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FIVE CHALLENGES CHILD WELFARE AGENCIES FACE IN MEETING CHILDREN’S MENTAL HEALTH NEEDS AND HOW TO SOLVE THEM

POLICY BRIEF

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Introduction

Children’s mental health is a growing public health crisis. Further magnified by the pandemic, pediatric mental health-related emergency room visits and suicide deaths for children are on the rise. An estimated one in five children experience a mental health condition in a given year, yet half may not receive needed treatment. In the absence of easily accessible and available community-based supports, these needs too often remain under- or unaddressed until they escalate to a crisis point or behaviors that can lead to emergency medical services, placement in a group facility, or involvement with the criminal justice system.

Children in foster care experience higher rates of mental health needs compared with their peers. For these children, the trauma of removal from their parent’s care can exacerbate existing mental health needs. Leaving children’s needs unaddressed may contribute to unhealthy or disruptive behaviors that make caring for them difficult and can result in multiple moves to different foster homes or placement into residential treatment programs. More than one in three children in foster care have experienced three or more placements, with behavioral challenges often cited as the primary reason for placement disruptions. Such disruptions can lead to longer stays in foster care, academic difficulties, and troubles maintaining interpersonal relationships.

Through our technical assistance projects, we have observed five common operational challenges child welfare agencies face in meeting children’s mental health needs:

1. Many children who would benefit from mental health services are not referred.
2. Referrals are often made too late in a placement after crises have already emerged.
3. Treatment providers often do not receive important information needed to match children with services that best meet their needs.
4. Long wait times between referral and the start of therapy creates delays in access to services.
5. Lack of systematic information about referrals and service delivery makes it challenging for agencies to identify how to improve access.

This brief describes these five challenges in more detail and offers tactical solutions that welfare agencies can use to address each for children in foster care.

To better understand challenges for coordinating timely access to mental health services for children in foster care, the GPL supported one jurisdiction to review Medicaid claims data for a cohort of children who entered foster care over a period of six months. For each child, the agency used billing information to identify whether that child ever attended an appointment for mental health services, and for those children who received mental health services, how much time elapsed between removal from their parents and the first service appointment. Among this cohort, more than two-thirds of children had not received mental health services during their first two months in foster care. In addition, placement stability data showed that one-third of foster care placements disrupt during these first two months, reinforcing the importance of quickly connecting children with mental health services after removal.

Breakdowns in the referral process rarely result from a single challenge and improving timely access to services for children may require changes at multiple parts of the process. As a first step, child welfare leaders may find it helpful to convene local stakeholders from the child welfare and mental health systems to collaboratively map the process for connecting children to services in order to identify pain points and elevate potential solutions.

**Strategies to address common challenges**

Below are five common operational challenges that child welfare agencies face in improving timely connections to mental health services for children entering foster care and potential strategies for addressing them. See the Appendix for a summary of these strategies.

While this brief focuses primarily on strategies for strengthening referrals and coordination of care, gaps in the existing service array may also create significant barriers to meeting children’s mental health needs. Particularly for children with acute needs, more intensive wraparound or home-based services may have limited slots or not be available at all. The mix of available providers may not reflect the communities they serve, or a shortage of culturally competent providers may create additional barriers to service engagement for children in foster care or from historically marginalized communities. In addition to the strategies outlined here, jurisdictions should explore addressing gaps in the children’s mental health service array itself by, for example, contracting for additional services, investing in youth peer positions, leveraging tools like telehealth to overcome geographic capacity constraints, or adjusting eligibility requirements to broaden access to more intensive community-based supports.

**Challenge 1: Many children who would benefit from mental health services are not referred.**

In most jurisdictions, caseworkers—rather than clinical experts—are the ones responsible
Make referrals to mental health services the default expectation for all children entering foster care, with exceptions in special circumstances or for specific exclusionary criteria (e.g., children under age 3).

Streamline the referral process—such as by eliminating duplicative steps or reducing paperwork—in collaboration with local mental health providers to reduce the work required by caseworkers in making referrals.

Utilize a clinical expert to screen for a child’s mental health needs and make referrals to mental health services when needed.

Organize quarterly workshops for foster care caseworkers led by local mental health providers to share information on the types of mental health services available, provide a step-by-step breakdown of the process for referring children to services, and answer caseworker questions to prepare them for making referrals to mental health services.

Potential innovations to test:

- Make referrals to mental health services the default expectation for all children entering foster care, with exceptions in special circumstances or for specific exclusionary criteria (e.g., children under age 3).
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How children in foster care access mental health services

In many jurisdictions, children in foster care access mental health services primarily through community-based systems of care that are administered separately from the child welfare system. For example, in one jurisdiction where the GPL has worked, children are connected to services only after a child’s foster care caseworker makes a referral to local Community Mental Health Service Program entities. These coordinating entities are part of the state’s public mental health system, separate from child welfare and funded jointly by Medicaid, block grants, and state and local funds. Largely through subcontracts with local providers, these organizations offer a wide array of behavioral health services to both children and adults in local communities, with a focus on serving individuals that would benefit from high intensity services.

Children may also be connected with services available through Medicaid health plans. Such Medicaid-funded plans provide mental health services for Medicaid-eligible children with mild to moderate needs. In some cases, local child welfare offices may also directly refer children to therapists contracted by the child protection agency if the child already has a relationship with the provider or if the service is not otherwise available in the public mental health system.
**Challenge 2: Referrals are often made too late in a placement after crises have already emerged.**
Despite common policy expectations for caseworkers to screen children entering foster care and quickly refer those who have experienced trauma to mental health services, many referrals may not be made until three or more months into a placement. One caseworker shared that children often do not exhibit behavioral challenges in the first three months, a period commonly referred to as the “honeymoon” phase of a placement. In many cases, waiting for behaviors to escalate can lead to crisis situations, which can cause placement disruptions and worsen children’s unaddressed needs.

**Potential innovations to test:**
- For every child placed into kinship or traditional foster care, include a discussion of potential mental health service needs as a standard agenda item during the first family team meeting with parents, caregivers, child welfare investigators, and foster care staff when placement details are being discussed. Consider the child’s trauma history when determining need for services in order to ensure referrals are made early during a new placement before behaviors escalate.
- Set clear expectations for referrals to be made early in a case, ideally within the first two weeks of a new placement, and institute mechanisms for supervisors and regional leaders to track compliance and follow up with caseworkers regarding referrals.

**Challenge 3: Treatment providers often do not receive important information needed to match children with services that best meet their needs.**
When case workers complete a referral for mental health services, they may not include specific details about a child’s trauma history or the maltreatment they experienced that could be important for determining what services would best meet their needs. During an assessment with clinical staff, children may be reluctant to share information with yet another stranger about trauma they have experienced. Therefore, providers must sometimes make decisions about the appropriateness of services based on incomplete information. This can lead to children being assessed and enrolled in services that do not adequately meet their needs—or even screened out as ineligible for services.

**Potential innovations to test:**
- Encourage parents, caregivers, and caseworkers to attend intake appointments with children to ensure information about the child’s case and trauma history are clearly communicated to providers.
- Redesign the referral form to capture important details about caregivers, parents, and a child’s trauma history so children are better matched by providers with the therapeutic care that can best meet their needs.
- Invite local mental health providers to attend an early family team meeting (FTM) to initiate the referral process and communicate key case information needed to match children with the right services.
Challenge 4: Long wait times between referral and the start of therapy creates delays in access to services.
Wait times between referral and start of therapy can be lengthy due to a lack of appointment slots, limited availability of therapists, or existing backlogs. In many cases it may take at least two weeks following referral to schedule an initial intake appointment and an additional two weeks until a child has had a first session with a therapist. The first available appointment may not work with the caregiver’s or child’s schedule, which can further prolong the time to access services. Rescheduled appointments or no-shows may lead to additional delays. These delays can leave children’s underlying needs unaddressed for a long time during a critical transition period.

Potential innovations to test in partnership with community mental health providers to:
- Automate eligibility for children in foster care in order to reduce number of screenings and handoffs required prior to the start of services so that children in foster care can more quickly begin treatment after referral.
- Reserve appointment slots for children in foster care to reduce wait times for the first available appointment, especially for cases with severe trauma history.
- Expand service hours to include appointments after school hours and outside of business hours to create greater flexibility for caregivers to bring children for appointments.
- Share information regarding no-shows with caseworkers in real-time so they can follow up with caregivers directly and provide support to enable children to attend future appointments.

Challenge 5: Lack of systematic information about referrals and service delivery makes it challenging to determine how to improve access and identify cases that may need follow up.
Child welfare agencies often do not know which children are already receiving services and which may have unaddressed mental health needs. Information about referrals and service delivery may sit across two different data systems for child welfare and the public mental health system, making it difficult to track. While child welfare may track placement and referral data, therapy-related information such as appointment dates and services received is tracked only by mental health providers and often in a siloed way that is rarely reviewed. This prevents agencies from identifying cases that are being left behind in real time in order to proactively resolve access bottlenecks.

Potential innovations to test:
- Create a system in collaboration with mental health providers for child welfare leaders to be able to collect and monitor data on mental health referrals on a weekly basis. To enable identification of barriers to access or system bottlenecks, this data should include key information such as removal date, mental health screening results, referral date, and service start for every child placed in foster care.
- Convene child welfare case supervisors and mental health providers on a monthly or quarterly basis to collaboratively review real-time data on referrals and identify and implement strategies to improve access.
Case study: Improving referrals and access to mental health services for children in Bay County, Michigan

With support from the GPL, child welfare leaders in Michigan’s Bay County sought to reduce placement disruptions for children in foster care by strengthening earlier connections to mental health services. To better understand how and when children were already accessing mental health services and begin to uncover opportunities for improvement, the County team reviewed Medicaid claims data for a cohort of children who entered foster care over a period of six months. For each child, the team used billing data to determine whether the child had attended a mental health appointment, and for those children who received services, calculated how much time had elapsed between removal and the first service appointment. Hoping to identify new opportunities to improve timeliness and fine-tune the referral process, the County had not expected to learn that nearly three-quarters of children were not receiving mental health services during their first two months in care. Additional analysis revealed that approximately one-third of children in foster care experienced a placement disruption by the end of this second month—often caused by escalating behavioral challenges—further underscoring the importance of quickly connecting children with mental health services soon after a placement begins.

In response to these findings, Bay County decided to convene foster care staff and representatives from local mental health service providers to collaboratively map out the referral process in order to elevate pain points and identify potential solutions. Learning that caseworkers often waited for a child’s behaviors to escalate before initiating a referral, the County Director tested a new policy for caseworkers to complete a trauma screening and refer all eligible children to mental health services within the first two weeks of placement—a more proactive approach to addressing children’s needs that also aimed to reduce the likelihood that crisis situations would emerge. Caseworkers also began discussing a child’s trauma history and potential mental health needs during initial family team meetings (FTMs) to more comprehensively capture important details that could be communicated to service providers. Ongoing monthly meetings with caseworkers and service provider staff helped ensure that cases did not fall through the cracks and created space to collaboratively troubleshoot any challenges that emerged in the referral process.

Over a period of six months, the share of children quickly connected to mental health services after removal more than doubled; now half of children begin receiving mental health services within their first month in foster care. The Bay County Director reflected, “We are now providing better support for our youth and better opportunities for them to remain in their placements. We have recently begun to observe a decrease in placement changes across the county, and less disruption means less trauma and better outcomes for our youth.”

For more on how to uncover gaps in social service referral systems and generate fixes that improve outcomes for their clients, see the GPL’s blog post on Six powerful questions every government ought to ask to diagnose problems in social service referral systems.
The Government Performance Lab, housed at the Taubman Center for State and Local Government at the Harvard Kennedy School, conducts research on how governments can improve the results they achieve for their citizens. An important part of this research model involves providing hands-on technical assistance to state and local governments. Through this involvement, we gain insights into the barriers that governments face and the solutions that can overcome these barriers. By engaging current students and recent graduates in this effort, we are able to provide experiential learning as well.

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