Unmet Mental Health Service Needs in Kinship Care: The Importance of Assessing and Supporting Caregivers

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Unmet Mental Health Service Needs in Kinship Care: The Importance of Assessing and Supporting Caregivers

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Although children in kinship care reportedly have better outcomes than their nonkinship foster care peers, some have unmet mental health needs or delayed service utilization. This study confirms the presence of unmet mental health needs among children in kinship care and indicates that concerns about caregivers moderate the relationship between identified service needs and service utilization. It is important that child welfare assessments consider caregiver capacity to meet each child’s needs and, especially within kinship care where not all caregivers are licensed, respond to the resource, housing, education, and service needs of caregivers.

KEYWORDS mental health, kinship care, service utilization

Children in foster care are at heightened risk for unmet mental health needs. An estimated 40% to 60% of children in foster care have clinically significant emotional or behavioral problems (Burns et al., 2004; Landsverk, Garland, & Leslie, 2002; U.S. Public Health Service, 2000). Children in kinship care reportedly have better outcomes than their nonkinship foster care peers (Cuddeback, 2004). However, they still have higher rates of emotional and behavioral disturbances than children in the general population (Billing, Ehrle, & Kortenkamp, 2002; Landsverk et al., 2002; Shore, Sim, Le Prohn, & Keller, 2002; Smith & Palmieri, 2007), and there is clear evidence of unmet need or delayed service utilization among children in kinship care (Early &
Mooney, 2002; Ehrle & Geen, 2002; Goodman, Potts, & Leslie et al., 2000; Pasztor, 2007; Villagrana, 2010).

Unlike adults, youth are almost always dependent upon caregivers to (1) identify need for the mental health treatment and (2) access such treatment. Caregivers must not only recognize symptoms of psychopathology, but also be able and willing to identify needed services and facilitate youth participation in treatment (Burnett-Zigler & Lyons, 2010). Their ability to do so depends on their own needs and characteristics, and on their previous involvement with service systems, including mental health, child welfare, education, and general health care. Many determinants for seeking care, some of which differ among related and nonrelated caregivers, have been identified. The purpose of this study was to examine the prevalence of mental health needs and service utilization patterns among children placed in kinship care. This research addresses the following questions: (1) What percentage of children in kinship care presented with an emotional or behavioral concern at the time of entry to foster care? (2) Was the presence of an emotional or behavioral concern associated with service utilization within six months? (3) Did caseworker concerns about the caregiver mediate the relationship between the child’s service needs and service utilization? This study contributes to the existing body of research on the identification of mental health needs and service utilization patterns among children placed in kinship care. This research addresses the following questions: (1) What percentage of children in kinship care presented with an emotional or behavioral concern at the time of entry to foster care? (2) Was the presence of an emotional or behavioral concern associated with service utilization within six months? (3) Did caseworker concerns about the caregiver mediate the relationship between the child’s service needs and service utilization? This study contributes to the existing body of research on the identification of mental health needs and service utilization patterns among children placed in kinship care, with a particular focus on children in kinship care, along with caseworker assessments of the caregiver’s ability to meet the child’s needs. Because a child’s receipt of mental health services is dependent on the efforts of the caregiver and other adults working with the family, it is important to frame the study within previous research findings on caregivers as well as other child, case, and systemic factors that shape service utilization.

Caregivers as Gatekeepers or Facilitators in Accessing Services

Having an identified need for mental health services should be the primary driver for provision of services; however, need alone does not guarantee service receipt. Among those with an identified need, estimates of service receipt range from 25% to 80% (Burns et al., 2004; Leslie, Hurlburt, Landsverk, Barth, & Slymen, 2004; Raghavan, Inoue, Ettner, Hamilton, & Landsverk, 2010). Unmet mental health need among children varies widely depending on race, socioeconomic status, geographic region, insurance coverage, and living arrangements (Burns et al., 1995; Kataoka, Zhang, & Wells, 2002; Sturm, Ringel, & Andreyeva, 2003).

Adults who play a significant role in a child’s life act as de facto gatekeepers to mental health services for that child (Leslie et al., 2004; Thompson, 2005; Villagrana, 2010). According to Thompson and May (2006), there are two stages of parental decision making around children’s mental health
service utilization, recognition of the need for services and choosing to seek treatment. Children with internalizing behavior problems are more likely to have unmet service needs. Child behavior problems may differ in the degree to which they spur parents or caregivers to seek help, and higher levels of caregiver stress have been found to be associated with higher levels of children’s mental health service use (Villagrana, 2010).

Kinship caregivers are disproportionately more likely than nonrelative caregivers to be older, single, less educated, unemployed, and of lower socioeconomic status (Cuddeback, 2004; Minkler & Fuller-Thomson, 2005; Sakai, Lin, & Flores, 2011; Strozier & Krisman, 2007). In addition, many kinship caregivers report health and mental health conditions such as hypertension, arthritis, cardiac conditions, diabetes, asthma, and clinical depression; these conditions constrain activity levels and overall functioning (Grant, 2000; Minkler & Fuller-Thomson, 2005; Sands & Goldberg-Glen, 2000; Waldrop & Weber, 2001). The lower utilization of mental health services by children in kinship care may stem from differences in supports provided by the child welfare system or caregiver characteristics, cultural beliefs, or preferences. When compared to their nonrelative counterparts, kinship caregivers receive fewer services, supports, and caseworker visits (Berrick, Barth, & Needell, 1994; Cuddeback, 2004; Sakai et al., 2011). The status or well-being of the caregiver has significant implications for overall family well-being, with potential for direct and indirect effects on the children in the family. Differences in mental health utilization among children in kinship care may also reflect caregivers’ cultural beliefs and preferences about formal mental health treatment (Garland, Landsverk, & Lau, 2003; Smithgall, Mason, Michels, LiCalsi, & George, 2006), differences in the strength of their support systems (Villagrana, 2010), or their tolerance of problematic behaviors (Early & Mooney, 2002).

Child, Case, and System Factors Associated With Mental Health Service Utilization

In addition to recognizing the significant role that caregivers play, published research on children’s mental health utilization suggests numerous child, case, and organizational characteristics associated with service receipt. Perhaps reflective of the age at which assessments are more often conducted or the developmental stages in which emotional and behavioral problems typically emerge, older children are more likely than their younger peers to receive mental health services (Early & Mooney, 2002; Leslie et al., 2004; Leslie et al., 2000; Raghavan et al., 2010). There are also differences in mental health utilization by gender. Males are more likely than females to receive mental health services (dos Reis, Zito, Safer, & Soeken, 2001; Early & Mooney, 2002; Katoaka, Zhang, & Wells, 2002; Leslie et al., 2000), although Thompson and May (2006) posit that gender differences in internalizing and externalizing behaviors may explain differences in service utilization.
Findings regarding race and ethnicity are more complex, and in some studies it may be difficult to disentangle issues of race and kinship care. Thompson and May (2006) report that African American children had a lower likelihood of receiving mental health services, but the differences were primarily around identification of need, not unmet need. They interpreted this finding as indicating that, once needs were recognized, disparities in use may be driven by practical barriers such as access, proximity, or cultural beliefs. Garland et al. (2000) also examined how racial differences in mental health service utilization varied by identification of need, reporting that White children were more likely to get services even when the total problem score on the Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2001) was relatively low, whereas African American children demonstrated the strongest relationship between problem severity and use of services. Latino children showed relatively low mental health service use, regardless of problem severity. Similarly, Leslie et al. (2004) found that African American youth were less likely to access mental health services when CBCL scores were lower; however, as scores increased, the discrepancy diminished.

With respect to the type of maltreatment, children placed in kinship care due to neglect were less likely to receive mental health services than those with physical abuse; and children placed due to sexual abuse were more likely to receive mental health services (Burns et al., 2004; Garland, Landsverk, Hough, & Ellis-McLoed, 1996). Leslie et al. (2000) found that type of maltreatment did not significantly influence the use of outpatient mental health services; however, Leslie et al. (2004) found that sexual abuse was a predictor of increased use of mental health services, unlike the findings of Garland et al. (1996) who found no association between sexual abuse and need for mental health services.

Although fewer in number, some studies have examined organizational or contextual influences such as insurance coverage (Raghavan et al., 2006) or court processes (Garland et al., 2003), on children's mental health utilization. Factors related to caseworkers and their levels of experience also represent a key area of concern, with a negative association between screening for mental health services and caseworkers’ level of experience (Raghavan et al. 2010). From the perspective of foster parents, poor communication between foster parents, caseworkers, and providers also impedes children's mental health utilization (Pasztor, Hollinger, Inkelas, & Halfon, 2006). Even when needs are recognized and caregivers are motivated to seek treatment, logistical barriers to attending treatment, perceptions that treatment was not relevant, and poor caregiver–therapist relationships have been found to be related to lower likelihood of use and early termination of treatment (Kazdin, Holland, & Crowley, 1997; Smithgall et al., 2009). Although caseworkers may influence the identification of mental health needs, the extent to which their involvement influences follow-through on referrals or sustained involvement in services remains unclear.
Comprehensive Assessments and the Illinois Integrated Assessment Program

The importance of actively engaging families in mental health services for children was emphasized in guidelines put forth recommending comprehensive mental health screenings for all children in out-of-home care (Committee on Early Childhood Adoption and Dependent Care, 2002; Romanelli et al., 2009). Meeting children’s mental health needs is also considered central to successful foster parenting (Buehler, Rhodes, Orme, & Cuddeback, 2006); however, few child welfare systems regularly assess foster parent capacity or functioning with respect to meeting a child’s needs, and current policies contain little to guide systems toward including families in providing support or participating in treatment (Schneiderman & Villagrana, 2010).

Recognizing the need for comprehensive family assessments that better integrate child welfare and mental health issues, the Illinois Department of Children and Family Services (DCFS) developed the Integrated Assessment (IA) program. The IA program partners child welfare caseworkers with licensed clinicians to conduct in-home assessments, providing better information about the functioning of children entering foster care and about child and family strengths, support systems, and service needs. The information-gathering activities and the collaborative process between the caseworker and licensed clinician produce higher-quality child and family assessments, which in turn facilitate the development of better service plans. The inclusion of caregivers in this assessment process is designed to produce a richer understanding of the child’s development and functioning. It also positions the child welfare system to identify service needs that relative caregivers may have in order to meet the needs of the child placed in their care.

Drawing on data from an evaluation of the IA program, this study examines the prevalence of mental health needs and service utilization patterns among children placed in kinship care. The following hypotheses were tested in this analysis:

1. There is no relationship between a child’s emotional/behavioral needs and mental health service utilization when analyzing the subset of IA cases with caregivers for whom there are concerns.
2. There is a significant positive relationship between a child’s emotional/behavioral needs and mental health service utilization when analyzing the subset of IA cases with caregivers for whom there are no concerns.

METHOD

This study utilizes an entry cohort design with analysis of data that is gathered and maintained by the Illinois DGFS and the Illinois Department of Health and Family Services (IDHFS) as part of their routine processes. Institutional
Review Board approvals for this study were obtained from both the University of Chicago and DCFS, a letter of support was obtained from IDHFS, and a waiver of HIPAA authorization approval was obtained from the University of Chicago.

Sample

This study includes standard placement cases in which a child was placed with a relative caregiver between January 2007 and June 2008, and for which an integrated assessment was completed by the caseworker and a licensed clinician as part of the IA program (N=1,285). Prior research suggests that the “standard” placement cases represent approximately one half of foster care entries and may over-represent families in crisis, whose risk exceeded the levels at which intact family services could be delivered (Smithgall et al., 2009). Just more than one half (59%) of the 1,285 children included in these analyses were younger than age 6 (see Table 1). Males and females were equally represented, and approximately one half of the sample was African American. The majority of children had “neglect” or “substantial risk of harm” as the most serious allegation for the incident that immediately preceded their placement in foster care.

<table>
<thead>
<tr>
<th>TABLE 1 Characteristics of the Sample</th>
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<table>
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<tr>
<th>Characteristic</th>
<th>Children placed with a relative (N=1,285)</th>
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<tbody>
<tr>
<td></td>
<td>n</td>
</tr>
<tr>
<td>Age (years)</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>250</td>
</tr>
<tr>
<td>1–5</td>
<td>502</td>
</tr>
<tr>
<td>6–13</td>
<td>410</td>
</tr>
<tr>
<td>14–18</td>
<td>123</td>
</tr>
<tr>
<td>Sex (Male)</td>
<td>638</td>
</tr>
<tr>
<td>Region</td>
<td></td>
</tr>
<tr>
<td>Northern</td>
<td>275</td>
</tr>
<tr>
<td>Central</td>
<td>554</td>
</tr>
<tr>
<td>Southern</td>
<td>183</td>
</tr>
<tr>
<td>Cook</td>
<td>273</td>
</tr>
<tr>
<td>Race/ethnicity</td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>598</td>
</tr>
<tr>
<td>White</td>
<td>687</td>
</tr>
<tr>
<td>Type of allegation</td>
<td></td>
</tr>
<tr>
<td>Physical abuse</td>
<td>237</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>30</td>
</tr>
<tr>
<td>Substance exposed infant</td>
<td>58</td>
</tr>
<tr>
<td>No indicated allegation</td>
<td>133</td>
</tr>
<tr>
<td>Substantial risk of harm/neglect</td>
<td>827</td>
</tr>
</tbody>
</table>

*A small percentage of cases had no indication of a substantiated allegation, mostly reflective of court-involved youth for whom custody was awarded to the child welfare system.*
Data Sources

This study uses three sources of data. The first is administrative program data from child welfare and health care systems in Illinois. Child welfare data were drawn from several statewide databases maintained by Illinois DCFS. The IA database tracks the assignment of cases and other benchmark steps in the IA program. The second database is the Child and Youth Center Information System (CYCIS), containing data on case openings, child demographics, region, and foster care placements. Finally, the Illinois outcomes database includes scores on the Child and Adolescent Needs and Strengths (CANS) assessment instrument (Anderson, Lyons, Giles, Price, & Estle, 2003) that is utilized in the initial assessment and further described in the next section. Records from each of these databases were linked at the child level, using a unique identifier-specific DCFS. Health care data were obtained from the IDHFS. Using a probabilistic records matching technique, Medicaid claims data were linked to CYCIS data for all youth between ages 0 and 18. Used widely in epidemiology and demography (Roos & Wajda, 1991; Roos, Wajda, Nicol, & Roberts, 1992), probabilistic record matching calculates the likelihood that two records belong to the same person by matching as many pieces of identifying information from each database as possible. Together, these linked, longitudinal data enabled us to model child, case, and caregiver factors that predict service utilization.

Measures

IDENTIFYING CHILD NEED FOR MENTAL HEALTH SERVICES

The CANS tool is a measure of psychological well-being, need for services and intervention, and strengths; it has multiple applications, including decision support, treatment planning, and outcomes management (Lyons, 2004). Individual items are scored on a 4-point scale according to the need for intervention to address the issue the item captures. A score of 0 indicates no need for action, a score of 1 suggests monitoring to ensure that no problem arises in the area, a score of 2 indicates the need for intervention, and a score of 3 indicates a need for immediate and/or intensive intervention to address the issue. Accordingly, analyses of CANS data for research purposes routinely dichotomize the rating scale for each item into “actionable” (2, 3) and “nonactionable” (0, 1) (Lyons & Weiner, 2009). The reliability and validity of the CANS have been established in previous studies focusing on child domains and child mental health issues (Anderson et al., 2003; Lyons, Sokol, Khalsa, & Lee, 1999). The CANS assessments for this study were completed as part of the initial Integrated Assessment done during the first 45 days of placement, and information needed to complete the CANS was obtained from caregivers (including biological and foster caregivers), as well as children, during the IA interview process.
The child emotional/behavioral domain of the CANS includes 13 items assessing dysfunction or distress: psychosis, attention-deficit/impulse control, depression, anxiety, oppositional behavior (compliance with authority), conduct, substance abuse, attachment difficulties, eating disturbances, affect dysregulation, behavioral regressions, somatization, and anger control. In this sample, fewer than 2% of children had an actionable score on substance abuse; only one child had only a substance abuse issue. For each child in the study, an actionable score by the caseworker on any one of these 13 items was considered indicative of the need for mental health services.

ASSESSING CAREGIVER FUNCTIONING AND ABILITY TO MEET THE CHILD’S NEEDS.

The items in the caregiver domain of the CANS assess the extent to which the caseworker indicates concern about the caregiver’s ability to meet the child’s needs, presumably identifying needed supports or services where concerns are noted. The following 12 caregiver items were used in this analysis: physical health, mental health, substance use, developmental, supervision, knowledge, organization, resources, residential stability, safety, marital/partner violence, and caregiver post traumatic reactions. A caregiver was considered to have an identified concern if any of those items was scored as requiring action to address a concern or if four or more of those items were scored as requiring monitoring.

MENTAL HEALTH SERVICE UTILIZATION

A dichotomous indicator for any mental health service utilization within 6 months after the IA assessment date was created based on Medicaid mental health claims. Mental health service utilization was defined as having any service with a mental health diagnosis, which was defined based on International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes. Diagnosis codes for mental health service include most codes of mental disorders including substance abuse, some selected codes of hereditary and degenerative diseases of the central nervous system and some selected codes of persons with potential health hazards related to personal and family history.

Analytic Approach

Analyses were conducted with SAS (version 9.2). A logistic regression model was constructed to test the primary hypotheses as stated in the introduction. The logistic model included an interaction term consisting of the CANS emotional/behavioral needs indicator (yes/no); and the indicator of having caregivers with high caregiver needs (yes/no). If the interaction term is
significant and positive, it means that there is a moderating effect. The model also included three demographic/social variables (age, race/ethnicity, and area of residence) and two baseline data for placement (reasons for removal from home and first placement type).

**RESULTS**

**Children’s Need for and Use of Mental Health Services at the Time of Entry to Foster Care**

In this sample, slightly more than one fourth (28.4%) of the children in kinship care had a CANS score indicative of the need for mental health services, yet the percentage of these children with a Medicaid claim indicating receipt of mental health services within 6 months of placement (14.2%) was half that. As anticipated, service receipt was higher when a child was assessed to have a need for mental health services than when no need was identified (27.1% vs. 9.0%). Thus, these data suggest that children placed with relatives were almost 4 times more likely to receive mental health services when a need was identified on the CANS versus when no need was identified (odds ratio [OR] = 3.75, 95% confidence interval [CI] [2.72, 5.18]).

**Assessment of Caregivers’ Ability to Meet the Child’s Needs**

In one fifth of the sample, a caseworker indicated an actionable concern about the caregiver on one of the 12 CANS items used to rate the caregiver’s ability to meet the child’s needs (see Table 2). Additionally, a small proportion (6%) of cases had four or more items scored as requiring monitoring. Overall, 331 cases, or one fourth of the sample, included a caregiver for which the caseworker had at least one concern requiring action or four or more concerns requiring monitoring. Two items were identified with the greatest frequency, the caregiver’s knowledge and ability to understand the rationale for treatment (knowledge) (7.7%), and the financial and social assets and resources that the caregiver can bring to bear in meeting the child’s and family’s needs (resources) (7.2%).

**The Moderating Effect of Caregiver Functioning**

A primary question of interest in this study was whether the identification of concerns about the relative caregiver’s ability to meet the child’s needs moderates the relationship between the child’s need for mental health services and his or her receipt of such services within 6 months of the assessment. When concerns were noted about the caregiver, the unadjusted odds ratio
for mental health service utilization is 1.72 (95% CI [0.89, 3.00]), compared to 5.35 (95% CI [3.64, 7.85]) when no concerns were noted. Thus, when there are no concerns about the caregiver, the relationship between the need for and receipt of mental health services is much stronger.

A logistic regression model was used to test whether the moderating effect of caregiver functioning remained statistically significant after controlling for other child and case characteristics such as age, race, type of maltreatment, and region. The adjusted differences confirm that, among children placed with a relative where there are concerns noted for the caregiver, there was no statistically significant relationship between the child’s emotional/behavioral needs score and their mental health service utilization (OR = 1.31, 95% CI [0.68, 2.52]). However, when there are no concerns noted for their relative caregivers, there were much greater odds of mental health utilization when a need was identified for that child (OR = 3.77, 95% CI [2.42, 5.71]). As suggested by the large

<table>
<thead>
<tr>
<th>Child and adolescent needs and strengths item</th>
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<tbody>
<tr>
<td>Caregiver’s knowledge of the specific strengths of the child and any problems experienced by the child and their ability to understand the rationale for treatment or management of these problems</td>
<td>99</td>
<td>7.70</td>
</tr>
<tr>
<td>The financial and social assets and resources that the caregiver can bring to bear in addressing the multiple needs of the child and family</td>
<td>92</td>
<td>7.16</td>
</tr>
<tr>
<td>Medical and physical challenges faced by the caregiver</td>
<td>51</td>
<td>3.97</td>
</tr>
<tr>
<td>Caregiver’s capacity to provide the level of monitoring and supervision needed by this child</td>
<td>33</td>
<td>2.57</td>
</tr>
<tr>
<td>Caregiver’s level of involvement with the planning and provision of child welfare and related services for this child</td>
<td>31</td>
<td>2.41</td>
</tr>
<tr>
<td>Caregiver’s mental health status</td>
<td>33</td>
<td>2.57</td>
</tr>
<tr>
<td>The ability of the caregiver to participate in or direct the organization of the household, services, and related activities</td>
<td>26</td>
<td>2.02</td>
</tr>
<tr>
<td>The caregiver’s current and future housing circumstances</td>
<td>21</td>
<td>1.63</td>
</tr>
<tr>
<td>Post-traumatic stress reactions faced by caregivers</td>
<td>8</td>
<td>0.62</td>
</tr>
<tr>
<td>The degree of conflict in the caregiver relationship</td>
<td>6</td>
<td>0.47</td>
</tr>
<tr>
<td>Caregiver’s pattern of alcohol or drug use</td>
<td>6</td>
<td>0.47</td>
</tr>
<tr>
<td>Caregiver’s developmental status (low IQ, mental retardation, developmental disability)</td>
<td>1</td>
<td>0.08</td>
</tr>
<tr>
<td>Any item requiring action</td>
<td>254</td>
<td>19.77</td>
</tr>
<tr>
<td>Four or more items requiring monitoring</td>
<td>77</td>
<td>5.99</td>
</tr>
<tr>
<td>Total with actionable items or four or more items requiring monitoring</td>
<td>331</td>
<td>25.76</td>
</tr>
</tbody>
</table>
difference in odds ratios (1.3 vs. 3.8), the interaction effect was statistically significant after including the additional child and case characteristics ($p = .03$).

Consistent with prior research, findings presented in Table 3 suggest greater odds of mental health utilization among older children, particularly those older than age 14 (OR = 1.94, $p < .01$), and lower odds of mental health utilization among girls (OR = −0.70, $p < .01$). With respect to region, children in kinship care in the central region of the state had moderately higher odds of mental health utilization than those residing in Cook County, a larger urban area including the city of Chicago as well as many surrounding suburbs.

**DISCUSSION**

Approximately one fourth of the children in this study needed mental health services, yet less than one fifth received such services within 6 months. This study confirms previous research indicating that some children in kinship care...
care have unmet mental health needs (Early & Mooney, 2002; Ehrle & Geen, 2002; Goodman et al., 2007; Leslie et al., 2000; Villagrana, 2010). Unique to this study, assessment data on the caregivers contributes to understanding children's unmet service needs. The strength of the relationship between children's mental health needs and service utilization differed significantly depending on whether caseworkers identified concerns about the caregiver.

It is important to recognize that the caregiver concerns most frequently noted by caseworkers were “knowledge” and “resources.” These concerns need not prohibit placement of the child with that caregiver but rather suggest the need for psychoeducational interventions and concrete supports to maintain the placement. The moderating effect of caregiver functioning on the relationship between a child's mental health needs and service use confirms the importance of including caregivers in child welfare assessments.

The next step is to ensure that consideration of caregiver functioning is factored into child and family service plans and that caregivers receive the resources, supports, or services necessary to perform their role in facilitating the child's access to and participation in services. This requires a detailed understanding of availability, accessibility, and acceptability of services for children placed with relatives, as well as the factors influencing the relationships observed in these data.

One possible explanation for the sizeable proportion of relative caregivers with identified concerns is licensure and compensation. Licensing requirements are different for relative caregivers, and those who choose to pursue licensure often do so because, and therefore after, a child is placed with them rather than in anticipation of a child being placed with them. We do not know how many relative caregivers in this sample were licensed or became licensed within 6 months of the assessment date. The status of licensure may explain differences in the concerns about a caregiver's resources, but the question still remains as to how those differences impact service utilization up to 6 months after the assessment. If the placement is deemed safe and appropriate and the child is considered to be in need of services, caseworkers could presumably take steps to address any cost or transportation barriers that might interfere with connecting that child to the needed services.

Communication between caseworkers and caregivers is another area that warrants further exploration to understand the unmet mental health needs among these children. Although caseworkers and clinical screeners in this study identified a child as having a need for services, these data do not indicate how that information was communicated with the caregiver. There may be differences in opinion about the severity of the need or a lack of communication regarding who is responsible for ensuring the child receives services. As already noted, relative caregivers may have different cultural beliefs or preferences with respect to formal mental health treatment (Garland...
et al., 2003; Smithgall et al., 2009), or they may tolerate problematic behaviors differently from nonrelative caregivers (Early & Mooney, 2002). Other research has shown considerable variability in the extent to which foster parents felt it was their role, or that they were even empowered, to facilitate connections to service providers (Pasztor et al., 2006).

It is not possible to rule out the fact that relative caregivers for whom caseworkers noted concerns may be more likely to reside in geographic areas where services are less accessible. This idea is further supported by the fact that geographic region remained a statistically strong predictor of service utilization in the final analytic model, even after controlling for need, caregiver concern, and the interaction of those two factors. Accessibility of social service providers varies across urban, rural, and suburban areas, and access is lowest within high-poverty census tracts (Allard, 2004). Proximity to resources is a statistically significant predictor of outcomes, especially in rural areas where service availability may be lowest (Weiner, Leon, & Stiehl, 2011). In assessing the accessibility of service providers for a given caregiver, caseworkers must consider circumstances at the family level. They must look at not only the needs of the child and issues like distance between the home and the provider, but also the needs and full responsibilities of the caregiver and the intersection of various policies and expectations regarding his or her role, employment, and financial supports. Accessibility encompasses ability to pay, proximity to home or available transportation, and the accommodation of family-level needs, such as child care and multiple family members’ schedules.

The receipt of additional assessments and needed services are in and of themselves important outcomes; however, future research should also examine the effectiveness of the services delivered and the implications of any unmet needs. Furthermore, these analyses focus only on whether any mental health claim was filed within 6 months of the assessment. It is unknown whether services were provided by specialty mental health providers or whether levels of service were sufficient to address the identified needs. Future research is needed to understand whether the services provided to those who needed and received mental health services improved their functioning.

Study Limitations

Although this study contributes significantly to the understanding of unmet mental health needs for children in foster care, there are some limitations that stem from the data used. Medicaid claims data may not be a comprehensive measure of mental health service utilization because some children may receive services billed through contracts, other funding streams, or other systems (i.e., schools). However, with respect to child welfare service provision in Illinois, DCFS implemented a shift from a comprehensive rate
to fee-for-service billing in April of 2007; therefore, more of the services delivered to DCFS wards are being captured in Medicaid claims data instead of through contracts with DCFS (McEwen & Grady, 2010).

This study produced estimates of the proportion of children needing mental health services that are within the wide range of estimates in published research; however, the estimates produced from this study may not be generalizable to the entire foster care population in Illinois. These data represent cohorts of children entering foster care, where the targeted timeline for completing assessments is within the first 45 days after placement. Thus, this study would not capture those children who did not initially present with mental health problems but whose behavior or mental health worsened over their time in care, perhaps as a result of placement moves or other developmental or placement-related experiences.

CONCLUSION

Findings from this study reinforce the importance of front-end child welfare assessments that consider not only a child’s need for mental health services but also caregiver capacity to meet those needs. Furthermore, in light of federal policies encouraging the expansion of kinship care through licensing waivers and use of family-finding programs, it is important that child welfare systems acknowledge and respond to any resource, housing, social service, and education needs of relative caregivers.

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