



Interagency collaboration and identifying mental health needs in child welfare: Findings from Los Angeles County[☆]



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ABSTRACT

Research has indicated that disparities between the need for and receipt of mental health services are in part due to challenges in identifying mental health problems in this population. Interagency collaboration between the child welfare system (CWS) and mental health organizations shows promise in circumventing these challenges. To this end, Los Angeles County's Department of Children and Family Services (DCFS) and Department of Mental Health (DMH) engaged in interagency collaborative efforts that included the development of a collaborative model detailing steps for systematic screening, assessment, referral, and continuum of care for mental health needs of DCFS-involved children. DCFS and DMH also developed a uniform agency mental health screening tool to be used by the DCFS staff to enhance identification of needs and expedite services for CWS-involved children at risk of mental health problems. This article describes the processes of interagency collaboration between DCFS and DMH, development of a uniform agency mental health screening tool, and demographic descriptors of an ethnically diverse cohort of CWS-involved children who received the mental health screening protocol (N = 4694) between 2011 and 2012. Findings indicate that collaborative efforts between DCFS and DMH facilitated the mental health screening of a large cohort of CWS-involved children, which resulted in the detection of need and referral for services.

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1. Introduction

The prevalence of mental health needs is high among children served by the child welfare system (CWS; Burns et al., 2004; Hurlburt et al., 2004). Research has indicated that children in the United States who come into contact with the CWS are at greater risk of poor mental health outcomes than those in the general population (Burns et al., 2004). Risk factors that often coincide with child maltreatment, such as prenatal drug and alcohol exposure and exposure to interpersonal violence and other trauma (Raviv et al., 2010), place many stressors on children's mental health (Kaplow & Widom, 2007). The CWS hence faces increasing organizational pressure (e.g., via lawsuits or federal mandates) to collaborate with specialized mental health service providers to provide timely and appropriate screening and assessment of mental health needs among CWS-involved children (Bonta, 2006;

Petersen et al., 2013). For example, as part of a settlement agreement from a class-action lawsuit (Bonta, 2006) to enhance identification of needs and expedite referral to mental health services for CWS-involved children, the Los Angeles County Department of Children and Family Services (DCFS) and Los Angeles County Department of Mental Health (DMH) adopted a model of interagency collaboration with the goal of providing streamlined services to CWS-involved children. This interagency collaboration (henceforth referred to as collaboration) is a significant landmark given the legal implications and the fact that DCFS and DMH provide services in Los Angeles County, one of the most populated and ethnically diverse locations in the United States.

This descriptive study highlights key collaborative practices and policies between these two large service systems in their efforts to meet client needs and address legal and organizational mandates to provide appropriate mental health services to CWS-involved children. First, we present an overview of the impetus for and strategies of the collaboration between DCFS and DMH. Next, we describe the uniform agency mental health screening tool (MHST) developed through this collaboration; this tool was intended for use by DCFS staff members (non-mental-health specialists) to help capture the mental health needs of children in the CWS. We also depict the establishment of a dual-agency referral and linkage team intended to coordinate mental

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health services for CWS-involved youths. Finally, we provide a description of demographics and child welfare characteristics of children who received this mental health screening in the context of collaboration.

2. Interagency collaboration: DCFS and DMH

2.1. Impetus for and strategies of collaboration between DCFS and DMH

The need to develop collaboration practices that increase coordinated mental health screening, assessment, and service provision for CWS-involved children is particularly salient in Los Angeles County. In 2002, several public interest law firms brought a child welfare reform class-action suit (Bonta, 2006) against the state of California and Los Angeles County, seeking the establishment and implementation of a community-based mental health service delivery system for California's children in foster care or at imminent risk of out-of-home placement. The suit challenged county and state agencies for neglecting their duties to provide necessary and legally mandated services to treat the mental health conditions of California's foster children. Los Angeles County entered into negotiations and settled the case in March 2003. The settlement obligated the county to enact comprehensive reforms, including better identification of mental health needs and prompt provision of services designed to promote stability and ensure quality care for children under the supervision of DCFS.

To fully meet the obligations of the settlement agreement, DCFS and DMH adopted a model of collaboration that included implementation of policies and collaborative practices and strategies such as: (a) the development of a memorandum of understanding for data sharing and linkages, (b) cross-systems training, (c) co-location of DMH staff members in DCFS offices, (d) automated referrals between agencies, (e) development and adoption of a uniform mental health screening tool, and (f) referral and linkages resource teams (composed of DCFS and DMH employees) in each DCFS office. These practices of collaboration (e.g., colocation and development of screening tools) used by DCFS and DMH align with existing literature that identified them as promising strategies in improving the identification of need and provision of mental health services to CWS-involved youths (Bai et al., 2009; Hurlburt et al., 2004). Indeed, one study using nationally representative data of CWS-investigated children suggested that higher engagement in these different types of collaboration strategies, such as information sharing at the agency level, can improve the delivery of mental health services (Bai et al., 2009).

2.2. Mental health screening tool

In addressing the stipulations of the *Katie A.* settlement, DCFS and DMH acknowledged that a key element of delivering mental health services is adequate and accurate mental health screening. However, among CWS agencies, delivery of expedited mental health screening is complicated by the fact that child welfare workers are not mental health practitioners; this likely contributes to the high variability in referral and receipt of mental health services among CWS-involved children. Additionally, although mental health screening tools abound, those with a current evidence base must typically be administered by trained mental health professionals (Day). Given the legal stipulations put forth by the *Katie A.* settlement, policy changes that required DCFS social workers to provide the initial screening for mental health needs, as well as organizational constraints to not overburden DCFS workers' workload, DCFS and DMH collaborated to adapt a mental health screening tool developed by the California Institute for Mental Health. This adapted screening tool (the MHST) was originally intended for use with children in the general population and modified specifically for DCFS staff members so that it was user-friendly for non-mental-health specialists or clinicians, required minimal formal training to use, and could be administered quickly to DCFS-involved children.

The MHST was first rolled out in 2009 in three service planning areas (SPAs) in Los Angeles County (of nine total SPAs), with full rollout to all SPAs in 2011. Only children with opened or newly substantiated DCFS cases qualified to receive the screening. Prior to using the MHST, all workers received approximately 2 h of training, during which they were instructed to complete the screening instrument using information provided in vignettes. To date, approximately 35,000 to 40,000 children have been screened using the MHST.

Two DCFS uniform agency screening tools were developed: one for children aged 0–5 and another for children older than 5. Items in the MHST assess for indicators of psychological or behavioral problems and environmental risk factors associated with the development of mental health care needs. The screening tool for children aged 0–5 includes questions such as: “Does this child exhibit unusual or uncontrollable behavior?”, “Does this child seem to be disconnected, depressed, excessively passive, or withdrawn?” and “Does this child reside with a parent/caregiver with a known recent mental health, drug and/or alcohol problem?” Questions for children aged 6 or older are similar, but include additional items such as: “Does the child have problems with social adjustment?”, “Does this child have significant functional impairment?”, “Does this child have significant problems managing his/her feelings?” and “Is this child known to abuse alcohol and/or drugs?” These items were included based on input from workgroups composed of representatives from county and community agencies and experts in child development, and represent guided questions and indicators to identify children most in need of mental health services.

The MHST was designed to be administered by DCFS workers to children and their caregivers and was available only in English. Based on child and caregiver responses, the DCFS worker checks off potential mental health need indicators on the MHST; the tool then guides the social worker to make informed decisions regarding whether or not the child is at risk of mental health needs and thereby would benefit from a more thorough mental health assessment. Children who are considered to be at risk due to signs or presence of risk factors associated with psychological or behavioral problems are screened as positive on the MHST. Positive MHST cases are triaged to co-located DMH workers to receive more in-depth assessment.

2.3. Coordinated services action team

Additionally, to create continuity of care for children identified as having mental health needs, DCFS and DMH collaborated to establish a referral and linkages resource team, known as the Coordinated Services Action Team (CSAT), in each DCFS regional office. Each CSAT consists of both DCFS and DMH resource and service coordination staff members and was designed to accomplish the following goals: ensure the consistent, effective, and timely screening and assessment of mental health needs across all populations of children served by DCFS; coordinate mental health services among DCFS and DMH staff members who link children to services within and across offices; and ensure the most appropriate service linkage. Overall, the CSAT staff members served as points of contact to ensure that there were no lapses in services as cases proceeded from initial screening by DCFS workers, to DMH assessment for further mental needs, to referrals for formal mental health evaluation. CSAT members were notified of lapses in services through automatic staff reports and worked with both DCFS and DMH staffs and supervisors to ensure continuity of mental health care for dually served children.

Fig. 1 outlines the screening, assessment, and referral steps overseen by the CSAT, from when a child first receives a MHST screening to processes for referral, assessment, and linkages to mental health services. In Step 1, the MHST is administered by a DCFS children's social worker to determine if a child is at elevated risk of mental health problems. Informed by responses by a child and his or her caregiver(s) to the MHST items, the DCFS worker makes a guided decision regarding whether or not the child is at risk of mental health needs and therefore would

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