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WORKSHOP OBJECTIVES

Show how an intensive case record review can:

• Begin to address gaps in knowledge about young foster children who are psychiatrically hospitalized

• Enrich child welfare research on the child’s experience of placement and hospitalization by using mental health lens

• Provide information that can be used to support efforts to improve service quality and outcomes

• Inform future research and evaluation
  • Offer strategies for measuring childhood trauma
  • Identify topics for future research
BACKGROUND

PURPOSE OF THE CASE REVIEW
Origins of the Study

• Analysis of 200 children identified as high risk
  • Majority of children who were 12 or younger and not in residential treatment were in specialized foster care

• Review of psychiatric hospital utilization data identified several specific concerns
  • Possibility of unnecessary psychiatric hospitalization
  • Hospital stays beyond medical necessity
  • Readmissions within short time after discharge
  • Placement instability and moves to residential care
  • Quality of discharge service planning and aftercare
PURPOSE OF CASE REVIEW

• Conclusion: Available data alone could not answer longitudinal and interactive questions
  • Needed a mental health lens

• Question: What do we need to know and when do we need to know it in order to prevent certain patterns of hospital utilization?

• Provide information that can be used to support efforts to improve service quality and outcomes
CONCEPTUAL AND METHODOLOGICAL STRATEGIES
APPLYING A MENTAL HEALTH LENS
APPLYING A MENTAL HEALTH LENS TO CHILD WELFARE AND EVALUATION

- Longitudinal/sequential focus on child’s experiences over time
  - Counterweight to cross-sectional bias in CW
- Developmental context (age, timing of coming into care)
- Interest in child’s concerns, perspective, and experiences of trauma
- Psychological importance of family to all foster children
- Psychiatric hospitalization as an intervention (understudied)
- Assess and support child’s care-giving environments, and service quality
Figure 1: PHC Clinical Perspective & Analytic Framework

**PHC ANALYTIC FRAMEWORK**

- **Pre-existing conditions** (< placement)
  - Case characteristics
  - History of maltreatment
  - Other familial trauma experiences
  - Windows of opportunity for intervention

- **Prior experiences in care** (< target PH)
  - Placement events
  - Placement disruptions (trauma in care)
  - Psychiatric hospitalizations
  - Windows of opportunity for intervention

- **Proximal reasons for target Psychiatric Hospitalization**
  - Child behavior
  - Contextual factors (foster home, school)

- **What happens during target hospitalization**
  - Services/Treatment
  - Collaboration
  - Discharge planning

- **Discharge & Post-Discharge Outcomes**
  - Length of hospital stay
  - Placement at discharge
  - Re-hospitalization
  - Placement changes/events
  - Services/supports
CASE REVIEW PROCESS

- 8 DCFS clinical staff: two day training/data collection
  - 4 from Cook County, 4 from rest of Illinois

- Review records (SACWIS) before, during, after target event:
  - Integrated Assessments (e.g., data on trauma, symptoms)
  - Case worker case notes (e.g., symptoms, communication with therapist, hospitalization decision) and service plans
  - Clinical consultations

- Enter data, ratings, comments on spreadsheet

- Gather administrative data (separate from reviewers)
  - Placement and hospitalizations: living arrangement data
  - Child maltreatment: from investigations data
PHC CASES: HIGH RISK SAMPLE (N = 32)

• Selection criteria:
  • In Specialized Foster Care (SFC) due to mental health problems/service needs
  • Subset of children (12 and under) who had a Target psychiatric hospitalization between November 2009 & March 2010
  • Cases included sequentially, except:
    • All children 8 and under (N=8)
    • Even split between Cook County and the rest of Illinois
  • Initial time frame for follow-up: 105 days post-discharge (N = 31)
ANTECEDENTS OF TARGET HOSPITALIZATION

FINDINGS AND IMPLICATIONS
SELECTED CHARACTERISTICS OF SAMPLE

• Pre-existing (pre-placement) conditions and trauma

  • High levels of pre-placement psychiatric hospitalization: 53%

  • Exposure to toxic stress in family (in addition to maltreatment):
    • DV (domestic violence (63%)
    • substance abuse (60%)
    • mental illness (60%)
    • criminal activity (73%)
Selected Characteristics of Sample

- While in placement *prior to target psychiatric hospitalization*
  - Most children in care for fairly long periods of time prior to target hospitalization
    - Median years from first case opening to target hospitalization = 3.8
    - Child’s age at first case opening: median = 5.1, with 16% were under 2 years old
  - High rates of various indicators of instability
    - 63% had been hospitalized since coming into care
    - 59% had 4 or more different foster homes
    - 69% had been in 3 homes within 18 months at some point
    - 50% had a disrupted kinship care placement
    - 31% had a disrupted “permanency”
    - Only 28% had been in same school for last 2 years
SELECTED FINDINGS

• High rate of hospitalization prior to child being placed—red flag
  • Should SFC be the default level of care for these children when they enter care?

• Over 40% of children were in their pre-hospital placements for 60 days or less
  • They were already in crisis
  • All transitions are hard for traumatized children

• Shorter time to SFC associated with better post-hospitalization outcomes: reduced risk of residential placement and placement instability
  • Children shouldn’t have to fail their way into SFC
  • SFC rarely used with these children when < 5 years old: should SFC utilization depend on age of child?
  • May need an early childhood/developmentally lens for SFC
SYMPTOMS PROMPTING TARGET HOSPITALIZATION

• Type of symptom
  • Physical aggression: 80%
  • Depression: 57%
  • Serious threats to harm others: 53%
  • Property damage: 43%
  • Psychotic thought processes: 43%
  • Suicidal ideation/actions: 40%
  • Sexual aggression: 23%
  • Running away: 17%

• Mean # symptoms = 4.8 (out of 14)
  • Very highly correlated with re-hospitalization and post-discharge residential placement
MANY CHILDREN HOSPITALIZED FOR REASONS OTHER THAN SYMPTOM SEVERITY

- Clinical reviewers: severity of child’s symptoms alone warranted hospitalization in only 50% of cases

- Factors related to how foster parents, educators, and other professionals perceived and responded to the child’s symptoms often appeared to contribute to decisions to hospitalize a child

  - Hard to talk about many of these symptoms (sexual aggression or sexualized behaviors, psychotic thoughts, aggression, cutting)
  - Environmental factors can be addressed through training and support for foster parents, caseworkers
NARROW FOCUS ON COMPLIANCE

- Child welfare professionals, educators, and caregivers often
  - focused too narrowly on behavior management strategies and compliance
  - failed to:
    - understand the relationship of symptoms to underlying causes (e.g., trauma)
    - listen to children
    - use anticipatory guidance strategies

- Helping child rather than: STOP IT!
HISTORY OF FAMILIAL TRAUMA

- Children with more types of familial trauma (e.g., parental mental illness, DV, substance abuse, criminality) prior to 1st placement:
  - Moved more quickly to SFC and psychiatric hospitalization after case opening
  - Had higher rates of placement instability prior to the target hospitalization
  - Had longer stays in the target hospitalization

- Gather trauma data systematically when children enter care
- Use trauma data to inform decision-making & service planning, and study hospitalization and placement outcomes
HISTORY OF FAMILIAL TRAUMA

• Two types of familial placement disruption:
  • Permanency (reunification, adoption, other)
  • Kinship care

• Associated with increased “negative” post-discharge outcomes (residential placement, placement instability)

• Familial placement disruptions may be particularly painful for children
• May influence placement trajectory, likelihood of hospitalization
ONGOING IMPORTANCE OF FAMILY AND FAMILIAL STRESSORS

- 77% of children preoccupied with concerns about family prior to hospitalization
  - concern and anxiety about family visits
  - disappointment and anger about missed visits
  - aggression targeted toward mother, grandmother, or siblings
  - feeling abandoned and left out of family events
  - worrying about the safety of a mother or sibling,
  - recent exposure to family violence or illness
  - intense anxiety about pending reunification
  - conflicted feelings about termination of parental rights

- Illustrate ongoing power of ambiguous losses (e.g., Samuels, 2008)
- Hard to talk about family (your mama!)
- Foster parents/caseworkers not skilled at talking with children about family
- Need increased sensitivity to each child’s cues and concerns
SYSTEMIC IMPLICATIONS

• There were multiple Windows of Opportunity when (earlier) better decisions or more effective intervention might have prevented psychiatric hospitalizations or placement disruptions
53% of children had at least 1 psychiatric hospitalization prior to placement.
OUTCOMES OF TARGET HOSPITALIZATION

FINDINGS AND IMPLICATIONS
**HOSPITAL UTILIZATION: LENGTH-OF-STAY**

Mean LOS = 24 Days

Considerable Variation

<table>
<thead>
<tr>
<th>Days</th>
<th>Children</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>4-10</td>
<td>8</td>
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<tr>
<td>11-40</td>
<td>19</td>
<td>59%</td>
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<td>41-80</td>
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<td>16%</td>
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**PLACEMENT STABILITY**

Hospital Discharge

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<th>Discharge Placement</th>
<th>Children</th>
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<td>Pre-admit Spec Foster Home</td>
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<td>New Placement</td>
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</table>
### Placement Stability

**End of follow-up period**

3.5 - 7 Months Post-Discharge

<table>
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<th>Current Placement</th>
<th>Children</th>
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<tbody>
<tr>
<td>Pre-admit Spec Foster Home</td>
<td>10</td>
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<td>New Placement</td>
<td>22</td>
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</table>
### Residential Placement or Hospitalization

<table>
<thead>
<tr>
<th>Residential Placement or Hospitalization</th>
<th>Children</th>
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</thead>
<tbody>
<tr>
<td>At 105 days (N = 31)</td>
<td>15</td>
</tr>
<tr>
<td>End of follow-up period (3.5 - 7 months)</td>
<td>22</td>
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</tbody>
</table>

Post-Discharge
SUMMARY AND IMPLICATIONS

• Outcome data suggest that any stabilization in child’s behavior or symptoms accomplished by psychiatric hospitalization was temporary and did not improve the child’s trajectory in care.

  • Alternative means of crisis response and stabilization may have potential to reduce hospital utilization
SUMMARY AND IMPLICATIONS

• Outcome data indicate that discharge to same specialized foster home did not necessarily contribute to placement stability
  • Suggests that antecedents to hospitalization including caregiver capabilities may also contribute to placement instability

• Transitions (even discharge to a familiar placement) are potentially difficult for children who have experienced abuse or neglect
CHALLENGES

PRACTICE, PROGRAM AND POLICY
MENTAL HEALTH LENS: CONTRIBUTIONS

• Shifts focus from purely placement to **well-being**

• Views psychiatric hospitalization as short-term intervention

• Hospital is *not* a placement

• Emphasizes critical, ongoing role of community-based mental health and crisis response services

• Stresses the importance appropriate and timely discharge service planning and *implementation*
CHALLENGES: CAREGIVER PREPARATION AND SUPPORT

• Mismatches between caregiver preparation and child’s mental health needs must be addressed
  • *Anticipatory guidance* for foster parents
  • Specialized trauma-informed training for foster parents
  • Crisis plan for children who have been hospitalized
  • Greater, more consistent and *ongoing* caregiver support

• Importance of understanding effects of trauma, recognizing potential triggers, and responding in an appropriate and timely way
CHALLENGES:
MENTAL HEALTH SERVICE RESOURCES

• Improving resources for in-home and community-based therapeutic and crisis-response services
  • Services that address needs of young children in foster care and have potential to reduce hospital utilization

• Strengthen collaboration between mental health service providers and caregivers
  • Addressing the potential for hospitals to work more effectively with foster parents
  • Preventing the use of psychiatric hospitalization as a vehicle for placement disruption and lockouts
NEXT STEPS

• Caregiver training
  • Implementation of NCTSN training (Illinois addendum)

• Casework practice
  • Develop structure for crisis plans, placement transition plans and anticipatory guidance plans

• New cases
  • Identify “red flags” at entry Integrated Assessment
  • Determine mechanism and resources for attaching focused mental health care management

• Phase II case review analysis
  • Therapy records and SASS crisis service data