Mental Health Treatment for Parents in the Child Welfare System and Family Reunification

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Background

- Parents in CA foster care system have ~15 months to demonstrate fitness to regain custody before parental rights are terminated.[1,2]
- Addressing parental mental health care needs is crucial to achieve family reunification within this time period.[3]
- Child protective agencies must collaborate with mental health care providers quickly.[4]
- Barriers to effective referral include poor interagency communication, limited access to resources, and inefficiencies in referral process, hindering parents getting needed care.[5]
- Little research examines impact of parental mental health service needs on family unity.

Objectives

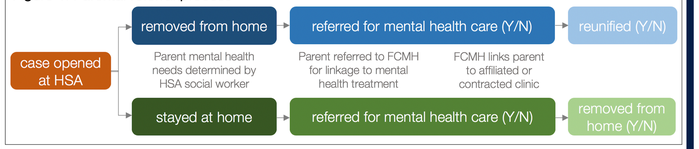
To determine the effects of parental mental health needs on family outcomes within the foster care system.

Methods

This quality improvement project examined 1) impact of parental mental health needs on child placement outcomes and 2) barriers and facilitators of effective inter-agency collaboration between child protective services and mental health services.

- **Setting:** The San Francisco Department of Public Health Foster Care Mental Health (FCMH) clinic provides mental health services to children/youth and families in the child welfare system. The San Francisco Human Services Agency (HSA) provides myriad public assistance to children and families, including medical services and protective services.

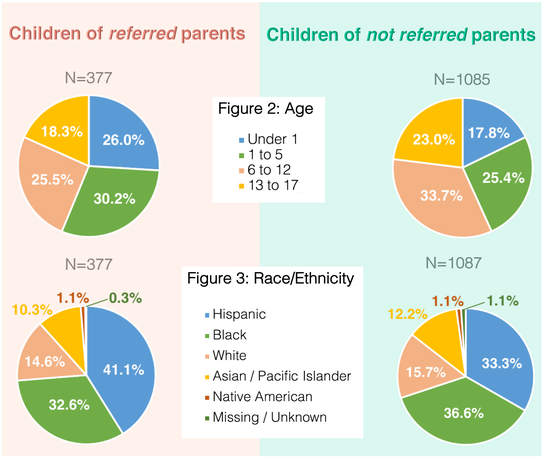
Figure 1: Parental referral process



- **Sample:** Parents of children with open HSA cases Jan 2018 – Dec 2020. Case defined as in-home if the child was removed from the home for 7 days or less.
- **Analysis:** We compared 12-month outcomes between cases with parents referred for mental health treatment vs. those who were not referred for: 1) family reunification rates among cases with children placed in foster care and 2) rates of removal from home among children assigned to in-home care. We also examined demographic (race/ethnicity, gender, age, and language) differences between groups. We were unable to obtain and link data on mental health services received. We used Chi-square and Fisher's exact tests for all comparison of proportions.
- **Interviews:** Due to multiple systemic barriers (see Table 1), we were unable to conduct stakeholder interviews. Barriers and facilitators described are based on PI personal experience as a provider in the FCMH system.

Results

Child demographic characteristics



- Similar proportions of children of referred parents were male (50.4%) compared to children of non-referred parents (47.5%).
- Majority of children (~84% in both groups) spoke English as their primary language, with no differences between referred and non-referred groups.
- Overall, children of referred parents were younger than those not referred (X^2=19.0, p<0.001). Specifically, the referred group had more parents of infants (z=3.4, p<0.001) and children under 6 (z=4.4, p<0.001) than the non-referred group.
- More parents of Hispanic children were referred vs not referred (z=2.7, p= 0.007).

Figure 4: Child placement outcomes for in-home cases

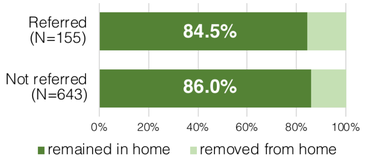
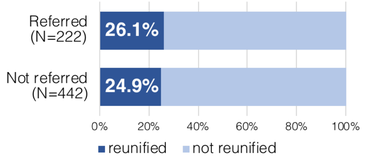


Figure 5: Child placement outcomes for out-of-home cases



- Smaller proportion of cases of referred parents were in-home (41.1%) vs. cases of non-referred parents (59.3%) (Z= -6.1, p<0.001).

Discussion

Table 1:

	BARRIERS	RECOMMENDATIONS
Poor inter-agency communication	• Privacy restrictions limit information HSA case managers can share with SFDPH providers • SFDPH providers lack information about court requirements and timelines • Differing schedules, high caseloads, limited time, various organizational stressors, and disagreements about shared mission hinder effective communication between organizations • Court timelines don't account for systems limitations	• HSA case workers obtain release of information (ROI) to single SFDPH case manager, who receives all referrals, conducts phone screen to assess parental needs, then facilitates referral process • Referral forms from HSA to SFDPH require details regarding reason for referral request • SFDPH to educate providers in requirements for treatment as established by the court (e.g. timelines for reunification, outcomes for families that fail to connect to care) • Schedule regular meetings for HSA social worker, SFDPH case manager, and referred provider to ensure needs of parent are being met
Access delays or denials	• Staffing shortages limit timely services • Providers deny services based on perceived lack of medical necessity • Parents may minimize mental health need due to stigma, fear of consequences for self & family	• SFDPH to hire peer navigators to support parents connecting to services • SFDPH to extend contracted provider network for greater service availability and variety • Consider adopting intensive case management model for parents with substance use disorders used by San Francisco Family and Children's Services' (FCS)
Inefficient practices	• HSA's determination of services for parents is not standardized • Sharp division between adult and child services at SFDPH limits provider collaboration in cases of whole family care	• HSA to standardize mental health assessment process for parents; include assessment results with referral • SFDPH to provide training and consultation for case workers to assess parent mental health needs and determine appropriate services • SFDPH to obtain ROIs and allow/support communication and collaboration between providers of children and parents receiving HSA recommended services

- Higher proportion of parents of infants and children under 6 referred for mental health services is a window of opportunity to intervene during this critical stage of development.
- Higher proportion of Black and Hispanic parents compared to White parents in the overall sample reflects overrepresentation of these populations with HSA cases in San Francisco, consistent with patterns across California.
- Greater proportion of Hispanic parents referred for mental health than not referred may suggest differing need or biases in likelihood of referral.
- Overall low reunification rates across referred and non-referred parents indicates critical need for more supports to these families.

Limitations and Future Directions:

- Outcomes of parental mental health referrals, including whether parent engaged in care were unavailable due to data sharing barriers and delayed approval processes.
- Interviews from key informants will be useful, particularly in understanding barriers and possible solutions from the perspective of HSA caseworkers.
- Ongoing inter-agency collaboration must continue to address systemic fragmentation, ethnic/racial inequities and increase support for the most vulnerable children.

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Acknowledgements

This work was supported by the San Francisco Family and Children's Services and San Francisco Department of Public Health Community Behavioral Health Services (Foster Care Mental Health, Psychological Assessment Services Program). We acknowledge Dr. Stephen Wu, and Dr. Christina Mangurian, Dr. Jim Dilley, and Dr. N Kyle Jamison from the University of California San Francisco Public Psychiatry Fellowship at Zuckerberg San Francisco General Hospital.