

Addressing the Mental Health Needs of Children in Out of Home-care and Reducing the Need for Foster Care Placement: Research and Constituent-informed Strategies

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Topic Areas

- I. Mental health challenges for youth in foster care and juvenile justice.
- II. Protective factors, life experiences, and services that help youth prepare for successful transition from foster care (predictors of success).
- III. Moving upstream: What kinds of mental health and other interventions can help families avoid the use of foster care? (Foster care prevention and accelerated permanency strategies.)

I. Mental Health Challenges for Youth in Foster Care and Juvenile Justice



“Nothing About Us Without Us”

Many Children Enter Foster Care with Mental Health Conditions

- **33-50% of children entering a new episode of foster care had significant behavior problems or had a CBCL score in the clinical range of concern.** (Baltimore, California)
- **15% of children entering foster care reported suicidal ideation and 7% reported homicidal ideation.** (Baltimore)
- **41.5% received outpatient mental health service during an 18-month follow-up period.** (San Diego)
- **47% of those diagnosed with psychiatric disorder had at least one other condition.** (Los Angeles County)

Youth in Juvenile Justice Services

- 65-70% of youth in juvenile justice facilities have a diagnosable emotional or behavioral disorder.
- 27% have “serious” mental health disorders or have been hospitalized because of one or more emotional or behavioral disorder.

(See National Center for Mental Health and Juvenile Justice, 2009, p. 1)

Juvenile Justice Youth (Cont.)

- Many of these youth have ***co-occurring substance abuse disorders*** and high rates of ***conduct disorders*** -- further complicating the situation.
- ***The ability of the juvenile justice system to deal with these youth needs is hindered by:***
 - confusion about which agencies should provide care and services,
 - inadequate screening and assessment,
 - lack of training,
 - inadequate funding and programs
 - overall lack of research.

(See <http://www.juvenilenet.org/jjtap/mentalhealth/index.html>)

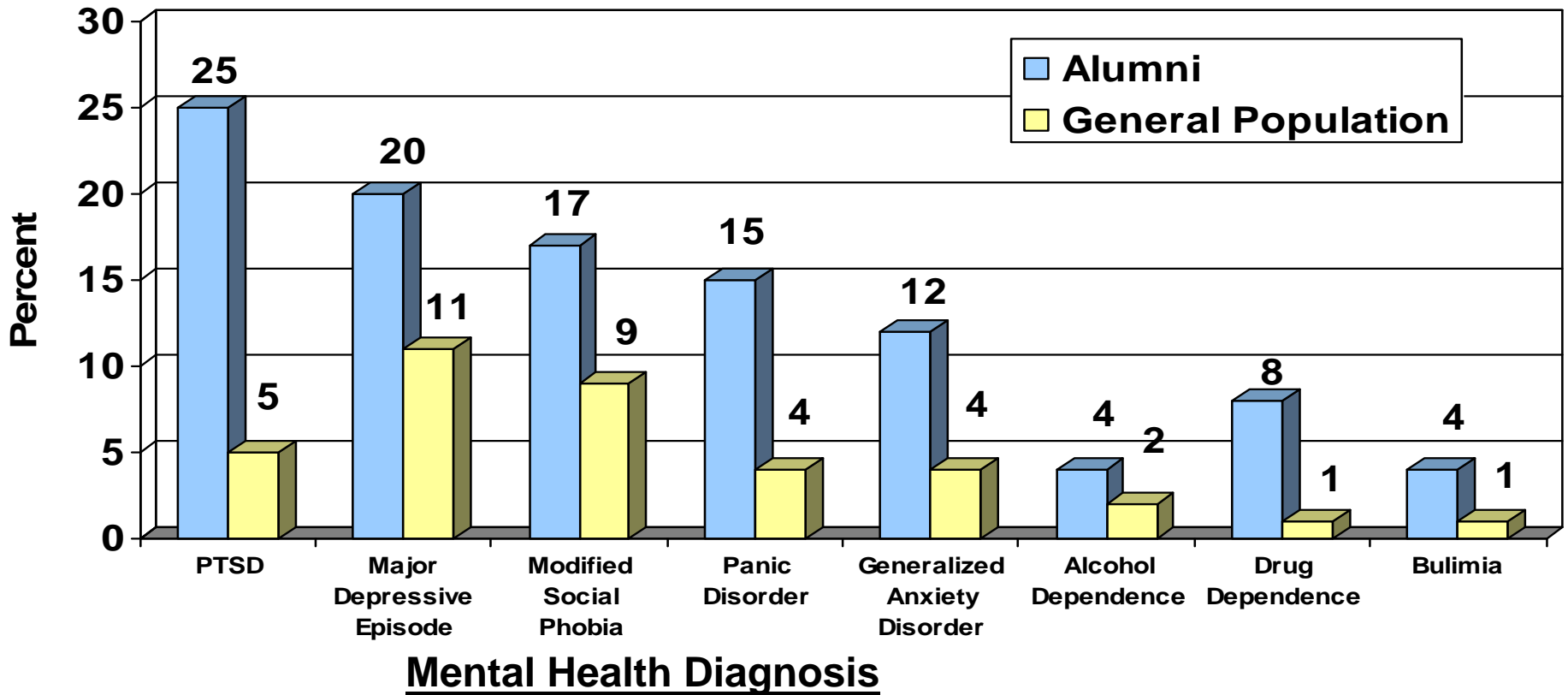
Rates for Lifetime Symptoms of Mental Health Disorders: NW Alumni Study

<i>Mental Health Outcomes</i>	<i>NW Alumni Study: % who had symptoms: life-time</i>
Major depression episode	41.1
Post-Traumatic Stress Disorder (PTSD)	30.0
Modified social phobia	23.3
Panic syndrome	21.1
Drug dependence	21.0
Generalized anxiety disorder	19.1
Alcohol dependence	11.3
<i>Sample Size</i>	<i>(479)</i>

Source: Pecora et al. (2005). Northwest Foster Care Alumni Study report. www.casey.org

Many Alumni are Living Currently with Mental Health Conditions

Twelve-Month Mental Health Diagnoses Among Foster Care Alumni and the General Population Matched by Age, Race and Gender



Source: Pecora, P. J., Kessler, R. C., Williams, J., Downs, A. C., English, D.J., & White, J. & O'Brien, K. (2010). *What works in family foster care? Key components of success from the Northwest foster care alumni study*. New York: Oxford University Press.

II. Paths to Healing and Predictors of Success



Predictors of Success: *What helps to promote child and FC alumni mental health?*

1. Child placement stability
2. Few school transfers; access to tutoring and other educational services
3. IL and employment training, feeling prepared for IL, had health insurance at exit
4. Access to counseling/MH trtmt, substance abuse treatment and group work/therapy.

(See Pecora et al., 2010, pp. 194 and 198.)

Program Fundamentals for Healing

1. Screening and assessment tools
2. Evidence-based practices training for treatment providers
3. Parent Engagement and Self-Advocacy Training (e.g., PESA)
4. Youth empowerment groups
5. Therapeutic youth groups
6. Everyday arts, social, sports and other recreational activities

Training to Help Youth Better Understand Mental Disorders and How to Access Services: *Taking Control*

- ***Taking Control* increases youth skills and feelings of empowerment.**
- **Based partially on the SPARCS model.**
- **The group is not intended as a psychotherapy group:**

Rather, it is designed to be a fun, safe, social and informal learning environment where youth members can learn new skills.

(See www.TheReachInstitute.org)

The Key Components of *Taking Control*

Co-Facilitators: A worker with expertise in mental health issues and a foster care alumnus.

Structure:

- 5 two-hour sessions
- A combination of learning, talking, and doing
- Encourages members to share their thoughts and experiences, but does not require members to give the specifics of events.
- Has the same structure each session:
 - A. Social activities (20 min.)
 - B. Interactive Self-Awareness exercise (10 min.)
 - C. Learning new skills (50 min.)
 - D. Group project (40 min.)

What Youth Learn in *Taking Control*:

- How to become more self-aware and slow down when they're upset. And how to deal with situations in functional ways. (Session 1).
- How their bodies react to stress and ways in which they currently cope with stress (S-2).
- Skills for getting through stressful times when they can't fix the problem right away (S-3), communication/ interpersonal skills (S-4), and problem-solving skills (S-5).

What Will Success Look Like?

- **Greater use of affordable assessment tools and training materials.**
- **Increased staff capacity to help youth meet mental health challenges.**
- **Policy change in terms of more states extending Medicaid coverage past age 18 for youth in foster care.**
- **Increased caregiver advocacy to access effective mental health services.**
- **Greater youth access to evidence-based treatments.**
- **Careful use of psychotropic meds.**

Psychotropic Medication Issues

“We are relying on the expertise of that psychiatrist to prescribe what is needed for that child... the [child welfare] workers get intimidated when a psychiatrist says, ‘Where did you get your medical license?’”

Psychiatrists identified liability concerns:

“We have liability issues to think about. If I send a kid out on no medication who knifes somebody because they have a history of being violent, and that goes to court. ‘Well doctor, why didn’t you put him on something?’”

Child welfare staff also had liability concerns after hearing this:

“I think our workers are the same as psychiatrists about the liability. What if we say, ‘I am uncomfortable with the child being on this many medications’ and the next day he committed suicide or attacked another child because he had no medications?”

(McMillen et al., 2007, p. 209.)

What Can We Do?

Medicate Less and More Carefully

- Of the foster children in a southwestern US state who had been dispensed psychotropic medication, 41.3% received 3 different classes of these drugs during July 2004, and 15.9% received 4 different classes.
- Most frequently used medications were antidepressants (56.8%), attention-deficit/hyperactivity disorder drugs (55.9%), and antipsychotic agents (53.2%).
- The use of specific psychotropic medication classes varied little by diagnostic grouping. Psychiatrists prescribed 93% of the psychotropic medication dispensed to youth in foster care.
- The use of 2 drugs within the same psychotropic medication class was noted in 22.2% of those who were given prescribed drugs concomitantly. (Zito et al., 2008)

Predictors of Success: *What helps to promote successful transition from foster care?*

- Child placement stability
- Few school transfers; access to tutoring and other educational services
- IL and employment training, feeling prepared for IL, had health insurance at exit
- Access to counseling/MH, substance abuse treatment and group work/therapy.
- Leaving care resources: \$250 in cash, driver's license, dishes and utensils. (Proxy for good IL skills preparation.) (See Pecora et al., 2010, pp. 194 and 198.)

III. What mental health and other interventions can help families avoid the use of foster care?



Cost-Effective Foster Care Reduction Programs

Foster care reduction programs are a sub-set of prevention-oriented family support programs.



Foster Care Reduction Programs that Work With Benefit-Cost Data

Program	Total Benefit-to-Cost Ratio (dollars in benefits for every one dollar of program cost per participant)	Total Benefits Minus Costs (per participant)
PREVENTION PROGRAMS		
Chicago Child Parent Centers ^a	\$4.82	\$31,036
Nurse Family Partnership for Low-Income Families ^{a,b}	\$3.02	\$18,054
INTERVENTION PROGRAMS		
Intensive Family Preservation Service Programs (Homebuilders [®] model) ^{a,c}	\$2.54	\$4,775
Parent-Child Interaction Therapy (Oklahoma) ^a	\$5.93	\$4,962
TripleP--Positive Parenting Program ^d	\$4.09 (1 year of benefit)	Not applicable

^a Washington State Institute for Public Policy estimates as of May 2008.

^d Also see the Triple-P websites: www.triplep.net and http://www.paxis.org/triplep/PPP_flash.aspx.

About 18% of children are placed in foster care because of emotional and behavioral problems

How can we prevent those placements?

- ❑ Child behavior management approaches for Explosive Behavior Disorders and other problems (e.g., Multi-Dimensional Treatment Foster Care, Parent Child Interaction Therapy)
- ❑ Early detection and treatment of emotional and behavioral disorders (CBT for depression & anxiety, Trauma-Focused CBT for PTSD)

Helping Youth with EBD in Foster Care and Juvenile Justice

- Careful assessment of physical, mental health, developmental, cognitive and other areas of functioning.
- Timely provision of specialized services to address areas of need, working with other responsible service systems. E.g., FBS, PCIT, TF-CBT, FFT, CBITS, MDTFC, Project KEEP.

Family-Based Services (FBS) Programs Share Some or All of These Characteristics

1. A primary worker or case manager establishes and maintains a supportive, nurturing relationship with the family.
2. Caseloads of two to twelve families are maintained.
3. One or more associates serve as team members or provide back-up for the primary worker.
4. Workers (or their back-ups) are available 24 hours a day for crisis calls or emergencies.
5. Home is the primary service setting for many programs.

Parent-Child Interaction Therapy

Parents are taught specific skills to establish a nurturing and secure relationship with their child....

and to increase their child's pro-social behavior and decreasing negative behavior.

Video Clips:

http://www.youtube.com/watch?v=hU_P9_shnro (Teen mom)

<http://pcit.php.ufl.edu/Video.htm> (9 min. overview)

http://www.cgcoc.org/nbc_tv_video_clip.php

Trauma-Focused Cognitive Behavior Therapy (TF-CBT)

- Trauma-Focused Cognitive-Behavior Therapy—or TF-CBT—was developed by Drs. Judy Cohen, Esther Deblinger, and Anthony Mannarino.
- Based on principles of cognitive behavior therapy and trauma treatment.

Examples of Other Foster Care Reduction Programs that Work but Lack Cost-Benefit Data

- Casey Family Services Family Reunification Program
- *Family Connections* and *SafeCare* for families where child neglect is a major problem.
- Family Group Conferencing
- Kinship Care with kinship navigators.
- *Project Keep*
- *Parents as Teachers – Born to learn*
- Subsidized guardianship
- Wraparound Services
- Permanency Roundtables (See WWW.Casey.org)

Examples of Other Foster Care Reduction Programs: Policy, Administrative and Practice Reform Strategies (Cont.)

Family Support, Family Reunification and Permanency Planning:

- Juvenile court judges hold more frequent hearings, hold hearings in local child welfare offices, and use other methods to reduce court review backlogs.
- Family court systems are reformed to better involve parents and extended families, including *mandatory* family-group conferencing/decision-making.
- Practice experts team with policy specialists and parent representatives to review the cases of children stuck in the system. E.g., Permanency Roundtables.

How do we effectively replicate model programs?

- Many excellent programs fail when replicated in other real world settings because they lack ***program fidelity***.

(I.e. the program is not implemented with the consistency and high quality of the original efforts.)

Program Implementation: Paying Attention to the Fundamentals

- 1. Systems interventions**
- 2. Careful practitioner selection**
- 3. Pre-service training**
- 4. Ongoing consultation & clinical coaching**
- 5. Administrative supports (“barrier busting”)**
- 6. Staff evaluation (assessment & feedback)**
- 7. Process and outcomes monitoring with incentives and consequences**

(Fixen et al. 2005, p. 34)

Never Underestimate.....

- The power, resources and strengths of families.
- The creativity and potential of youth in care.
- The exponential power of systems working together *with* families and local communities.

References

To see a 14 minute **video** about reunifying families in foster care in Austin, go to:

<http://www.casey.org/Resources/Initiatives/austinreintegration/>

For a **report** on how Georgia is helping hundreds of children find permanence, go to

<http://www.casey.org/Resources/Publications/garoundtable.htm>

To learn more about Florida's efforts to prevent foster care placement see

<http://www.youtube.com/watch?v=aAUv1n3zVYQ>

For PESA and Taking Control curricula and therapist training for EBT: Contact Dr. Lisa Hunter Romanelli at the REACH Institute: lisa@thereachinstitute.org

www.TheReachInstitute.org

For consensus guidelines for mental health services in child welfare, see the REACH Institute website and the journal *Child Welfare*, 88(1), Special Issue.

For Multi-Dimensional Treatment Foster Care (MDTFC) cost-effectiveness:

<http://www.colorado.edu/cspv/blueprints/modelprograms/MTFC.html>

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- Washington Department of Health and Human Services
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 - **Co-Principal Investigators:** Ronald Kessler, Diana English, James White, Chris Downs

Appendix A

Supplemental Information About Mental Health Services Challenges and Healing Strategies

Learning from Consumers through Casey Mental Health Focus Groups

What we've been told:

❖ Youth and alumni

- Feel disconnected from decision-making processes
- Feel misdiagnosed, labeled, and overmedicated
- Feel that interventions should be more strength-based and varied
- Feel that trust and relationship are critical
- Feel that support groups are helpful
- Describe themselves as “normal kids in abnormal situations”

Casey Mental Health Focus Groups (Cont.)

❖ Foster parents and kinship caregivers

- Feel that providers need training in issues specific to out of home care
- Feel that providers must use a “team” approach that includes caregivers
- Feel that youth are commonly mis/over-diagnosed and overmedicated
- Feel that caregiver support groups are very helpful

Casey Mental Health Focus Groups (Cont.)

❖ Staff

- Report a very high percentage of youth with mental health challenges
- See the value of having a diverse and comprehensive set of interventions available
- Feel frustrated: systems do not work together and resources are inadequate in their communities
- Feel Medicaid providers are overburdened and/or under trained
- Feel that teamwork is essential – providers that work with staff are more effective

Help Caregivers Access Better Mental Health Services for Youth in Care

- Adapt the Columbia *Parent Empowerment Program* curriculum to train birth parents, foster parents and caseworkers to become better advocates for the mental health care of their children.
- New curricula: *Parent Engagement and Self-Advocacy (PESA)*.

(See www.TheReachInstitute.org)

Parent Training

- **Parents can be powerful advocates for quality mental health services!**
- **A birthparent and a professional co-train birth parents, foster parents and caseworkers *simultaneously*, and offer continuing support.**

Help Mental Health Staff Provide Evidence-Based Treatment

- **Address the “supply side” of the mental health system by training providers.**
- **Offer one-year certification training in evidence-based treatment for MH conditions such as depression, anxiety, PTSD, ADHD, and impulsive aggression for local MH staff serving foster care youth.**
- **There appears to be value in low-cost, year-long therapist development programs pioneered by teams of Psychiatrists, Psychologists and Social Workers. (E.g., see TF-CBT website and the REACH Institute website: www.TheReachInstitute.org)**