from a summaries provided by the Administration for Children and Families; by the Division of Child and Family Services, Utah Department of Human Services; and from remarks made by Jerry Milner and Joan Ohl of the Administration for Children and Families at the Annual Meeting of States and Tribes in January 2003.

### **Program Improvement Plans**

For any of the outcomes or systemic factors in which the State is determined not to be in substantial conformity, the State must develop and implement a program improvement plan (PIP) designed to correct the area of non-conformity. The PIP must be developed and submitted to the Regional Office for approval within 90 days of the State receiving written notification of non-conformity. The Children's Bureau supports the States with technical assistance and monitors implementation of their PIPs.

### **PENALTIES**

Penalties are assessed commensurate with the level of non-conformity from a pool of Federal funds comprised of the States' Title IV-B allocation and a portion of its Title IV-E allocation. The initial penalty is one percent of the pool for each of the seven outcomes or seven systemic factors determined not to be in substantial conformity, and increases to two percent and three percent on subsequent reviews if the State has not successfully implemented a PIP. Penalties associated with non-conformity are suspended while the State implements the approved PIP, and are rescinded if the State is successful in ending the non-conformity through completion of the PIP.

**APPENDIX B**  
**CHILD AND FAMILY SERVICE REVIEWS**  
**Outcomes, Indicators, and Systemic Factors**

The Child and Family Service Reviews examine outcomes for children and families in three areas: safety, permanency, and child and family well-being. Within these three areas, seven outcomes are assessed through statewide data and review of cases. There are 23 indicators (called items) for these seven outcomes.

**SAFETY**

Safety Outcome 1                      Children are first and foremost, protected from abuse and neglect.

Item 1: Timeliness of investigations  
Item 2: Repeat maltreatment

Safety Outcome 2                      Children are safely maintained in their homes when possible and appropriate

Item 3: Services to prevent removal  
Item 4: Risk of harm

**PERMANENCY**

Permanency Outcome 1                Children have permanency and stability in their living situations

Item 5: Foster care re-entry  
Item 6: Stability of foster care placements  
Item 7: Permanency goal for child  
Item 8: Reunification, guardianship and placement with relatives (for FY 2002). Independent living services (for 2001)  
Item 9: Adoption  
Item 10: Other planned living arrangement

Permanency Outcome 2                The continuity of family relationships and connections is preserved

Item 11: Proximity of placement  
Item 12: Placement with siblings  
Item 13: Visiting with parents and siblings in foster care  
Item 14: Preserving connections  
Item 15: Relative Placement  
Item 16: Relationship of child in care with parents

## **WELL-BEING**

Well-being Outcome 1	Families have enhanced capacity to provide for children's needs  Item 17: Needs/services of child, parents, and foster parents Item 18: Child/family involvement in case planning Item 19: Worker visits with child Item 20: Worker visits with parents
Well-being Outcome 2	Children receive services to meet their educational needs  Item 21: Educational needs of child
Well-being Outcome 3	Children receive services to meet their physical and mental health needs  Item 22: Physical health of the child Item 23: Mental health of the child

## **SYSTEMIC FACTORS**

The reviews also examine seven systemic factors that affect the quality of services delivered to children and families and the outcomes they experience. The statewide assessment includes the State's evaluation of Federal requirements related to each systemic factor. During the onsite review, selected State and community stakeholders are interviewed to determine how well each of the systemic factors functions in the State. The systemic factors are:

Statewide Information System

Service Array

Case Review System

Staff Training

Quality Assurance System

Agency Responsiveness to the Community

Foster and Adoptive Parent Licensing, Recruitment, and Retention