HMA

INTEGRATING BEHAVIORAL HEALTH AND CHILD WELFARE:
Critical To Prevention Of Adverse Child And Family Outcomes

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AGENDA

❑ Data illustrating the problem

❑ The value of intersectionality among behavioral health and child welfare in the prevention arena

❑ Data integration strategies

❑ Promising examples of coordinated system approaches

OBJECTIVES

1

Understand how child welfare services departments currently interact with the behavioral health service continuum in the prevention arena.

2

Learn how to build value by identifying areas where the intersection of child welfare, and behavioral health helps improve outcomes and mitigate risk for children and families.

3

Learn about data integration strategies that support meaningful whole family approaches to improving protective factors and strengthening family resilience.
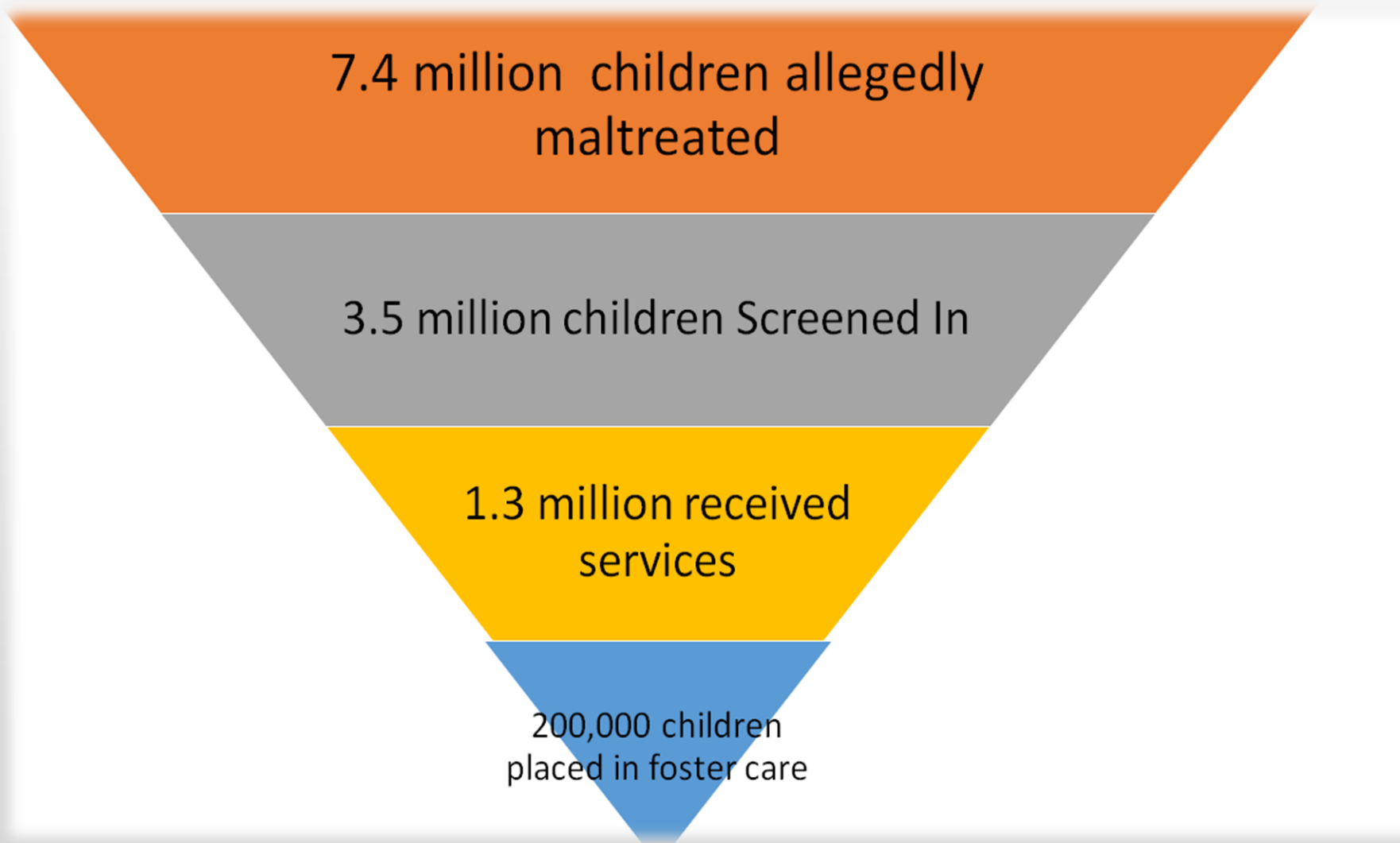
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Highlight examples of how other jurisdictions have applied solutions and strategies aimed at better integrating child welfare systems, and behavioral health.
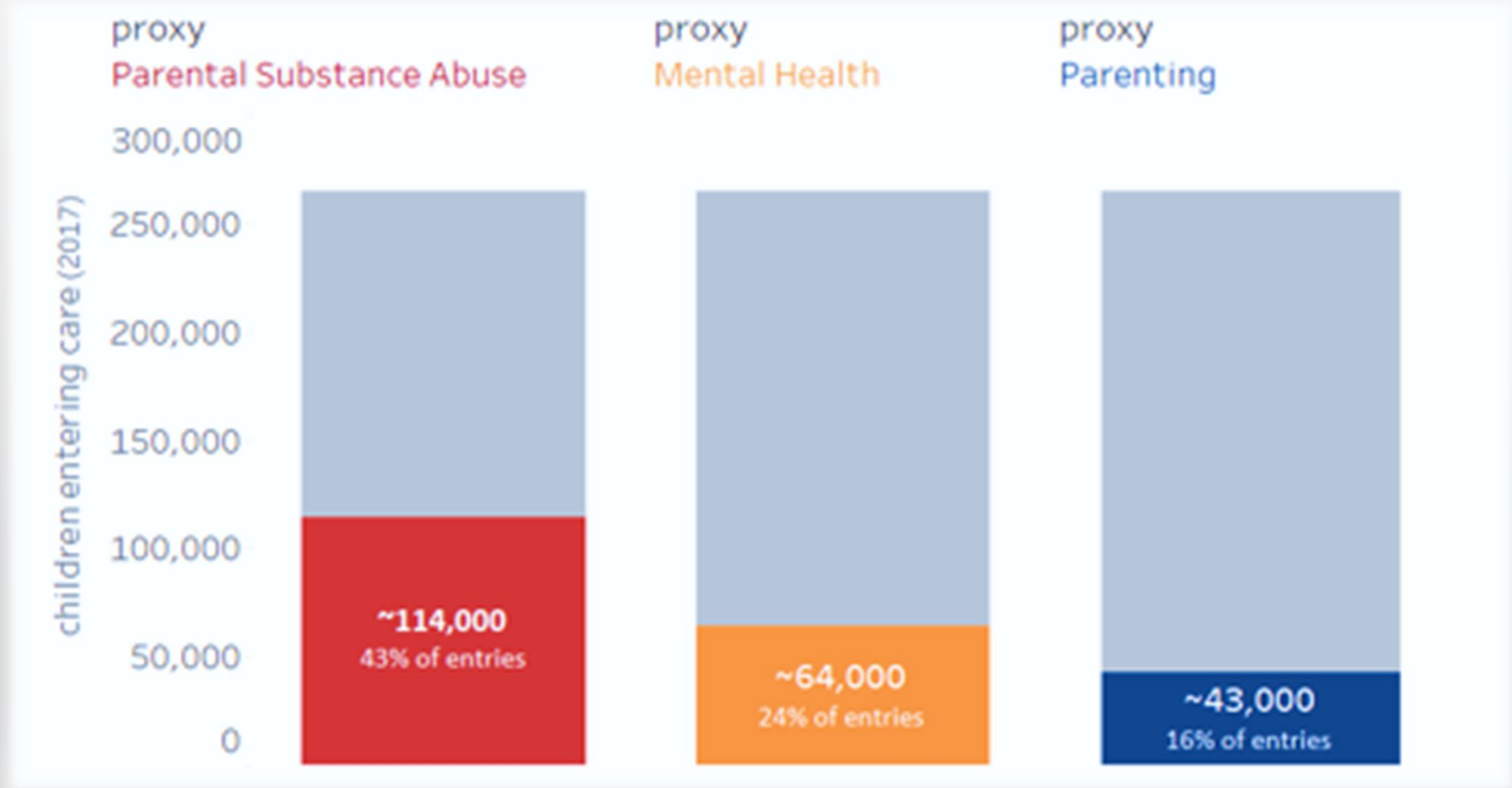
THE CONTEXT

7.4 million children allegedly maltreated

3.5 million children Screened In

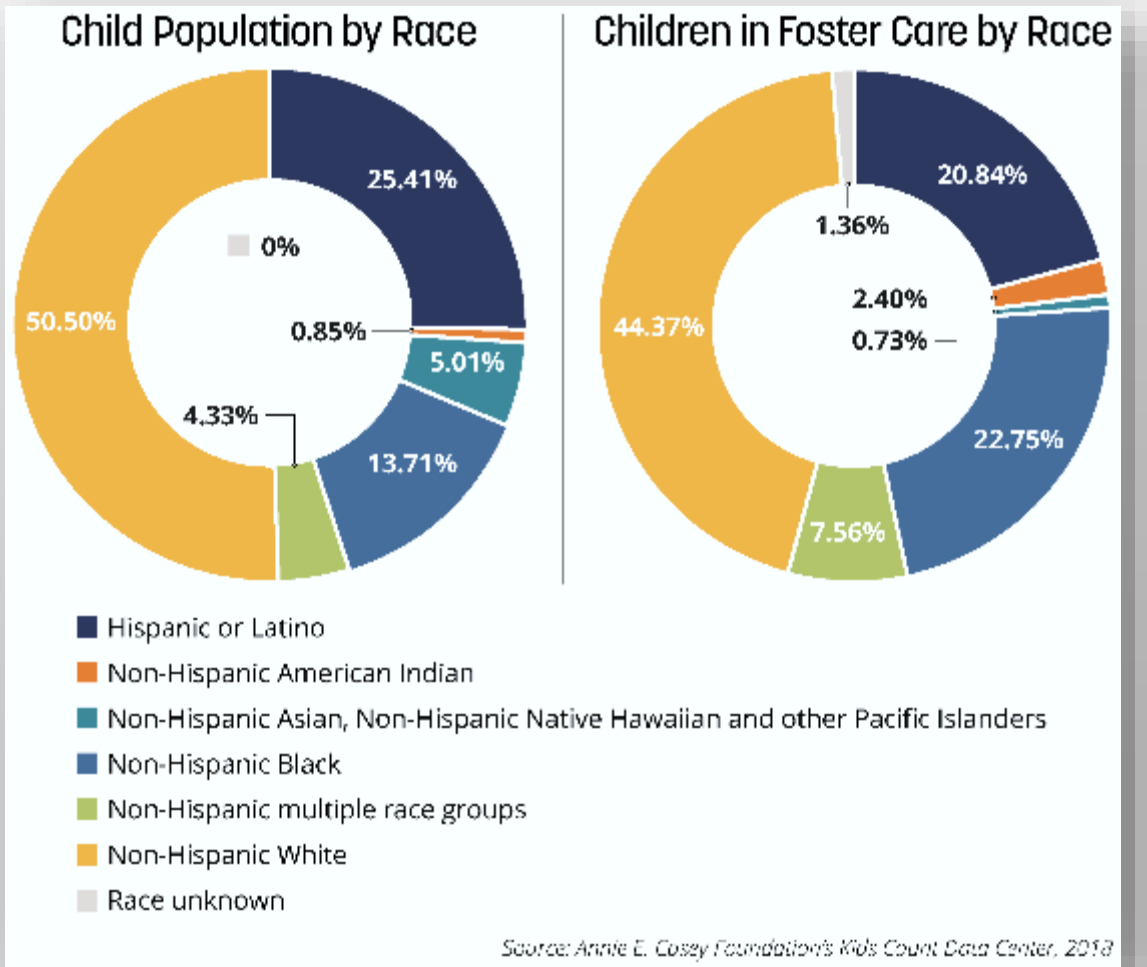1.3 million received services

200,000 children placed in foster care

- 1 in 27 maltreatment referrals leads to placement in foster care

- Up to 80% of children in foster care have BH issues[3]

- 70-85% of children served by the child welfare system who are in need of mental health services *do not receive such services*[4]

Source: Child Maltreatment 2019; Children's Bureau.

More Than Half Of Entries Into Foster Care Are In Categories Targeted By FFPSA Prevention Services Categories

proxy
Parental Substance Abuse

proxy
Mental Health

proxy
Parenting

children entering care (2017)

300,000

250,000

200,000

150,000

100,000

50,000

0

~114,000
43% of entries

~64,000
24% of entries

~43,000
16% of entries

Disproportionality In Foster Care

Child Population by Race

- 25.41%
- 0%
- 50.50%
- 0.85%
- 5.01%
- 4.33%
- 13.71%

Children in Foster Care by Race

- 20.84%
- 1.36%
- 2.40%
- 0.73%
- 44.37%
- 22.75%
- 7.56%

Legend:
- Hispanic or Latino
- Non-Hispanic American Indian
- Non-Hispanic Asian, Non-Hispanic Native Hawaiian and other Pacific Islanders
- Non-Hispanic Black
- Non-Hispanic multiple race groups
- Non-Hispanic White
- Race unknown

Source: Annie E. Casey Foundation's Kids Count Data Center, 2018
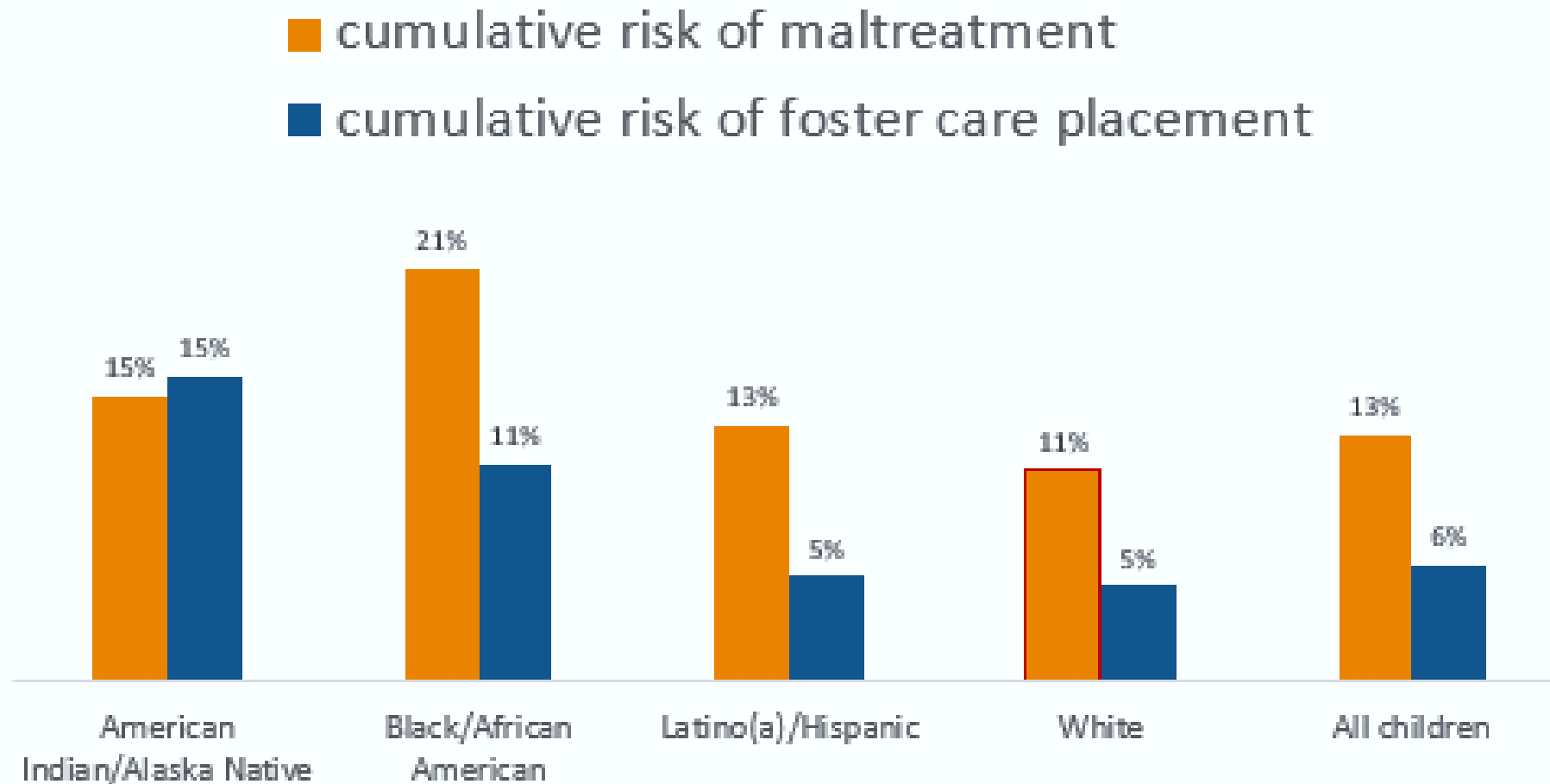
- According to 2018 data, Black children were 13.71% of the population, yet **22.75% of children in foster care were Black**

- According to 2018 data, **American Indian/Alaska Native children didn't even account for 1% of the population, yet they made up 2.4% of children in foster care**

- According to 2018 data, white children made up 50.5% of the population, yet they accounted for only 44.37% of children in foster care

- Black and American Indian/Alaska Native children also make up a disproportionate number of children identified as victims by child protective services and children waiting to be adopted
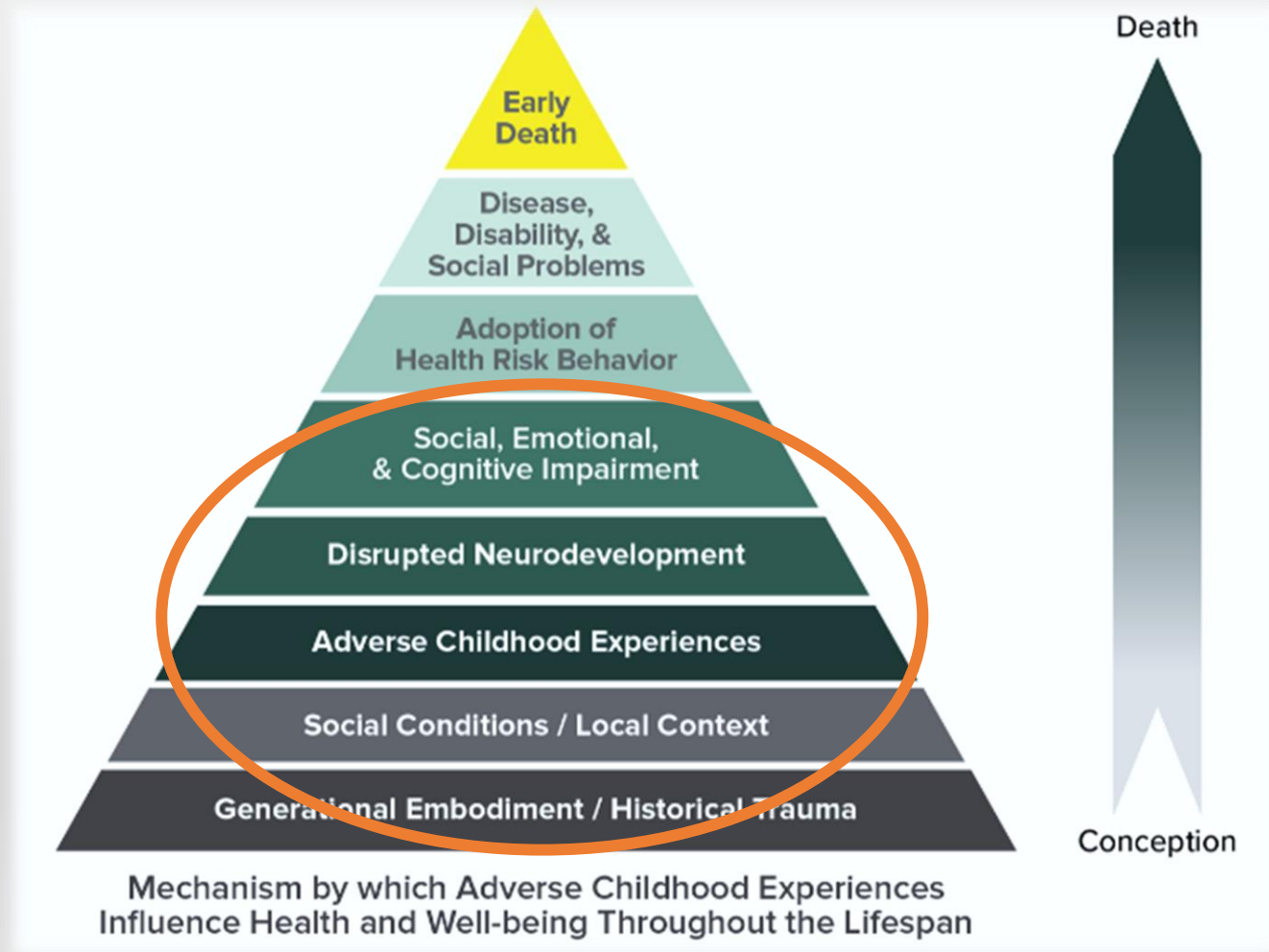
Cumulative Risk of Child Welfare Involvement by Age 18

■ cumulative risk of maltreatment
■ cumulative risk of foster care placement

	American Indian/Alaska Native	Black/African American	Latino(a)/Hispanic	White	All children
cumulative risk of maltreatment	15%	21%	13%	11%	13%
cumulative risk of foster care placement	15%	11%	5%	5%	6%

Source: Wildeman, C. et al. The Prevalence of Confirmed Maltreatment Among US Children, 2004-2011. JAMA Pediatrics. 2014; 168(8): 706-713..

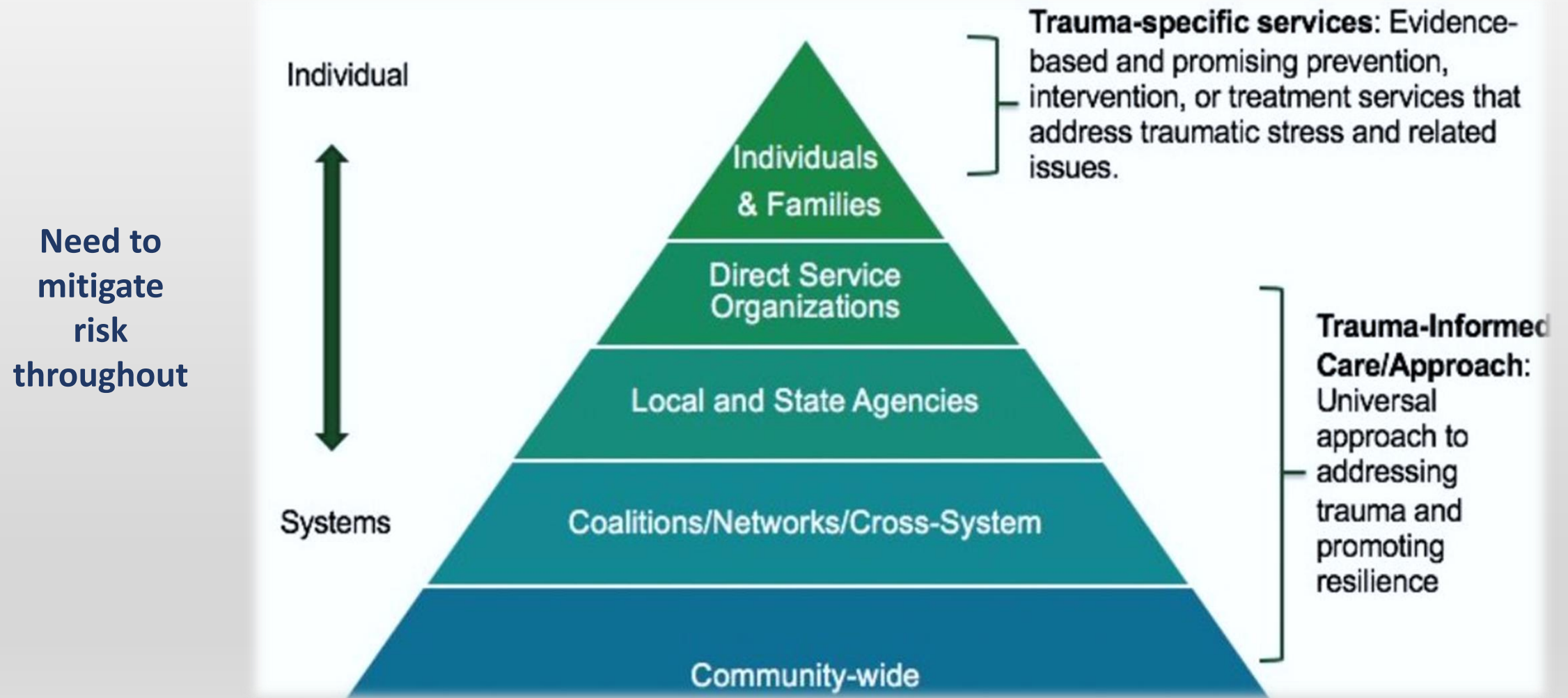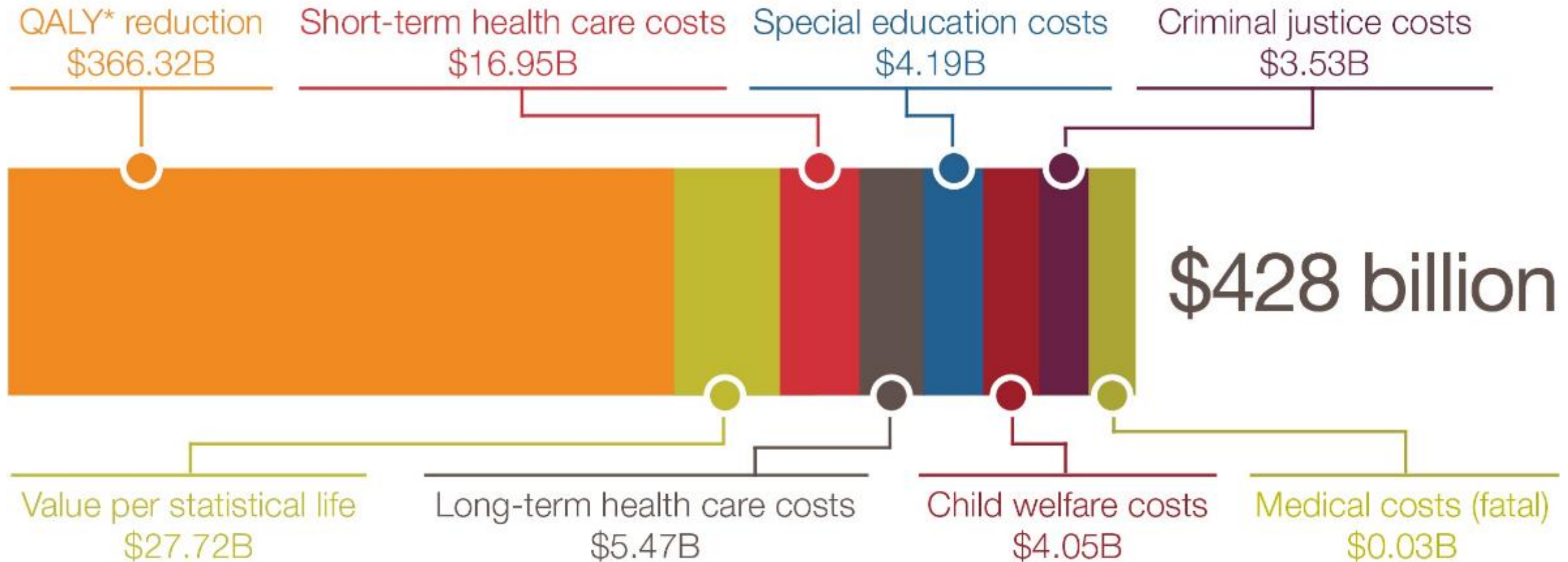# Call To Action For Coordination

Mechanism by which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

The ACE Pyramid

Systems of Care Offers Opportunity for Coordination

Need to mitigate risk throughout

Individual

Systems

Trauma-specific services: Evidence-based and promising prevention, intervention, or treatment services that address traumatic stress and related issues.

Individuals & Families

Direct Service Organizations

Local and State Agencies

Coalitions/Networks/Cross-System

Community-wide

Trauma-Informed Care/Approach: Universal approach to addressing trauma and promoting resilience

Advancing Trauma-informed Care Within and Across Child-Serving Systems
https://www.chapinhall.org/research/mstic-guide/

The Financial Stakes are Significant

TOTAL LIFETIME ECONOMIC BURDEN OF CHILD MALTREATMENT PER YEAR[4]

QALY* reduction
$366.32B

Short-term health care costs
$16.95B

Special education costs
$4.19B

Criminal justice costs
$3.53B

$428 billion

Value per statistical life
$27.72B

Long-term health care costs
$5.47B

Child welfare costs
$4.05B

Medical costs (fatal)
$0.03B

*QALY (quality of life years): values of morbidity and mortality that attempt to include the intangible costs of pain and suffering experienced by the affected individual and broader community

Peterson, C., Florence, C. & Klevens, J. (2018). The economic burden of child maltreatment in the United States, 2015. *Child Abuse & Neglect*, 86, 178-183. Accessed from https://www.casey.org/population-based-approach/

Other On-the-Ground Realities

Workforce challenges

Opportunity for policy and financing coordination

Access and Eligibility Barriers – renewed emphasis on Equity

Fragmented Services between child and family serving agencies and behavioral health

Opportunity with FFPSA and SAMHSA Block Grant Enhancements and CCBHC approaches

Opioid Epidemic and the impact on families

Increased recognition of impact of Trauma on lives of children and families who touch child welfare

Gradually growing menu of EBPs – but not enough and often not tested on minority populations

Pandemic Impacts on lives of families and children – increasing evidence of exacerbation of behavioral health conditions

Limited data sharing across systems

Shortage of crisis response and stabilization services

Lack of Parity b/t Medicaid and marketplace insurance
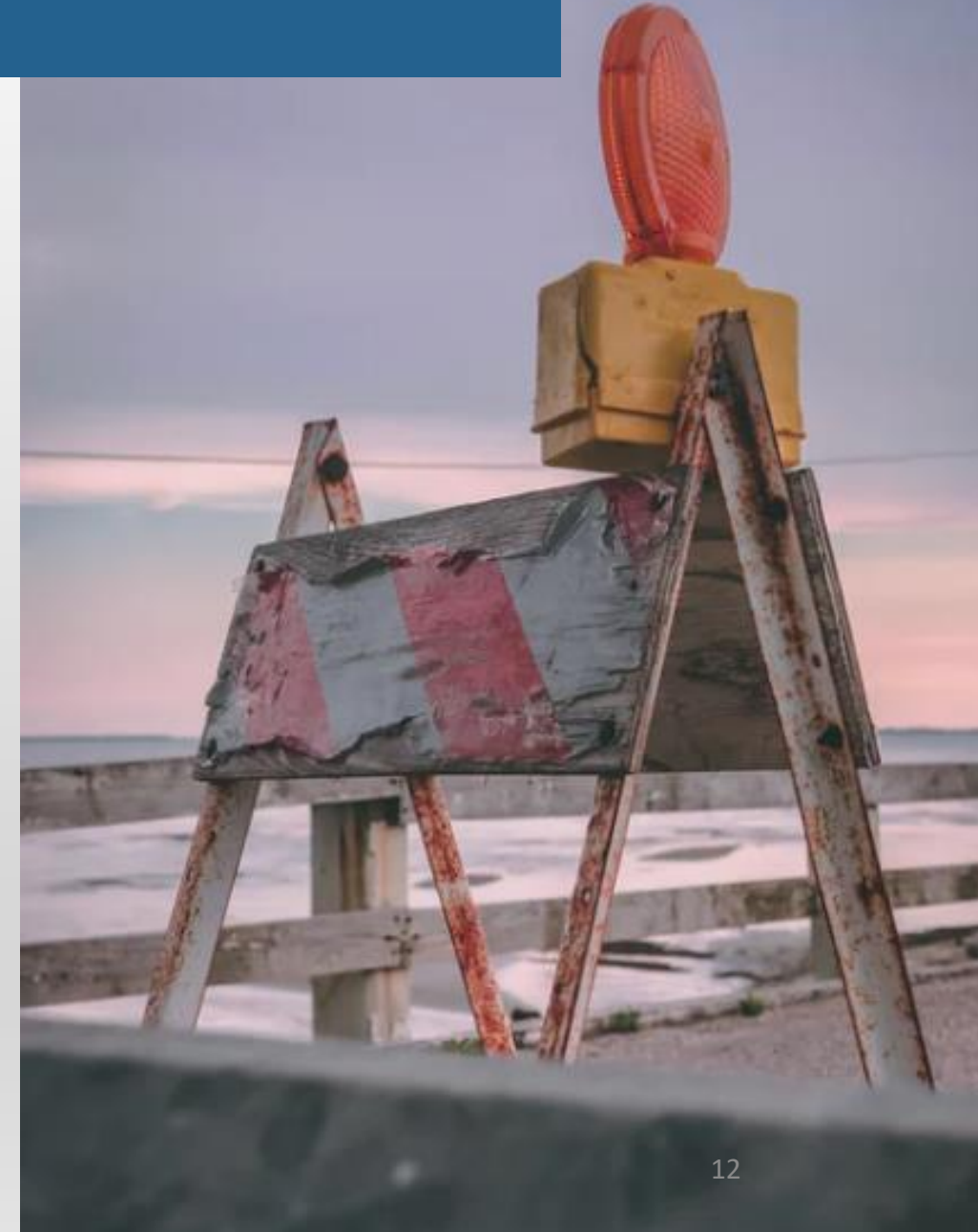
THE DATA PROPOSITION
FOR INTEGRATION

HEALTH MANAGEMENT ASSOCIATES

Three Assumptions About Data

Actionable Intelligence can best be derived from integrated data.
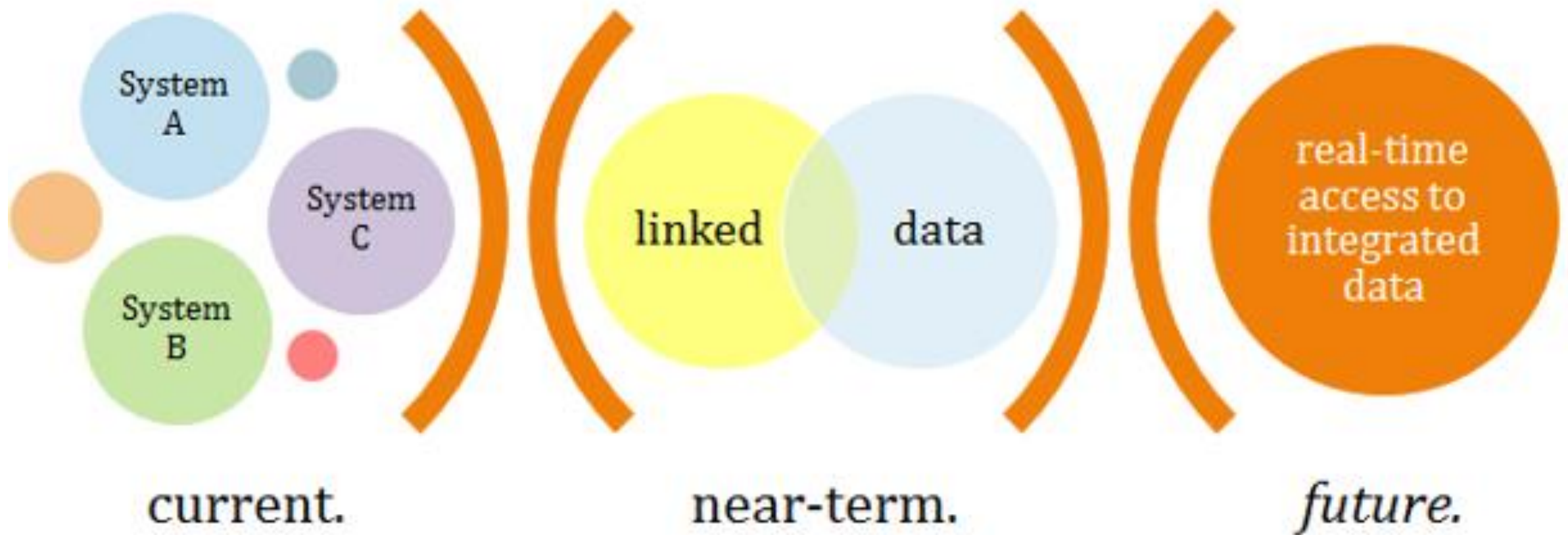
A Life Record begins with birth and ends with death.

Medicaid will always be (the elephant) in the room

It Matters Where You Start

Diverse Stakeholders Are Invested In Asking The Questions That Inform Whole Family Approaches

Call Screening Process

Call information received and processed

Assigned Call Screener collects additional information from sources including, but not limited to, the individual who reported the maltreatment and the Client View application that displays individual-level prior service involvement.

Call Screener assigns risk and safety ratings based on information collected.

NEW STEP
Call screener runs the Allegheny Screening Tool

Consultation with the Call Screening Supervisor

In limited cases, a field screen is conducted

ALLEGHENY COUNTY FAMILY SCREENING TOOL (ACFS)

FOR MORE INFORMATION ABOUT THE AFST, SEE HTTP://WWW.ALLEGHENYCOUNTY.US/HUMANSERVICES/NEWS-EVENTS/ACCOMPLISHMENTS/ALLEGHENY-FAMILYSCREENING-TOOL.ASPX

Child Welfare Call Screening Decision

Screen Out → Provide family with information for other services or agencies they may find helpful

Open Investigation → **Investigation Findings/Service Decision**

Accept for Services → **New Child Welfare Case Opens**

Do Not Accept for Services → Provide family with information for other services or agencies they may find helpful

Real Time Data Integration In Allegheny County

Figure 10: Technical Implementation of the Screening Tool (source: Allegheny County)
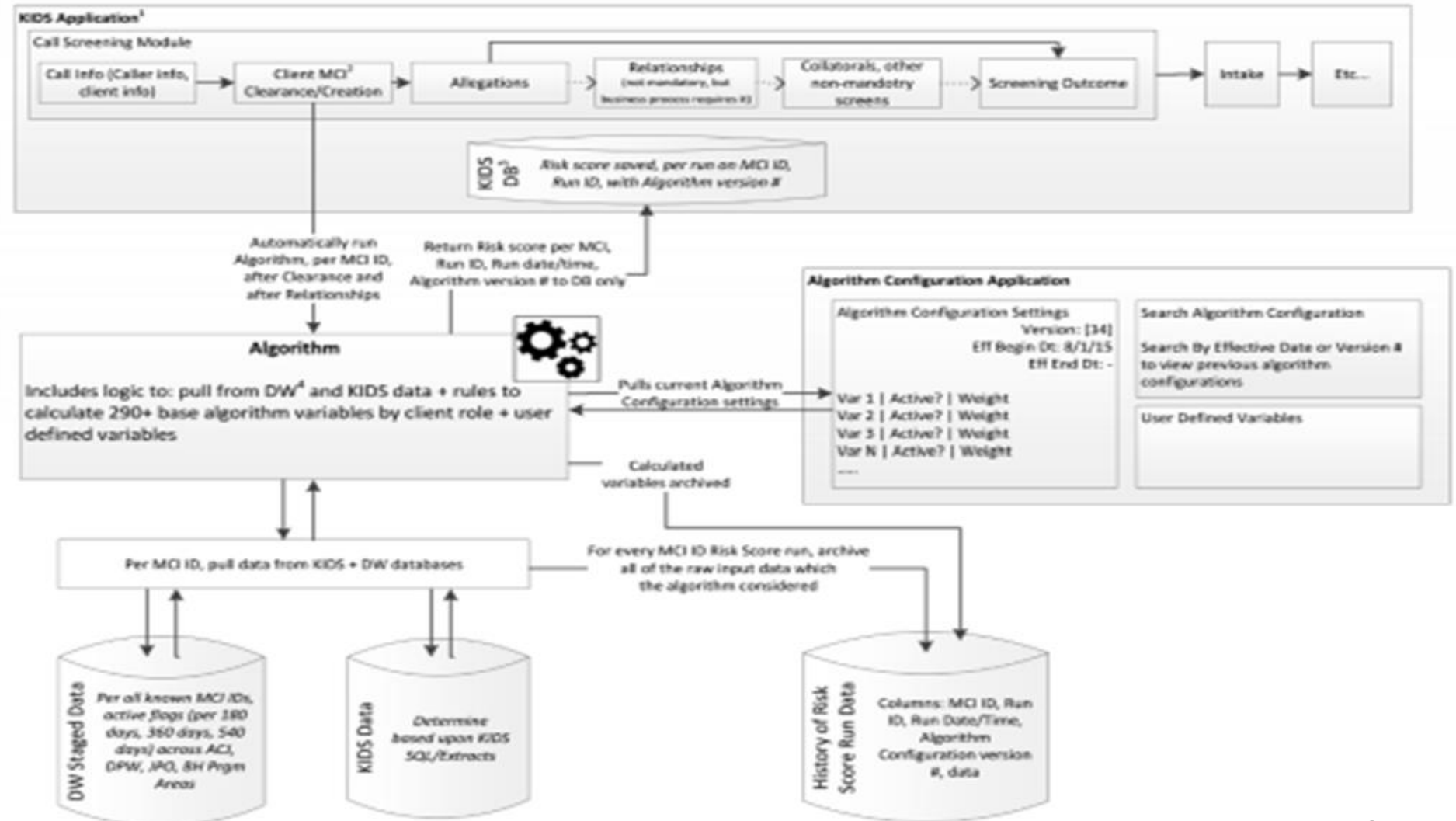
Source: Allegheny County, Developing Predictive Risk Models to Support Child Maltreatment Hotline Screening Decisions

18

BRINGING THE DATA TOGETHER:
How Researchers Combined Data In Cleveland To Tell A Story About The Interaction Between Housing Conditions And School Readiness
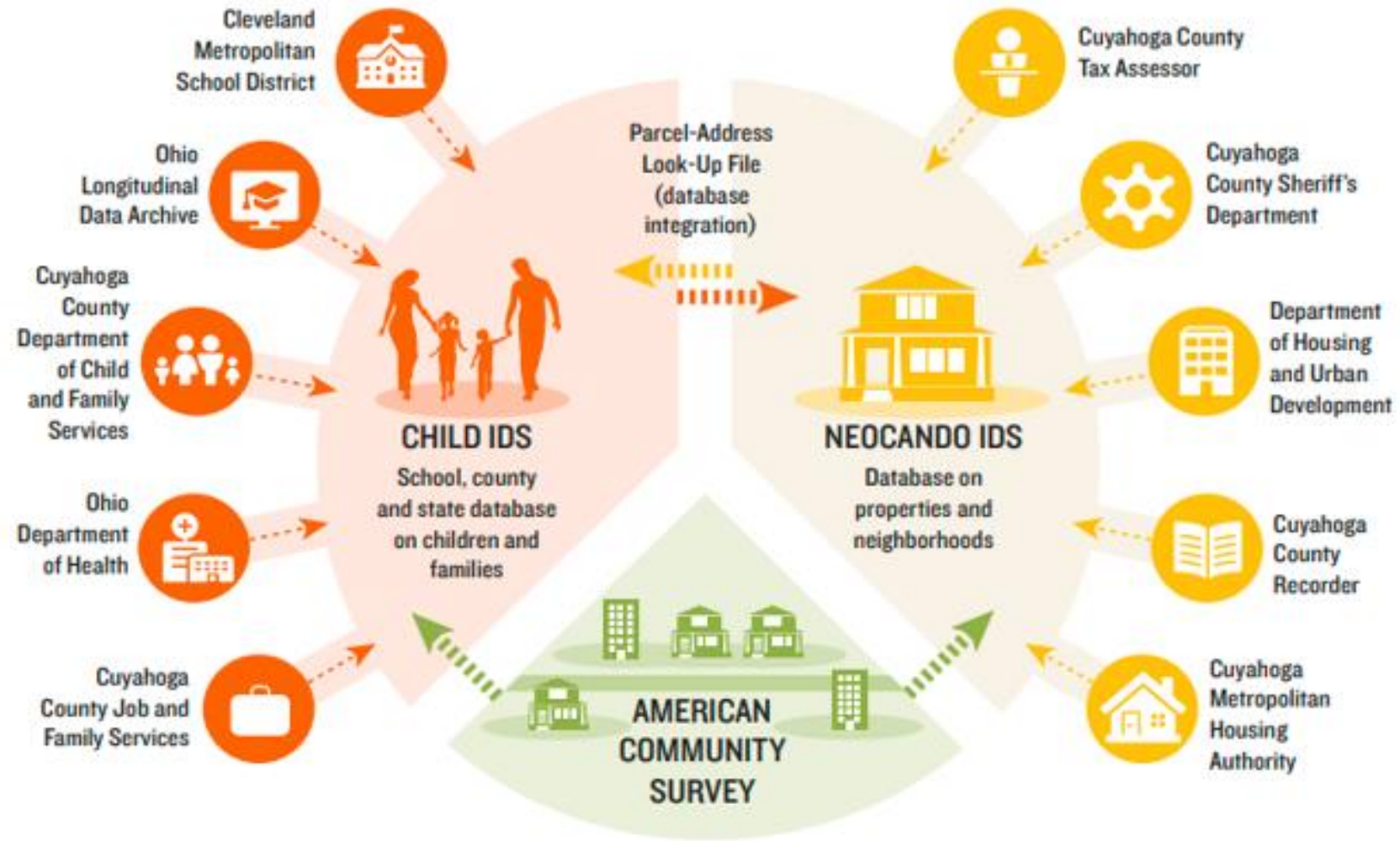
Users In Different Environments Pose Questions To Improve Practice And Policy

Integrated data allow **government agencies** to integrate various databases and bridge the gaps that have traditionally formed among them and between government agencies and community providers.

Researchers can compare data across various agencies and ask probing questions about issues that have stymied public agencies' past efforts to improve policies.

Integrated data reveal patterns of risk and resilience, allowing **executive leaders, policy makers, and policy analysts** to design more targeted interventions and higher-impact policies.

Different questions requiring different data. Integrated data supports asking integrated questions.

Can we create a system with no wrong entry door?

What are correlates and root causes?

What interventions work for each subpop?

In the data forest, Medicaid is the elephant in the room.

CMS data covers a large percentage of the US population.

More than a third of births are paid by Medicaid.

10 out of 10 people prefer seamless integration over duplicate data collection

EXPANSION OF AFCARS
OR THE EVOLUTION OF WELL-BEING

AFCARS
Adoption and Foster Care
Analysis and Reporting System

AFCARS 2020
Technical Bulletin 20: Data Elements for Out-of-Home Care & Adoption and Guardianship Assistance Data Files

| AFCARS ITEM #	DOMAIN
1-21	Demographics and ICWA
22-34	Health
35-37	Education
38-40	Pregnancy and parenting
41-46	Prior Adoptions/Guardianships
47-55	Economic Assistance
56-58	Siblings
59-68	Birth parent information
69-105	Removal reasons, conditions
106-111	Sex trafficking
112-146	Foster care placement
147-186	Permanency planning, exit

THE VALUE OF INTERSECTIONALITY

No System Can Do This Alone

- Families and Children often **seek support from multiple avenues** – benefits support; domestic violence programs; homeless services; schools; community based organizations; personal networks such as friend, family, church pastor, others long before they touch formal systems such as behavioral health or child welfare

- The key to **access and eligibility rests in building community resilience and non-threatening access points such as at schools, in trusted community institutions or community based organizations**

- An "All Doors are Open" Approach is critical across a **multi-sectoral frame with whole family approaches**

- Often children and families with complex socio-economic and socio-emotional needs require a responsive tiered system of care that continues to support a least restrictive delivery system with an emphasis on matching need to service – **right dose at the right time for the right problem**

- Families and children need **both socio-economic and socio-emotional support and services** to ensure that children and families have good outcomes – increased protective factors, improved health and wellbeing outcomes that builds resilience and strength

- A clear articulation of outcomes should result in the development of performance-based contracts that incent good outcomes
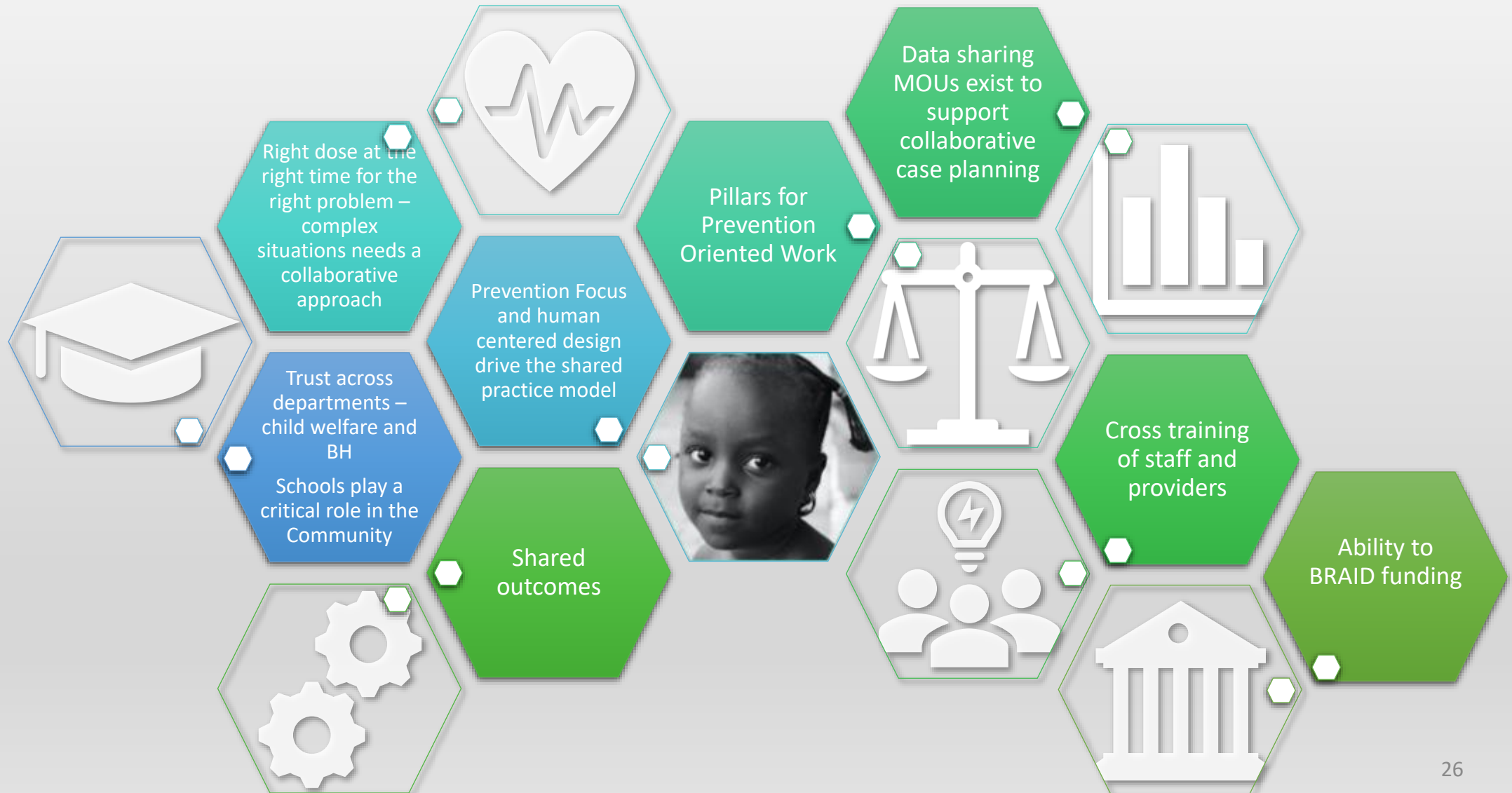
Multi-sectoral Intersectionality
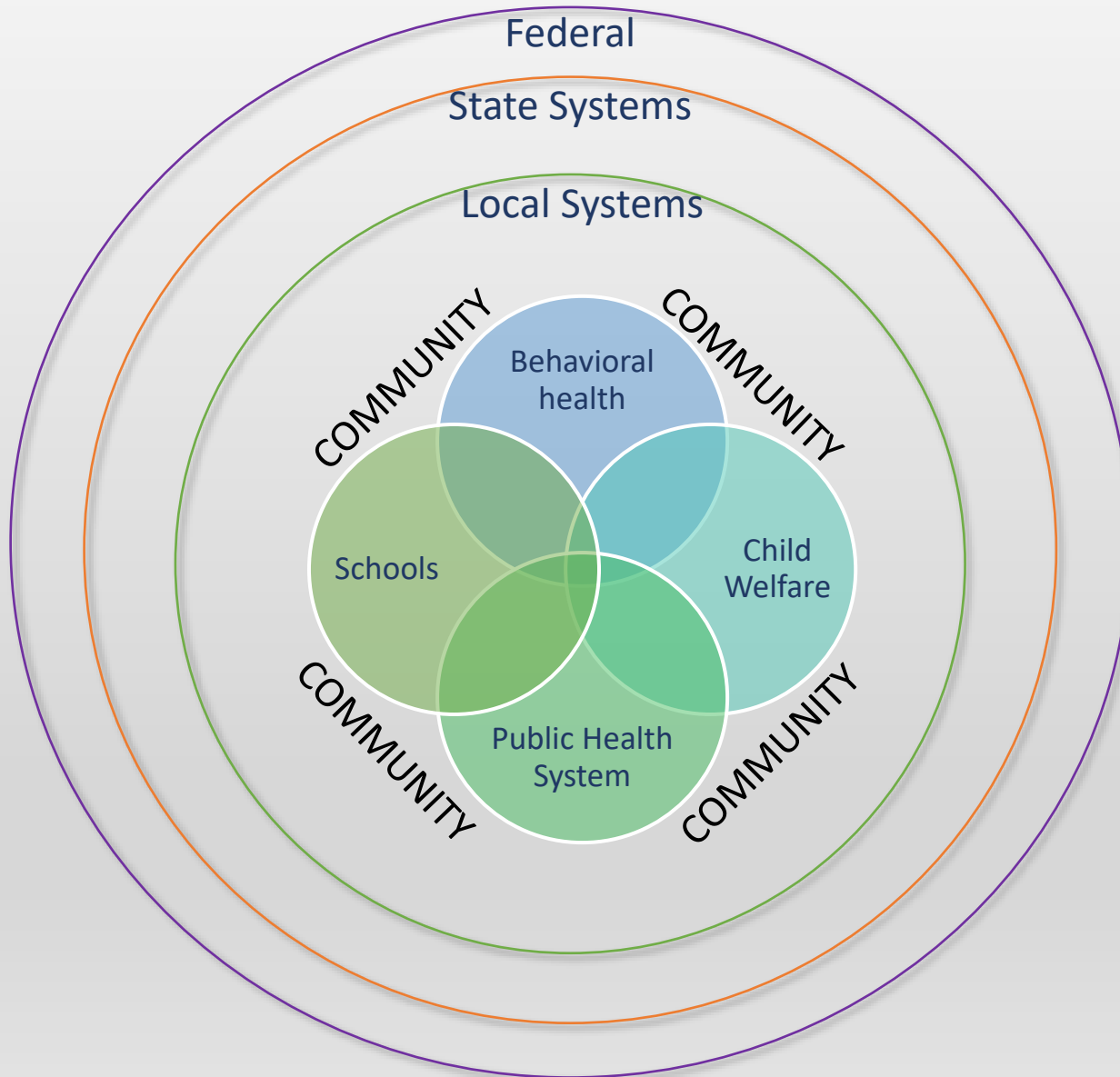
- Due to the recognition of the importance of social determinants of health, healthcare is now a frequent partner in integrated care discussions

- There is much to be learned from Public Health Prevention models to strengthen protective factors and health and wellbeing in families with children

- BH has led systems of care efforts that are anchored in engaging families and ensuring consumer voices are heard

- With FFPSA the field of child welfare is moving up stream and into prevention

- Collaboration is often stronger at the local level than State level because Consumer and Community are always included

Elements Of A Successful Cross System Collaborative System Of Care

Right dose at the right time for the right problem – complex situations needs a collaborative approach

Data sharing MOUs exist to support collaborative case planning

Pillars for Prevention Oriented Work

Prevention Focus and human centered design drive the shared practice model

Trust across departments – child welfare and BH

Schools play a critical role in the Community

Cross training of staff and providers

Shared outcomes

Ability to BRAID funding

PREVENTION AND UPSTREAM EFFORTS – WHY THE FIELD IS SHIFTING

HEALTH MANAGEMENT ASSOCIATES

Pillars for Prevention Oriented work

Socio-Economic Mobility

Health and Wellbeing

Equity – Enshrined in consumer voice

Reasons For Policy And Practice Shifts

Improved understanding of **ACES**

Perverse Incentives that prevent efforts to strengthen and support whole family approaches but rather support deep end high-cost interventions

Increased focus on **inequities and recognition of historical harm to BIPOC Families** with harmful practices by public health and human services agencies

New opportunities created through **technological innovations**; creative and innovative data sharing practices

A shared recognition and focus on:

Two-Generation Approaches

That children thrive in Families

Early Intervention is both cost effective and improves outcomes

Successful Access Points For Families In The Community
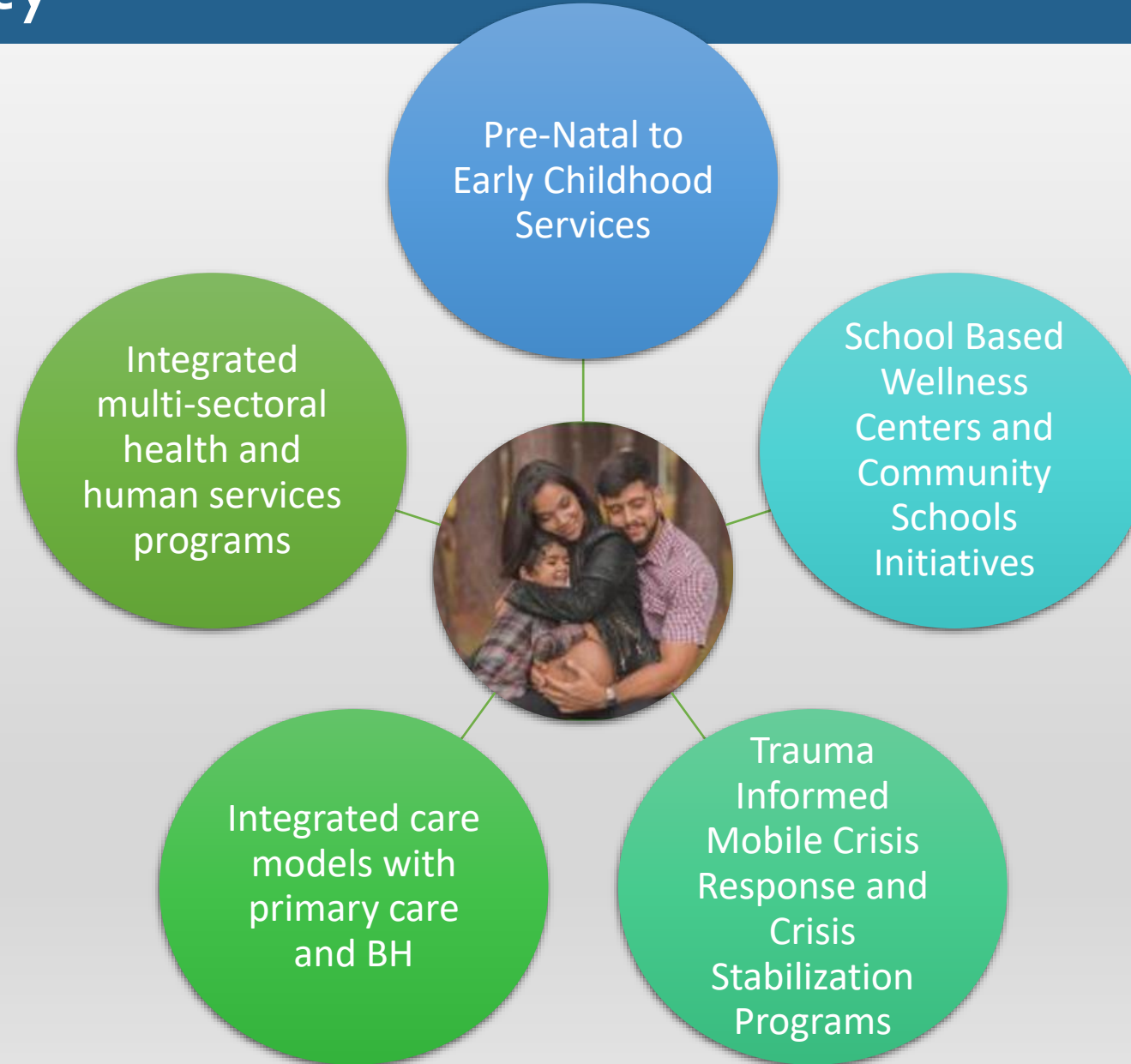
OPPORTUNITIES AND RISKS OF EVIDENCE-BASED AND EVIDENCE INFORMED PRACTICES

HEALTH MANAGEMENT ASSOCIATES

Shifting Toward Using Evidence

*"For many experts in the field of evidence, **rigorous evaluation** designs such as RCTs and **quasi-experimental designs (QED) are the gold standards for measuring true effectiveness for all programs**, including those being implemented within communities of color."*

Intervention Impact

Significant positive change in intended outcomes can be attributed to the program, and research shows no evidence of harmful effects.

Evaluation Quality

Carefully designed research studies — at least two high quality comparison studies or one high-quality randomized control trial — produce reliable findings of the program's effectiveness.

Intervention Specificity

Program descriptions clearly identify the intended outcomes, targeted risk and protective factors, the population the program intends to reach and how the program's elements contribute to those outcomes

Dissemination Readiness

The program includes written guidelines and the necessary training, technical assistance and other support to use the program with a large number of children in a school, public system or community.

EBP = ROI

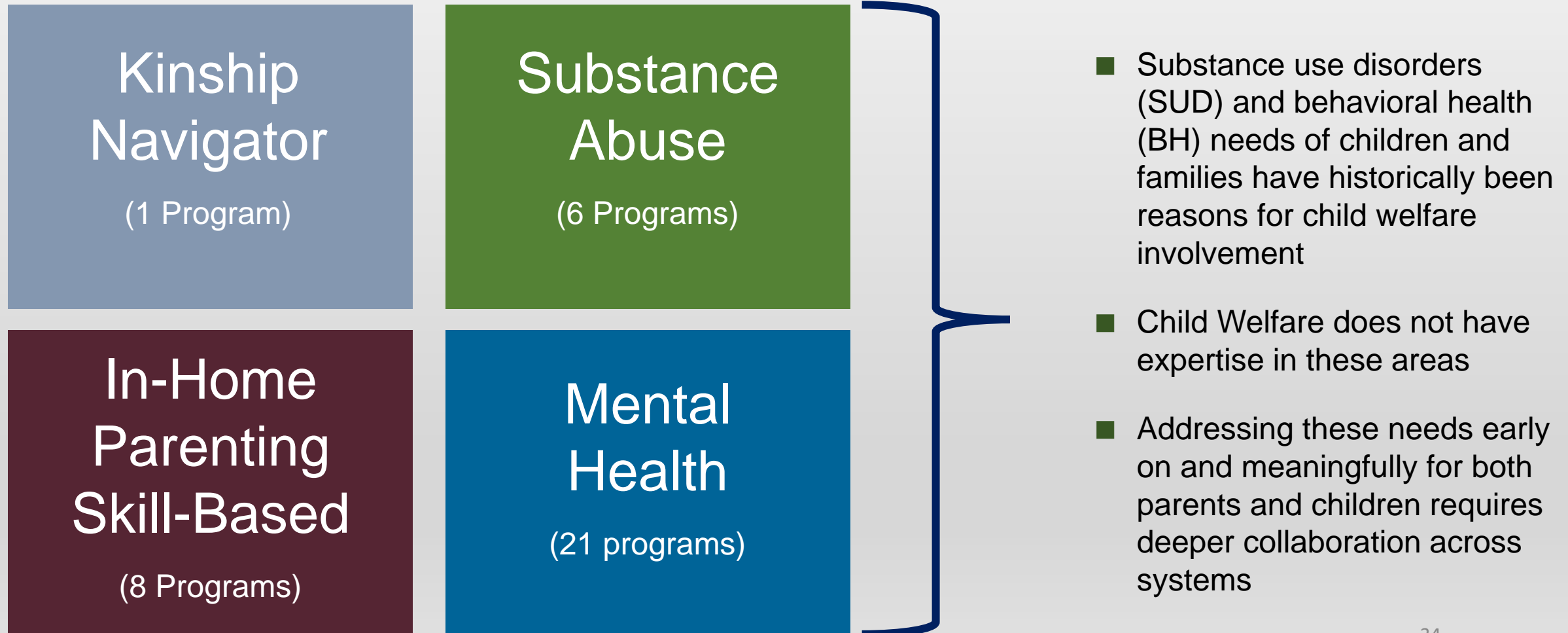Clearly articulated approaches to address specific needs of children and families

Evidence that supports that the approaches work for the intended population served

Implementation supports

FFPSA Presents a New Opportunity and Mandate to Invest in the Evidence Approaches

Kinship Navigator

(1 Program)

Substance Abuse

(6 Programs)

In-Home Parenting Skill-Based

(8 Programs)

Mental Health

(21 programs)

- Substance use disorders (SUD) and behavioral health (BH) needs of children and families have historically been reasons for child welfare involvement

- Child Welfare does not have expertise in these areas

- Addressing these needs early on and meaningfully for both parents and children requires deeper collaboration across systems

What's Missing? – Evidence and Communities of Color

Challenges to Building Evidence By and For Communities of Color:

- Inadequate funding resources to support building evidence for programs for communities of color throughout the RCT/QED stages;

- Gaps in culturally specific understanding of sensitivities around data collection approaches being implemented during the evaluation process;

- Evaluation professionals with limited knowledge and training in cultural issues facing these communities.

- Intervention population with limited racial/ethnic diversity

Discussion

Q&A

CONTACT US!

If you have any questions
please to not hesitate to reach out.

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