Getting a grip on systems of care and child welfare using opposable thumbs

John D. Fluke a,*, Elizabeth Oppenheim b

a Child Protection Research Center, American Humane Association, 63 Inverness Drive East, Englewood, CO 80112, United States
b Walter R. McDonald & Associates, Inc., 12300 Twinbrook Parkway, Suite 310, Rockville, MD 20852, United States

ARTICLE INFO

Keywords:
Child protection
Child welfare
Systems of care
Family driven
Collaboration
Serious emotional disturbance
Young children

ABSTRACT

The purpose of this response paper is to discuss issues raised by two of the components of the definition of systems of care proffered by Hodges et al. [Hodges, S., Ferreira, K., Israel, N., & Mazza, J. (this issue). Systems of care, featherless bipeds, and the measure of all things. Evaluation and Program Planning]. In particular, this response will present some implications of the definition of the focus population and the value and core principle of family-driven care. It will also consider why these two components of the definition might serve as challenges to the applicability of the concept of systems of care to child welfare, and, in turn, integration of the model across child welfare and mental health. Recommendations for expanding and refining these component terms are provided.

© 2009 Elsevier Ltd. All rights reserved.

This paper examines the utility of the Hodges, Ferreira, Israel, and Mazza (this issue) definition of systems of care from a child welfare perspective. Two aspects of the definition – the focus population and the value and principle of family-driven care – require expansion in order to be more relevant to children involved in the child welfare system. Modification of these two aspects would provide a more relevant definition of systems of care for child welfare and, in turn, facilitate collaboration and integration between child welfare and mental health agencies.

1. Focus population

In FY2006, an estimated 3 million children and youth (hereafter referred to as children) were subjects of child maltreatment investigation or assessment responses—the primary entry point for child welfare agencies across the country. More than 800,000 children in these responses had cases opened for post-investigation services, but the children were not removed from their homes (USDHHS, 2008a). In addition, more than 241,000 other children were removed from their homes. Approximately 510,000 children were in foster care, of which 49% had a goal of reunification with their parents (USDHHS, 2008b). Clearly, there is a substantial population of children and families engaged in child welfare who have need for support services, including mental health services.

Recent studies suggest that children involved in the child welfare system have or are at high risk for emotional and behavioral problems. Problems can range from clinically significant issues to trauma-related problems (Burns et al., 2004; Dore, 2005). Findings on mental health service needs indicate that many children involved with child welfare who have clinically significant challenges are not receiving mental health services. One study indicates that there is a potential benefit to increasing the use of specialized mental health services by this group, particularly among younger children (Hurlburt et al., 2004).

Young children as analyzed under several definitions of age who are victims of maltreatment are at considerable risk for developing mental health problems. Kaplow and Widom (2007) find in their long-term prospective study, that early-onset maltreated children are at greater risk for long-term deleterious mental health outcomes compared to older children who are maltreated. This is especially concerning for maltreated children who are involved in child welfare as the majority (55%) of these children are younger than 7 (USDHHS, 2008a).

Finally, the mental health status of parents and caregivers appears to be an important factor associated with children who are maltreated (DiLauro, 2004). Thus, while some children may not exhibit any mental illnesses, their parent’s mental health condition may place them at continued risk for maltreatment and the attendant risk for developing mental health symptoms.

The substantial numbers of children served by the child welfare system and their unmet need for mental health services points to a major gap in mental health services for this population. However, the focus population (i.e., individuals served by systems of care) in the system of care definition proffered by Hodges et al. (this issue) is “children and youth with serious emotional disturbance and their families.” This population definition addresses a fraction of children in the child welfare system with mental health needs.
Many children receiving child welfare services have experienced significant trauma and have or are at risk of having significant mental health needs. However, many may not have been diagnosed, or due to technical reasons (see below) are not able to be diagnosed with serious emotional disturbance.

According to the historical population definitions presented by Hodges et al. (this issue), the original 1986 definition (Stroul & Friedman, 1986) references children with “severe emotional disturbance.” Beginning with the definitions provided by Pires (2002a, 2002b) and Stroul (2002), the population definition was expanded to include “emotional/behavioral disorders” “multiple and changing needs of children,” and in 2006 the population in the definition by the Center for Mental Health Services references “serious mental health needs.” The more recent definitions may offer an advance in thinking, rather than returning closer to the original definition of the focus population of children with “serious emotional disturbance.” Beginning with the definitions provided by Pires (2002a, 2002b) and Stroul (2002), the population definition was expanded to include “emotional/behavioral disorders” “multiple and changing needs of children,” and in 2006 the population in the definition by the Center for Mental Health Services references “serious mental health needs.” The more recent definitions may offer an advance in thinking, rather than returning closer to the original definition of the focus population of children with “serious emotional disturbance” as suggested by Hodges et al. (this issue).

Drawbacks of the Hodges et al. (this issue) definition are an important consideration and are tied to using a strict interpretation of a determination that a child has a serious emotional disturbance. A strict interpretation requires adherence to conditions described in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM–IV) and involves meeting one of six specific behavioral characteristics (Code of Federal Regulations, Title 34, Section 300.7(c) (4) (iii)). Current interpretation may also include the cross-walked elements of the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, Revised (DC:0–3R) and the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM), and the Dominance, Influence, Steadiness, Conscientiousness (DISC) assessment.

Despite the introduction of the DC:0–3R, it still may not readily establish a mental health diagnosis. Furthermore, the population component in the Hodges et al. (this issue) definition seems to rule out the possibility of applying systems of care to families whose children are at risk of developing a serious emotional disturbance. Currently, several Substance Abuse and Mental Health Services Administration (SAMHSA)-funded system of care sites with early childhood populations of focus are struggling with this very issue (Early Childhood Community of Practice, 2008). Finally, even though caregiver mental health status is tied to increased propensity to maltreat children, and even though maltreated children appear likely to develop serious mental health problems, an apparent precondition to aiding families under the Hodges et al. (this issue) definition is that the child first has characteristics of a serious emotional disturbance. This precondition would exclude child welfare children and families from benefiting from systems of care when the child has no characteristics of a serious emotional disturbance.

Allowing for the fact that many systems of care are funded under the auspices of federal mental health policy and that its definition must, therefore, be tied to mental health constructs, it may be that the broader concept of what is meant by a system of care should extend beyond what is required within the current policy and funding context. Locally developed and funded systems of care could apply a broader view of the population component and still meet a more flexible system of care definition, albeit not necessarily the definition that would qualify for federal funding. For systems of care, it may be important to consider how mental health and other services may prevent the onset of a serious emotional disturbance, particularly among abused and neglected children. In a child welfare context, a prevention focus could also help to orient systems of care services to support the ongoing needs of families needing help to avoid having a child removed from their home or, if the child is reunified, to reduce the likelihood of the child re-entering out-of-home placement.

2. Family-driven care

The second component of the proposed definition of systems of care Hodges et al. (this issue) that raises issues for the child welfare system is the value and principle that the system of care approach to the provision of services be family driven. The working definition of family-driven care is “families have a primary decision-making role in the care of their own children, as well as the policies and procedures governing care for all children in their community, State, Tribe, territory and nation” (USDHHS, SAMHSA, 2007). This includes choosing supports, services, and providers; setting goals; designing and implementing programs; monitoring outcomes; and determining the effectiveness of all efforts to promote the mental health of children and youth (USDHHS, SAMHSA, 2007). At the center of this definition is the guiding principle of shared decision-making authority and responsibility for outcomes by families and the professionals at both an individual and system level.

This principle of family-driven care is challenging to realize with parents in the child welfare system. There is a legally mandated differential in authority that parents and professionals have from the onset of a child welfare case, and timeframes in which services must be provided and the safety issues remedied. Conversely, the underlying value of family-centered practice and family involvement and engagement also found in the definition of family-driven care is an aspect of the current child welfare practice paradigm recognizing that “lasting solutions to problems are ones that grow out of, or can fit with, the knowledge, experiences, and desires of the people most affected” (Burford & Hudson, 2000).

Involvement in the child welfare system most often begins with an allegation of maltreatment made by a professional involved with the child, who is mandated, by law, to report child maltreatment. Parents are rarely the source of reports of abuse and neglect and involvement in child welfare, at least initially, is involuntary. Most parents do not request services from child welfare (Burford & Hudson, 2000). In contrast, involvement with the public children's mental health system is often initiated by parents seeking services or support for their children (Pires, 2002a, 2002b).

The overarching responsibility of the child welfare system is to ensure the safety of children who have been abused and neglected or are at risk for abuse and neglect. Abuse and neglect are defined in both federal and state laws, which provide the grounds for intervention in the lives of families. Once an allegation of abuse and neglect is made, parents may find themselves subject to a succession of police investigators, social work investigators, social case workers, mental health professionals, and court hearings. Judges, police, caseworkers, and others will make recommendations or critical decisions about their family life. The consequences of determining that a child has been abused or neglected can be momentous: the agency can seek court authorization to intervene with the family to protect the child and potentially impose treatment services, remove a child from the home, and even terminate parental rights.

Historically, families were excluded from the process of determining the services and supports that would assist them to remedy the issues that brought them into the child welfare agency. The role of the parents was to successfully meet outlined conditions and complete prescribed programs in the case plan. The focus was on compliance by parents and keeping the child safe. Often this led to children being placed in foster care to keep them safe while parents worked to improve the conditions that led to the abuse or neglect (Scheme, 1998; National Technical Assistance and Evaluation Center for Systems of Care, 2008).

Given the consequences of a determination of abuse and neglect, the general conflict tension between ensuring the safety of
children and strengthening families, and the presence of court oversight, it is not difficult to understand the difficulty in implementing family-driven care within this context. Even when determined that the case does not meet the legal definition of abuse or neglect, there is still the possibility of further agency or court intervention. In these cases, the agency provides or arranges for supports and services to help families ensure that they can provide for the safety and well-being of their children and prevent the need for removal. In these cases, the concept of family-driven care may be easier to implement.

In the last 10 years there has been a paradigm shift in child welfare practice from a strictly professionally driven, “system knows best” model to one striving toward a family-centered practice with family involvement and engagement in the decision-making process (Christenson, Curran, DeCook, Maloney, & Merkel-Holguin, 2008; National Technical Assistance and Evaluation Center for Systems of Care, 2008). Increasingly, agencies are implementing new practice approaches that include families in the case planning process and the passage of both federal and state laws have articulated the value of family-centered practice and family engagement. Examples include family involvement models such as Family Group Decision Making (FGDM) and Differential Response. Also, implementing regulations of the ASFA (1997) Adoption and Safe Families Act of 1997 (ASFA, P.L. 105-89) state that parents are to be involved in the design of services aimed at ensuring the safety and timely permanency for their children. (45 C.F.R. §1357).

Many state statutes require the child welfare department to include the parents in case planning (Child Welfare Information Gateway, 2005).

Conversely, ASFA also limits the “reasonable efforts” that states must make in order to reunify a child with his family, requires expedited case reviews and permanency plans, and enforces termination of parental rights when children are in placement for 15 of the previous 22 months. By contrast, the mental health system has no time constraints in achieving the outcome of improved mental health. It is widely understood by mental health constituencies (including children, families, and professionals) that treatment may be a life-long process, allowing ample time for the emergence of positive outcomes for children and their families.

There is also the issue of capacity to “drive” the system. Families involved with the child welfare system often have multiple and complex needs. Many parents struggle with substance abuse problems; others struggle with mental health issues of their own. Both of these issues can impair a parent’s ability to make good decisions for themselves and their children and has implications for the ability of these families to drive the system as prescribed by the system of care principle of family-driven care.

Furthermore, to be effective in a child welfare context, the definition of “family” now needs to be expressed more broadly. Family must include relatives, members of a child’s tribe, godparents, stepparent, or any adult with a kinship bond with a child—possibly including foster parents. For many children in child welfare, these adults may be vital to achieving a better understanding of the family’s problems and can be equal partners with professionals in formulating and implementing identified solutions. Ultimately, extended family members may be the responsible party for a child if the parents are unable or unwilling to care for the child. To be consistent with the system of care principle of delivering culturally and linguistically competent services, this may mean that extended family can and should play a much broader role in driving services and policies.

This is all to suggest that, in order for child welfare to fully implement the system of care approach to the transformation of service provision, the concept of family-driven care may need to be thought of as a continuum that encompasses a range of different degrees of family involvement and engagement. Along the entire continuum would be the value of family-centered practice. Each level of family involvement and engagement would take into consideration a number of factors including the level of safety and risk concerns, the capacity of the parent to recognize the child’s needs, the parents’ ability and willingness to partner successfully with the agency, and the degree to which extended family must be involved. This more fully realized conceptualization of family-driven care would be more consonant with the goals and needs of children and families served in the child welfare system and would facilitate the effective collaboration of the child welfare system within a system of care.

By including the concept of a continuum of family involvement and engagement, there is recognition that family involvement at both the individual and system levels can take shape differently based on the particular circumstances of each family that becomes involved with the child welfare system. This conception demonstrates an understanding of the limitations on families to “drive” the system as equal and empowered partners with system professionals since they necessarily enter the system with much less authority. If a child is placed in foster care or if the court orders services for the child and family, then the decision-making authority ultimately resides with the court. A continuum in the definition must also recognize the legally mandated timeframes that prevent agencies from implementing all family engagement practices, especially given the time and resources it takes to engage families in the child welfare system in a meaningful way.

From the standpoint of system-level family involvement, a continuum in the definition recognizes that families have valuable experience and firsthand knowledge that can be used to improve the child welfare system. It should be a system that provides a range of opportunities for families to participate in informing system reform from sitting on advisory councils to providing training, to becoming peer mentors for other families involved in the system. Yet, it also recognizes that families may not want to continue their relationship with the child welfare agency and the difficulty that may be inherent in moving from the role of being a system client to participating fully as a partner in system change. As in the mental health system, stigma is a major barrier to participation at all levels of the system, and for child welfare-involved caregivers and their extended families, stigma may be even more acute.

These suggested refinements to the definition of system care provide for a balancing of two essential elements of child welfare—the legal framework and its concomitant mandates, and the value and importance of family involvement in ensuring the safety, well-being, and permanency of their children. These elements are integral to the successful collaboration and integration of systems of care with the child welfare system for the delivery of appropriate and culturally and linguistically competent services for children and their families.

3. Conclusion

Among the current guiding principles in the “mode of system response” component of the proposed definition by Hodges et al. (this issue) are that children should receive integrated services, that systems of services in the community need to be collaborative, and that early intervention should be promoted. These principles suggest that attention to developing a definition of systems of care that takes the constraints and capacities of other systems into account must be a part of the dialogue that facilitates integration and collaboration. The reason for this is simple: if agencies involved in systems of care in a community are aligned more closely in ways that help address their key populations, it is more likely that effective collaboration can be achieved and sustained. In the case of child welfare, the proposed definition is misaligned and
may hinder the achievement of full integration of services especially in communities where child welfare populations are prioritized as part of the population of focus. This is because the definition does not appear to address the full range of mental health needs of children and families in the system and because child welfare system constraints may be at odds with implementation of the system of care as a fully family-driven service provider.

This is not meant to suggest that systems of care should take direction from a single collaborator. Rather, as is the case in system of care communities today, the constituencies must be clear about the population they are attempting to reach with services and the identification of appropriate collaborators that would be logical partners in that effort. Depending upon which key collaborators are identified, some of the wording that goes into the components of the definition may need to be addressed and modified to permit greater collaborative alignment.

The development of the definition of systems of care as proposed by Hodges et al. (this issue) may be of great value not so much for its specifics, but because it breaks the definition into components. One could envision modifying the wording (or elaborations of wording) of the components that would be customized for the critical collaborations agreed to by a community’s stakeholders. In this way, the definition and its customized components could serve as a valuable tool to both clarify the goals of the system of care and align these goals with the potentially competing goals associated with each of the child-serving sectors collaborating with the system of care. Such a tool could be introduced early in the inception of a system of care and provide valuable direction throughout the life of the system of care in addressing the needs of children and families who are served.

References


John D. Fluke. PhD, has 29 years of experience in service delivery system research in Child Welfare and Children’s Mental Health and is the founding director of the Child Protection Research Center at the American Humane Association. As a researcher he specializes in analyzing decision making in human services delivery systems and is known for his innovative and informative work in child welfare administrative data analysis, workload and costing, and performance and outcomes measurement. He has worked with all levels of government, in the private not-for-profit sector, and with national foundations/associations that include work both in the U.S. and internationally.

Elizabeth Oppenheim, JD, has more than 20 years of experience in the field of human services. She is currently a Senior Research Manager for Walter R. McDonald & Associates. As part of the National Evaluation Team for the Comprehensive Community Mental Health Services for Children and Their Families Program, Liz is focusing on analyses of the intersection of child welfare and systems of care. Liz’s diverse background includes direct practice, program development and management, policy analysis, legal advocacy, qualitative and quantitative research, and training and technical assistance. She has in-depth expertise in child welfare service delivery across agencies.