

Obstacles and Opportunities in Accessing Mental Health Services for Children in Foster Care: Lessons from Recent History in Illinois

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Abstract

This article examines the reasons for a shortfall in mental health services for children in foster care in Illinois in 2003 and 2005, and explores efforts to improve mental health services by the Illinois Department of Children and Family Services (DCFS). The shortfall reflects both overall deficits in funding and staffing children's mental health services in Illinois and specific challenges to the child welfare system. From 1988 to 2001, DCFS mental health change efforts focused on substantially reducing high rates of psychiatric hospitalization and residential treatment and overhauling an ineffective system of psychological assessment, leaving much undone regarding more routine mental health services. Spurred in part by federal review and statewide grassroots children's mental health advocacy, DCFS since 2005 has initiated a range of new assessment and treatment programs. However, ongoing problems with Medicaid funding and reimbursement hinder service delivery. More rapid improvement of mental health services for this population may require a coalition with a specific commitment to children in foster care.

Introduction

Several studies have documented a gap between the mental health needs of children in foster care and the mental health services they receive (Kortenkamp & Ehrle, 2002; Leslie, Hurlburt, James, Landsverk, Slymen, & Zhang, 2005; Takayama, Bergmann, & Connell, 1994; U.S. Department of Health and Human Services, 2003), and the companion paper in this issue (Cross & Bruhn) adds to this literature, focusing particularly on Illinois in the years 2003 and 2005. Eliminating this gap requires an understanding of how a shortfall in mental health services developed, what obstacles block access to services, and

what opportunities exist to improve access. Research that studies a specific state in depth is especially valuable, because child welfare is a state function and significant improvements are most likely to come from state initiatives. There are, however, few policy studies of mental health care for children in state custody (but see Webb & Jones-Harden, 2003), and we are not aware of any study that examines the reasons for a shortfall of mental health services for children in foster care in a given state and comprehensively explores a state's efforts to improve mental health services for children in foster care. The current paper does just this for the state of Illinois, and is designed to complement a companion paper (Cross & Bruhn, in this issue) which found that Illinois children in foster care in 2003 and 2005 were less likely to receive mental health services than children in foster care nationally. This research is valuable both to assess Illinois' current efforts and to provide an instructive example for other states.

Illinois makes for a good case study, not only because data in Cross & Bruhn (this issue) suggest that Illinois' shortfall in services has been particularly pronounced, but also because an improved Illinois Department of Children and Family Services (DCFS) and a statewide Illinois Children's Mental Health Partnership have a number of initiatives in process that may enhance mental health services for children in foster care. Documenting the obstacles to mental health service delivery for Illinois children in foster care could help identify similar obstacles in other states. Studying Illinois' efforts to improve mental health services for children in foster care may suggest strategies other states may want to pursue, and may also identify areas in

which gaps in services are likely to continue and new policies and programs should be developed.

This paper draws from a variety of sources for its analysis, including reports of Illinois state and federal organizations, state program evaluations, DCFS and other state agency documents, Illinois-based empirical research studies, newspaper reports, and interviews with stakeholders in the state's child welfare and children's mental health communities. The paper describes major system changes in Illinois child welfare, which began in the late 1980s and led to a substantial overhaul, in the 1990s, of mental health care for the most troubled of children in foster care. The paper also describes continued efforts in the 2000s to identify obstacles to mental health care for a broad range of children in custody and to develop improvements in mental health care. Finally, the paper discusses what this history suggests about the apparent shortfall in mental health treatment reported in the companion article (Cross & Bruhn, this issue), and assesses current efforts to improve mental health services for children in foster care.

The Shortfall in Mental Health Care for Illinois Children in Foster Care

Cross & Bruhn (this volume) report troubling results regarding mental health services from the Illinois Child Well-Being Study (IL-CWB), a periodic study of well-being and service delivery for children in foster care conducted for the Illinois DCFS (see Bruhn, Helton, Cross, Shumow, & Testa, 2008; Hartnett, Bruhn, Helton, Fuller, & Steiner, 2009). Standardized child mental health measures were completed and caregivers were interviewed for random samples of Illinois children in foster care in 2003 and 2005, and the results were compared to parallel results on children in foster care from the National Survey of Child and Adolescent Well-Being (NSCAW), a national probability study of children involved with child welfare services (see, e.g., U.S. Department of

Health and Human Services, 2003). In the IL-CWB, a substantial proportion of Illinois children, ranging from 46.5% to 55.9%, scored in the borderline clinical to clinical range based on the caregiver measure used, the Child Behavior Checklist. Children with scores in the clinical range were considered to need mental health intervention and those with scores in the borderline clinical range were considered probably to have this need. The proportion of children in NSCAW in this range was about the same as in Illinois, but a consistent pattern showed that children in the NSCAW samples were significantly more likely to receive mental health services than children in the Illinois samples. This was true across eight service variables, including both whether any specialty mental health service (provided primarily by licensed mental health professionals) was provided and whether *any* mental health service was provided. The percentage of Illinois children who received a mental health service ranged from 38.9% to 45.6%, depending on the specific sample, whereas the percentage of children in foster care in the national samples who received a mental health service ranged from 57.8% to 65.5%. Considering that most children in foster care have histories that would normally result in a need for some form of mental health care, the measures used to indicate need undoubtedly underestimate the number of foster children who need mental health services. It should be noted that this study concerned mental health services provided in mental health and other service settings, and did not measure provision of mental health services by private practitioners (although private practitioners are extremely unlikely to close the gap).

The finding that Illinois children in foster care were less likely to receive mental health services than children in foster care nationally leads naturally to the question of *why* this is so. This article explores possible reasons why and examines system changes designed to improve mental health service delivery.

A Gap in Public Mental Health Care for All Illinois Children

The mental health of children in foster care is arguably not only the responsibility of DCFS, but also of other state agencies concerned with the health and well-being of Illinois children. A shortfall in mental health services for children in foster care may be to some degree a function of a shortage for *all* Illinois children who need public mental health services. In its 2007 review of children's health care in Illinois, the MidAmerica Institute on Poverty of the Heartland Alliance (citing data from the National Survey of Children's Health) reported that 37% of Illinois children with behavioral, developmental, or emotional problems did not receive any mental health service in the year prior to the survey. Part of the difficulty, it reported, was that only 16% of the state's psychiatrists and psychologists accepted public insurance, according to 2007 Illinois Kids Count data (see discussion of Medicaid later in this article). The 2007 report (MidAmerica Institute on Poverty of Heartland Alliance, 2007) echoed conclusions from a 2003 report of the Illinois Children's Mental Health Task Force (discussed later). The Task Force report stated: "[t]he system of care for children with severe mental health problems is grossly underfunded, resulting in a lack of capacity to serve the children and families most in need" (2003, p. 8). Thus, "most services are focused on the needs of children with severe mental health problems and disorders" (p. 8). Lack of funding prevents rendering of services in individual cases, and has also contributed to a system in which there is a shortage of mental health centers and individual professionals capable of providing child mental health services.

A general gap between children's mental health needs and service delivery, however, is not unique to Illinois. Nationally, many children who need mental health services do not receive them (Kataoka, Zhang, & Wells, 2002), a problem that has been recognized for decades (see, for example, Saxe, Cross,

& Silverman, 1988). An understanding of some factors contributing to the lack of adequate mental health care for children in Illinois may shed light on this persistent problem nationally. The rest of this paper focuses specifically on the challenges of providing mental health services to Illinois children in foster care and efforts to improve those services.

Historical Perspective

1988 to 2001: The B.H. Consent Decree and Initial Changes in Mental Health Care

The Illinois foster care system encountered substantial challenges in the late 1980s and early 1990s that arguably have had a long-term impact on service delivery for children in foster care. Much of the system response in the 1980s and 1990s was reactive to major crises in the system and was focused on reducing and then preventing excessive numbers of children in foster care and high utilization of the restrictive, costly mental health services of psychiatric hospitalization and residential treatment. Several crises were successfully addressed, but broader, systematic consideration of mental health care had to wait for the following decade.

All DCFS action in the late 1980s and 1990s took place in the context of general upheaval and system change in the Illinois Department of Children and Family Services. Starting in the mid-1980s, there were substantial upturns in the number of children referred to DCFS and the number landing in foster care (Testa, Fuller, & Rolock, 2005; Testa, Shook, Cohen, & Woods, 1996). The number of children in foster care increased from fewer than 15,000 in 1987 to a peak of more than 50,000 in 1997. Both social changes, such as the crack cocaine problem at that time, and increasing formal involvement of DCFS in what had previously been informal kinship care contributed to the upturn (Rolock, 2008). Though motivated by a desire to protect more children, these increases led to enormous caseloads for individual DCFS

workers (frequently more than 75 children per worker in Cook County; Mezey, 1998), which increased the difficulty of providing adequate child welfare services. A *Time* magazine article, entitled "Calcutta, Illinois," described some of DCFS's failures from that period (Van Biema & Grace, 1994; see Rolock, 2008).

In 1988, the American Civil Liberties Union sued the Illinois DCFS on behalf of 20,000 foster children in Illinois regarding its failure to provide services for children in its care (*B.H. v Johnson*, 128 F.R.D. 659 (N.D. Ill. Dec. 19, 1989); 715 F. Supp. 1387 (N.D. Ill. May 30, 1989), 49 F.3d 294 (7th Cir. 1995), *reh'g & reh'g en banc denied* (Apr. 7, 1995); see Mezey, 1998, 2000). To avoid an extended trial, the contending parties collaborated with Judge John Grady to develop a 69-page consent decree that outlined minimum standards to meet the safety, permanency, and well-being needs of children in foster care placement. Consent decrees such as this are not unique to Illinois; Kosanovich and Joseph (2005) analyzed 35 child welfare consent decrees with similar elements across nearly as many states.

Illinois undertook several system changes in response to the consent decree. DCFS appropriations rose 129% from FY1992 to FY1997, with the largest single increase coming in FY1994 to FY1995, the year the consent decree was to be fully implemented (Mezey, 1998). Caseloads were reduced in response to the judge's 1994 deadline to institute a ceiling of 25 cases per worker. Several steps were taken to reduce the number of Illinois children in substitute care (Testa, Fuller, & Rolock, 2005; Rolock, 2008). Performance-based contracting was implemented, which established a goal for agencies to move children into permanent homes and financial incentives for them to do so (Illinois Department of Children and Family Services, n.d., b; Testa, Fuller, & Rolock, 2005; Vinson, 1999). Illinois also passed legislation to align case planning and goal-setting more closely with the mission of establishing children in permanent homes (Testa, Fuller, & Rolock, 2005). In

addition, a nationally recognized subsidized guardianship program was implemented to provide support for kin who were willing to care for children permanently outside of foster care but did not want to terminate the rights of the original parent (see Children and Family Research Center, 2007; Rolock, 2008; Testa, 2002). The result was that the number of Illinois children in substitute care fell from a high of more than 50,000 in 1997 to just over 30,000 in 2000. Also, the number of children in foster care entering permanent homes more than tripled from FY1997 to FY2000, with more than a sixfold increase in the number of children adopted (Rolock & Testa, 2008).

Parallel to the crisis in the number of children in DCFS custody was a crisis in the number of these children who were in psychiatric hospitals and residential treatment centers, the latter including many youth who were placed out of state. Because of this, attention to mental health problems was an element of the *B.H.* consent-decree efforts almost from the start, and mental health improvement efforts during this period focused on these children. One target was overutilization of psychiatric hospitalization for children in foster care who could be served in less restrictive settings.

To address this need, DCFS collaborated with the state's public health and mental health agencies to create the Screening, Assessment and Support Services (SASS) program for children and adolescents at risk of hospitalization (Illinois Department of Children and Family Services, n.d., a; see also He, Lyons, & Heinemann, 2004; Lyons, Kisiel, Dulcan, Cohen, & Chesler, 1997). To prevent hospitalization when possible, SASS providers screen children in crisis, and provide crisis therapy and connection to community treatment and other resources to deal with the issues fueling the crisis. They monitor children, provide consultation, and support foster parents to supervise and respond effectively throughout the crisis. SASS agencies also provide services for children leaving the

hospital to help prevent rehospitalization. SASS was implemented along with a policy decision not to admit foster children to public psychiatric facilities. Substantial reductions in the number of hospitalizations followed the implementation of SASS (Illinois Department of Children and Family Services, n.d., a), though it is not clear if the numbers of children receiving SASS services paralleled this reduction. In 2003, SASS was broadened to serve all Illinois children receiving public mental health services. A 2005 program evaluation found that SASS had reduced hospitalization and its attendant costs and that youths' severe behavior problems abated upon receipt of SASS services (Mental Health Services and Policy Programs [MHSP], 2005; see following sections).

Another DCFS effort addressed overutilization of residential treatment. Research conducted for DCFS revealed that about one-third of children in residential centers did not have emotional or behavioral problems that required such a restrictive level of care (Lyons, Mintzer, Kisiel, & Shallcross, 1998), and that many were placed out of state, far from families and communities (Illinois DCFS, n.d., a). Payment rates for residential treatment also varied wildly because rates were based on what each center had historically billed for its services rather than on a rational, comprehensive system. DCFS collaborated with Illinois universities to gather data on the profiles of residential programs and establish new standards for residential care. Placement review protocols were established for both admissions and discharges, and a new, data-driven decision-making model was developed at Northwestern University (see He et al., 2004). DCFS also engaged university psychiatric professionals to conduct a utilization review of residential centers in and out of state. So-called "wraparound" funds (see, e.g., Ferguson, 2007) were provided, which could be used flexibly by case managers to intervene with families in whatever ways promoted children's mental health and stability (e.g.,

transportation to important events, pursuit of hobbies and interests, etc.) (Robert Wood Johnson Foundation, 2000). These efforts led to a 35% reduction in use of residential treatment over 10 years and a reduction from 870 children placed out of state to 15 (Illinois DCFS, n.d., a; see also Illinois DCFS, 2003).

Another initiative to provide better, less restrictive care to children in crisis was the Intensive Therapeutic Services program (Patricia Chesler, former Deputy Director for Planning, Research and Development, Illinois DCFS, personal communication, August 18, 2008). This freed up money tied to specialized foster care to be used flexibly to respond to DCFS wards in crisis, regardless of what type of placement they were in. One benefit of this program was to increase access to a wide array of services, such as case management and intensive family crisis intervention, by the growing number of troubled children in kinship care and subsidized guardianships, who previously did not have access to the array available to children in family foster care. A Placement Stabilization Services program addressed the needs of youths in crisis who had a history of multiple placements. Within 60 to 90 minutes of calling the service, families received help with conflict resolution and other methods for managing child behavior problems, as an alternative to seeking further residential treatment (see Illinois DCFS, 2001). A program called Pathways provided services to adolescents transitioning out of foster care into independent living (Youth Network Council, n.d.). New funding strategies shifted costs from DCFS general revenue to federal funding from Medicaid (see later discussion on Medicaid) and Title IV-E, the latter being money that the federal government, through the Social Security Act, provides to states to support foster care and adoption.

Most of the system change efforts in the 1990s related to mental health services for children in foster care thus focused on youth who had the most serious mental health problems and were in restrictive care

or on youth in crisis. But DCFS also did a 1997 review of psychological evaluations for the general population of children involved with the department (Larry Small, Associate Deputy for Clinical Services, Illinois DCFS, personal communication, May 10, 2009). The review found that DCFS spent \$14 million that year on psychological testing for these evaluations. Unfortunately, these evaluations were often not useful, because referral questions were lacking, the evaluations focused excessively on individual pathology and overlooked family dynamics, they were sometimes unnecessarily duplicated, and they were used in a way that competed with rather than complemented caseworker judgment. Standards setting fair payment for evaluations and for communicating results were lacking. DCFS created the Psychology Program in 1997, which provided psychological consultants to help prepare effective referrals for psychological evaluations and established credentialing, guidelines, and quality assurance for these evaluations. This substantially reduced the cost of testing to \$2 million, but still relied heavily on testing of individuals rather than a more comprehensive family assessment.

Thus, in the 1980s and 1990s DCFS faced multiple system crises, which left a great deal undone in providing more routine mental health services for children in foster care. More improvement of the assessment process, improved coordination between mental health providers and caseworkers, and greater attention to outpatient services for a broader range of children in foster care were needed.

2001 to the Present: Broader Attention to Mental Health

By the 2000s, Illinois had made significant changes in response to the crises of the 1980s and 1990s. The number of children in substitute care fell further from its 1997 peak to less than 18,000 in 2006, and DCFS, formerly blamed for “Calcutta, Illinois,” was now being referred to as the “gold standard” by the deputy director

of the Pew Commission on Foster Care (Rolock, 2008; Testa, Fuller, & Rolock, 2005). The *B.H.* consent decree was established as a way of life for DCFS. As less attention was required for system crises, there came a greater call for attention to the well-being of children in foster care.

Child and Family Service Review

In the 2000s, a focus on the mental health of children in foster care followed in part from a national movement in the child welfare field to attend more to the well-being of children in custody (see, e.g., Pew Commission on Children in Foster Care, 2004; Webb & Jones-Harden, 2003; Wulczyn, Barth, Yuan, Jones-Harden, & Landsverk, 2005), and from greater federal involvement in the quality of child welfare services. In 2000, the final year of the Clinton administration, the federal Administration for Children and Families (ACF) launched a major initiative to improve child welfare services nationally. Within a few years, this initiative, entitled Child and Family Services Reviews (CFSRs; see Children’s Bureau, n.d.) weighed in on the problems with delivering mental health services to Illinois children in foster care. The CFSR is the mechanism through which states are made accountable to the federal government for the quality of their services. Service accountability is tied to eligibility for federal child welfare block grants. Each state must undergo a CFSR, in which the state provides standardized data to the ACF and expert reviewers hired by the ACF conduct site visits and review each state’s services in depth. The Illinois first-round reviews were conducted in 2003–2004, and the second round was scheduled for 2009 (Green, n.d.).

As it has done in every state, the CFSR process identified a number of obstacles to quality services in Illinois and identified areas in which the Illinois DCFS needed to improve (U.S. Department of Health and Human Services, Administration for Children and Families, 2004). The state review reported that psychiatric,

psychological, and counseling services were very limited and difficult to access for children in foster care. Poor mental health assessment procedures and a paucity of providers who could bill Medicaid were cited as major obstacles to service delivery (see more on Medicaid later in this article).

Part of the CFSR process is the development of a Performance Improvement Plan (PIP) to guide statewide quality improvement efforts in response to problems identified by statewide assessments. Illinois developed a PIP that addressed the shortfall in mental health services in a number of ways (Illinois Department of Children and Family Services, 2004). Supported by new legislation in 2005 that formalized new DCFS services to enhance the response to behavioral health (Blagojevich, 2005), DCFS has implemented several elements of the PIP as well as taken other steps to improve services.

One major new service effort is the Integrated Assessment Program (IAP), initiated in 2005 (see Hartnett & Hochstadt, 2007; Illinois Department of Children and Family Services, 2004). An improvement of the Psychology Program of 1997, the IAP aims to make screening and assessment comprehensive and streamlined, and to identify a range of child and family needs (mental health and other) that will then be addressed more effectively in service planning. To enhance assessment, clinical screening specialists are paired with investigating caseworkers to develop a comprehensive assessment report. The IAP was implemented only for new cases entering the system; thus, it did not address the needs of children already in the system, who may be at greater mental health risk because of difficulties achieving permanency.

The Child and Adolescent Youth Investment Teams (CAYIT) program, begun in 2005, aims to improve the process of decisionmaking and service planning when youth experience multiple placements or when caseworkers seek to

move youths to a substantially different (usually more restrictive) placement, such as residential treatment or specialized foster care (Samuels, 2006). Such situations typically indicate crises that require careful assessment and good service planning to meet multiple needs. CAYITs are teams of full-time mental health, child welfare, and other service professionals that assess children's needs to determine their level of care and their specific service needs. CAYITs are designed to help prevent unnecessarily restrictive placements, to move youths who need more intensive placements into appropriate situations more quickly, and to help stabilize placements by identifying and advocating for services to counter the problems leading to disruption.

Efforts to prevent and reduce restrictive placements evolved, as funding for Intensive Therapeutic Services, Placement Stabilization Services, and Wraparound Planning Services were combined in a new System of Care (SOC) program (see DCFS Web Resource, n.d.; Wyman & Townsend, 2007). SOC offers an array of short-term interventions, including intensive home-based counseling, case management, mentoring, and provision of concrete resources (e.g., camp scholarships) to a range of youths at risk of placement disruption. Similar in some ways to the SASS program (discussed more later), SOC aims both to prevent restrictive placements for youth in foster and kinship care and to help youths transitioning from these restrictive placements to a family situation.

Many of these programs (e.g., IAP, CAYIT, SOC) use a common assessment tool, the Child and Adolescent Needs and Strengths (CANS) instrument, developed by the Mental Health Services and Policy Program (MHSP) at Northwestern University. The CANS is designed both to assist service planning and outcome assessment for individual youths and to provide an aggregate measure of service needs to be used in system planning (see, e.g., Lyons, 2004). Outcome data from CANS have been included as a component

of providers' performance assessments in DCFS's performance-contracting system (Mental Health Services and Policy Program, 2007).

DCFS has a number of other specific initiatives to improve care, in partnership with mental health provider agencies. These include:

A program entitled "Psychiatry for Adolescents and Children in Transition" (PACT) that will provide psychiatrists' services to children in foster care across the state (Diahann Moore, Associate Director for Psychiatric Services, Illinois DCFS, personal communication, March 13, 2009). Larger population centers will have special clinics staffed by part-time child psychiatrists to provide direct services and consultations, and "telepsychiatry" services will be provided in areas lacking psychiatrists. The first clinic began operating in Chicago in 2006.

A new Trauma Initiative was inaugurated to make DCFS a "trauma-informed system" (Illinois Violence Prevention Authority, 2006, p. 2), by training workers to recognize and respond to trauma and make sure that practices based on the best available research information are used.

In 2008, an online searchable database of mental health service providers was initiated. This database provides specific information to caseworkers about what treatment modalities individual agencies offer, what populations they serve, and what assistance they provide to overcome barriers to access (e.g., transportation to families) (Weiner, 2008). The database also has a geomapping function that allows the system to display the distribution of different resources geographically. This helps make it a systems planning tool as well as a resource for individual cases.

A Comprehensive Assessment and Response Training System (CARTS) program, run by the University of Illinois at Chicago (UIC), works with treatment agencies contracted with DCFS to enhance

the response to youth who have experienced multiple psychiatric hospitalizations and placement disruptions (Naylor, Anderson, & Morris, 2003; University of Illinois at Chicago, 2008).

A small UIC psychiatric inpatient unit was developed specifically for children in foster care (Naylor, Anderson, & Morris, 2003; University of Illinois at Chicago, 2008).

UIC's Clinical Services in Psychopharmacology Program was developed to provide medical review, oversight, and consultation regarding psychiatric medication for children in foster care (University of Illinois at Chicago, 2008).

An evaluation of one IAP setting, La Rabida Children's Hospital in Chicago, found promising effects but also problems with implementation (Hartnett & Hochstadt, 2007). The IAP's addition of the clinical screening specialist seems to have enriched the quality of the assessment. The evaluation found that the IAP assessment reports did an "excellent job" of identifying child and parent mental health needs and issues to be addressed. They also provided detailed recommendations that were clearly linked to the assessments. However, there was a "glaring" disjunction between the information in the IAP report and client service plans in one-third of cases, and service planning generally made inadequate use of the insights from the IAP report. Sometimes IAP recommendations were simply ignored. More often, detailed, specific recommendations in the assessment report were translated into vague, general, and less useful recommendations in the client service plan, although the evaluation did not quantify how often this happened. The evaluators provide a case example in which the IAP report offered instructions as to the exact skills needed in a therapist and the specific issues to address, and also recommended a separate substance-abuse evaluation for the youth. In the service plan, the detailed recommendations and need for a separate substance-abuse assessment were mutated to "Child agrees to attend

individual therapy to discuss her defiant behaviors, substance abuse, depression and sexual abuse" (p. 30).

The Illinois Children's Mental Health Partnership

In parallel to mental health change efforts in DCFS, a grassroots advocacy effort has arisen in Illinois that aims broadly at mental health for all children, but specifically addresses mental health services for children in foster care as well. In 2001, a small group of advocates and educators visiting a high school in Illinois became alarmed about the level of depression, anxiety, and other mental health problems they found among students in the school, some of it traceable to students' exposure to violence in their homes and community (Illinois Children's Mental Health Task Force, 2003). The concerns of this small group led to the development of a much larger Illinois Children's Mental Health Task Force, which persuaded the legislature to pass the state's Children's Mental Health Act of 2003. This act directed the state to develop a Children's Mental Health Plan with recommendations for comprehensive mental health prevention, early intervention and treatment services; and to establish an Illinois Children's Mental Health Partnership (ICMHP) to develop and monitor the implementation of the plan. The Act also reorganized SASS services to screen *all* children served by Medicaid who are being considered for hospitalization, not just children in foster care.

An evaluation of SASS found that the program was able to help prevent hospitalization for a substantial number of lower-risk youth, who improved more in the community than comparable youth who were hospitalized (Mental Health Services and Policy Program, 2005). The most severe behavior problems of youth in SASS abated considerably, although the majority of SASS clients continued to have more chronic problems requiring ongoing mental health services from providers other than SASS. The Illinois Children's Mental

Health Partnership's annual report (2006) states that the enlarged SASS program led to \$44.1 million in cost savings in FY2005 and FY2006, although this report does not provide information on exactly what agency realized those savings and whether those savings were offset by increased costs to agencies that were providing services in lieu of hospitalization.

ICMHP continues to advocate for the mental health care of Illinois children. The Partnership includes representation from many different disciplines, most particularly representatives designated by the directors of the Department of Human Services (which contains the state mental health agency), the Department of Education, and DCFS. The Illinois Children's Mental Health Plan that was developed included a wide range of priorities, from addressing maternal depression, to promoting social-emotional learning in the schools, to maximizing availability of federal funds to pay for services. Given the breadth of its scope, most ICMHP efforts have focused on children in general, with little specific or direct impact on children in foster care (see Illinois Children's Mental Health Task Force, 2003). However, some of the partnership's dozens of recommendations were specifically aimed at children in foster care or would have a special impact on this population. ICMHP advocated increases in funding of mental health treatment and respite services for DCFS clients, and full implementation of the Integrated Assessment Program. The Partnership also recommended specific ways to find more funds to match federal Medicaid dollars, and to reduce unnecessary and costly psychiatric hospitalization and shift savings to other forms of treatment. It also proposed expanding the array of mental health professions that can become eligible to bill Medicaid (see later discussion). In addition, the mental health needs of youths transitioning out of foster care into adulthood were specifically mentioned as a priority in the Task Force's 2003 report (Illinois Children's Mental Health Task Force, 2003).

Its annual reports (ICMHP, 2005, 2006, 2007) illustrate where ICMHP has been able to make progress and where progress remains to be made. As required by the Children's Mental Health Act, Illinois' Medicaid agency obtained an additional \$4.5 million through federal reimbursement of Individual Care Grants (see ICMHP, 2007). ICMHP has also devoted small amounts of money (e.g., \$50,000 in FY 2007) to augment services for children affected by trauma, which includes a number of children in foster care but is not limited to children involved with DCFS. Other recommendations on foster care have yet to be implemented. This is understandable given the ICMHP's many recommendations, its comparative youth as an organization, its expansive scope, and the limited political power of a broad coalition in its circumstances—Illinois has historically been very reluctant to support (or fund) mental health care for its citizens.

Medicaid

Because children involved with the child welfare system tend to be impoverished and dependent on public funding for mental health care, Medicaid figures prominently in discussions of mental health services for children in foster care in the 2000s, both in Illinois (Illinois Children's Mental Health Task Force, 2003; U.S. Department of Health and Human Services, Administration for Children and Families, 2004) and nationally (e.g., Bazelon Center for Mental Health Law, 1999a, 1999b; Cooper, 2008; Field, 2004; Stroul, 2007). Major problems with Medicaid impede service delivery, but the program also presents opportunities for expanding funding for children's mental health services. Because all youths in DCFS custody are automatically eligible for Medicaid coverage (see, e.g., U.S. Department of Health and Human Services, Health Resources and Services Administration, 2004), a large (but uncertain) proportion of their mental health treatment could be billed to Medicaid, though many administrative and other difficulties with the program often make billing

problematic. Though state administered, Medicaid is funded through a combination of state and federal dollars (Kaiser Family Foundation, 2007), and increasing the range and amount of treatment billed to Medicaid means increasing the amount of federal dollars brought in to support services and thereby easing the pressure on the Illinois state budget. However, states must provide a match in dollars to claim federal Medicaid funds, which is a challenge.

Problems with accessing Illinois Medicaid dollars for mental health services have repeatedly been cited, both for children in foster care and other children covered by Medicaid. According to the 2003 Child and Family Services Review of Illinois (U.S. Department of Health and Human Services, ACF, 2004), the biggest problem for children in foster care was that the rules surrounding Medicaid and reimbursement practices discouraged or prevented mental health providers from rendering services to them. The review cited stakeholders who reported that it took three to six months for providers to receive copies of the Medicaid reimbursement form, which was then found not to be compatible with existing claims software and procedures. Billing Medicaid continued to be cumbersome enough for children's mental health services providers that it was one factor dissuading providers from accepting Medicaid cases (Melissa Ludington, Vice-President for Family-Centered Services, Children's Home + Aid, personal communication, August 15, 2008). In addition, as both the Children's Mental Health Task Force Report and to a lesser extent the Illinois CFSR noted, a range of mental health providers cannot be certified to bill Medicaid, because the program only reimburses certain types of health care organizations, schools, and private physicians, but not other types of organizations, nor psychologists, social workers, or other counselors in private practice.

More general problems with Illinois Medicaid also affect mental health services. Illinois' handling of Medicaid has been

the subject of considerable attention and partisan controversy for a number of years (see, e.g., Illinois State Senate Republicans, n.d.; Keith, 2008), with much of the criticism related to the program's cost rather than its service coverage. Though Illinois has won plaudits for broadening the numbers of children provided with health insurance (see Gifford, Morgan, Marks, & Trenholm, 2008; Ross, Cox, & Marks, 2007; National Conference of State Legislatures, 2006)—Illinois was the first state in the country to provide universal child health care coverage (National Conference of State Legislatures, 2006)—the state has also received considerable criticism from many different quarters for mismanagement of Medicaid (e.g., Illinois Policy Institute, 2008; Illinois State Medical Society, 2006; Stanek, 2006; see Keith, 2008). A 2008 report by the state's auditor general (Illinois Office of the Auditor General, 2008) found that service providers were reimbursed for their services at a low rate and experienced considerable delays in receiving Medicaid reimbursements; in fact, the auditor general reported that the state owed \$1.5 billion in late payments for various Medicaid costs. Multiple sources have documented how Illinois systematically delays Medicaid payments for months at a time as a means of managing its budget (Illinois Office of the Comptroller, 2009; Jaeger, 2009; Koenig & Peterman, 2009). It should be noted that such problems with Medicaid are not necessarily unique to Illinois. Complaints about low Medicaid reimbursement rates, for example, are common in many states (see, e.g., Cooper, 2008; Frank, Goldman, & Hogan, 2003).

These problems with Medicaid all contribute to the difficulty of securing mental health treatment for children in foster care. Many providers are not certified for Medicaid, and some of those that are refuse to bill Medicaid and look instead to limited DCFS funds to pay for treatment (Melissa Ludington, Vice-President for Family-Centered Services, Children's Home + Aid, personal communication, August 15,

2008; Terry Carmichael, Behavioral Health Care Associate, Community Behavioral Health Care Association, personal communication, September 3, 2008). There are several reasons for this: Medicaid's rates are low; agencies find billing Medicaid onerous and uncertain both in its setup and its day-to-day implementation; and some agencies, confronted with a fixed amount in Medicaid contracts, sometimes reserve these dollars for poor children who are not involved with DCFS and therefore not eligible for DCFS funding. In effect, children in foster care are in competition for Medicaid dollars with Medicaid-eligible children who are not in foster care. The shortage of providers (especially those who are Medicaid-certified) and funds makes it difficult to provide mental health treatment for all children who need it, particularly children with less disruptive problems that do not pose threats to their placements.

Despite the difficulties with Illinois Medicaid, the program is also seen as a possible source for improvement, primarily because of the promise of increased federal funding if Illinois can raise more matching funds. Increasing the yield from Medicaid has been one focus of the Illinois Children's Mental Health Partnership. In addition to its successful advocacy to obtain Medicaid reimbursement for Individual Care Grants (mentioned earlier), the Partnership has recommended identifying new or underused state and local funds for mental health care, including money allocated to county mental health boards, so as to draw in more matching federal Medicaid dollars (Illinois Children's Mental Health Task Force, 2003).

Paralleling initiatives in other states (see, e.g., Snowden, Masland, Wallace, Fawley-King, & Cuellar, 2008), the ICMHP also recommends that all children enrolled in Medicaid be assessed for mental health problems through the Early and Periodic Screening Diagnostic Treatment (EPSDT) program, the child health component of Medicaid. An EPSDT screening can expand the range of services available to a child

through Medicaid, because the federal government requires state Medicaid plans to cover service needs identified by EPSDT, even if the state did not choose that particular service option for its Medicaid coverage plan (see, e.g., Bazelon Center for Mental Health Law, 1999b). In a 2004 study, the Office of the Inspector General (OIG) of the Department of Health and Human Services (U.S. Department of Health and Human Services, Office of Inspector General, 2004), a watchdog agency that audits use of federal health funds, investigated Illinois' EPSDT screening for mental health problems among children in foster care. Despite the availability of a state behavioral health screening instrument to assist health care providers (Semansky, Koyanagi, & Vandivort-Warren, 2003), OIG reported that only 3 out of 14 children sampled who were eligible for a mental health screening received one, and only one of these was conducted with the required 21 days.

In an effort to broaden the availability of providers, 2007 Illinois legislation *allowed* (but did not require) the Illinois DCFS to provide Medicaid reimbursement for clinical social workers' mental health services (Illinois General Assembly, 2007). This could considerably expand mental health services for children in foster care because, nationwide, the majority of mental health care is provided by clinical social workers. However, as of this writing, the Division of Health Care and Family Services has not implemented this option (Daniel Potter, Illinois office, National Association of Social Workers, personal communication, May 23, 2008; Jan Schoening, Associate Director, Child Care Association of Illinois, personal communication, September 5, 2008). A similar bill for psychologists and mental health counselors (HB 4862) is in the rules committee of the Illinois legislature as of this writing (Illinois General Assembly, 2008).

Continuing issues with Medicaid could mean a continuing shortage of mental health providers for children in foster care and problems with the quality of care.

Remediating problems with Medicaid will be an essential step in improving mental health services for children in foster care.

Summary of Reasons for Shortfall and Improvements in Care

This analysis found a number of possible reasons for the gap in mental health services delivery for Illinois children in foster care in 2003 and 2005. One problem is that the public mental health system serving *all* children with limited means, including foster children, is underfunded in Illinois, as it is in many states (Illinois Children's Mental Health Task Force, 2003). Also, historically, considerable Illinois child welfare money was tied up in expensive, restrictive services such as residential treatment and psychiatric hospitalization. In some cases there was insufficient flexibility, as the money available was earmarked for only certain categories of children and services. Medicaid funding for mental health services for children in foster care is also lacking because of limited state funds to secure matching federal dollars, a lack of Medicaid-certified providers, low reimbursement rates, difficulties with billing, and significant delays in reimbursement. In part because of the lack of resources, there is an insufficient number of mental health professionals and agencies that serve children (Illinois Children's Mental Health Task Force, 2003), particularly children in foster care (U.S. Department of Health and Human Services, Administration for Children and Families, 2004). In addition, adequate assessment to identify mental health problems among children in foster care has been lacking (U.S. Department of Health and Human Services, Administration for Children and Families, 2004).

Illinois has done a great deal in the past two decades to improve mental health services for children in foster care, particularly children with serious emotional disturbances who are at risk of disrupted placements or psychiatric hospitalization. State actions include successful efforts to

reduce the number of children in restrictive environments, efforts to improve both standard and crisis assessments for children in care, and efforts to improve access to mental health providers. However, will these steps be adequate to address the shortfall in mental health services for children in foster care? What additional steps might be needed to improve care? Ultimately, a judgment of the efficacy of these improvements depends on whether they have helped enhance the mental health of Illinois children in foster care since 2005. Data on this are just now becoming available on this from the Illinois component of the National Survey of Child and Adolescent Well-Being (see Cross & Bruhn in this issue for a description).

Discussion

This historical review of policy developments makes it clear that Cross & Bruhn (this volume) is only the latest and most empirically grounded of several reports that identify a shortfall in mental health services for Illinois children in foster care. Insufficient or inadequate mental health services for this population was a problem identified by the *B.H.* consent decree process, the Illinois' Child and Family Service Review, the Illinois Children's Mental Health Partnership, and various initiatives in Illinois' DCFS. There are obstacles at every step of the process of providing mental health services, from identifying children's problems to finding providers to paying for services. A number of system improvement efforts are taking place on several fronts in Illinois: new programs designed to improve assessment and reduce unnecessarily restrictive and expensive services; a new database designed to help link children with service providers; and attempts to increase federal support for children's mental health care through Medicaid. Questions remain, however, about how well the gap in mental health service delivery will be addressed.

The Need to Make Mental Health Care Available to Children in Foster Care

Many Illinois initiatives have focused on small percentages of the most troubled, most at-risk youth. SASS targets children at risk of hospitalization, SOC children at risk of placement disruption, and CAYIT children with multiple moves or facing a major placement change. Yet, data from Cross & Bruhn (this volume) as well as other studies suggest that many children in foster care suffer from emotional and behavioral problems that do not involve placement disruption or possible hospitalization, but nevertheless detract from their quality of life and interfere with their development. Other new initiatives focus on assessment and referral (e.g., IAP, CAYIT and the provider database). They do not, however, deal with the shortage of mental health providers for this population and the shortage of funds with which to pay them.

Complexity of the Problem

This analysis suggests how complex the problem of providing mental health care to children in foster care has been. Multiple obstacles have impeded appropriate and effective mental health services, including inadequate assessment, difficulties with caseworker follow-up, shortages of mental health service providers, cumbersome Medicaid provider eligibility rules and procedures, and delayed and meager Medicaid reimbursement. DCFS has the major responsibility in this area, and is the single agency doing the most to improve mental health services for children in foster care, but it is neither the sole source of the obstacles to services nor the sole agency that needs to make changes. The state's public health and mental health agencies are collaborating with DCFS on some programs, and clearly agencies besides DCFS could do more. Illinois' Medicaid agency could potentially make changes to increase availability of and access to funds. There is no quick fix nor single solution, and multiple government agencies, professional organizations, universities, and advocacy groups will have to be involved.

The Difficulty of Prioritizing Mental Health Services for Children in Foster Care

Most of the reform efforts detailed in this article aim for substantial system change, either of the child welfare system (e.g., the *B.H.* consent decree and the CFSR), the array of agencies and professionals that provide mental health services for all Illinois children (the ICMHP and Mental Health Act of 2003), or the system of financing public child health care (efforts to change Medicaid). They have the potential to improve mental health services for children in foster care either directly, because this is explicitly a part of their agenda, or indirectly, because general improvements in services will benefit children in foster care as well as other children.

However, the breadth and ambition of many system change efforts raise concern about whether they can have a sufficient impact specifically on mental health services for children in foster care. In child welfare system improvement efforts, mental health has to compete with other major priorities such as child safety and permanence. A shortfall in mental health care was only one of many deficiencies identified by the *B.H.* consent decree and the Illinois CFSR, and relates to only one part of the subsequent change efforts. Likewise, in mental health service improvement initiatives, children in foster care compete with other, much larger populations. The Illinois Children's Mental Health Partnership has a broad focus, and thus far, its efforts specific to mental health services for children in foster care have been limited. Changes related to Medicaid do not specifically address the cumbersome process that slows the determination of eligibility for mental health service providers under Medicaid, nor would they ensure that Medicaid-eligible providers and provider agencies will necessarily be in place to offer mental health services to children in foster care.

Given DCFS's crises of the 1980s and 1990s, and the demands of other priorities in the child welfare, mental health, and health care financing systems, it is understandable

that improving access to mental health services for children in foster care has taken considerable time. Several new mental health efforts for children in foster care are recent and too new to be conclusively evaluated. As of this writing (May 2009), the Integrated Assessment Program has been in operation for less than four years, and its initial evaluation took place in its second year. The geomapping and mental health treatment provider search software was implemented in April 2008, and cannot address the problems of the limited overall pool of Medicaid-eligible treatment providers. It will take years for the ICMHP to develop specific change plans for its many recommendations, and clearly, Illinois Medicaid has large problems that may divert its attention from the comparatively small issue—in Medicaid terms—of mental health services for children in foster care.

More rapid improvement of mental health services for this population may require more targeted change efforts advanced by a coalition of advocates from different professional communities that each makes a specific commitment to children in foster care. Such advocates could push for further changes in Medicaid to enroll more mental health service providers to serve children in foster care, and could enlist mental health professional groups to expand the list of providers available to children in foster care. Their advocacy might involve engaging the Illinois Children's Mental Health Partnership, the federal Administration on Children and Families, and other groups to place children in foster care higher on the list of priorities. Child-serving agencies and advocates should also look for different venues (e.g., schools) and modalities (e.g., group treatments) for providing mental health services for this population.

Opportunities for Improving Financing of Mental Health Services

The problem with payment for child mental health services is not unique to Illinois. A number of publications detail

the difficulties of financing mental health services for children in foster care and poor children generally (see, e.g., Cooper, 2008; Field, 2004; Stroul, 2007; Webb & Jones-Harden, 2003). Chronic problems with financing have the pernicious effect of discouraging the development of provider agencies and professionals with the expertise to work with children in foster care (Field, 2004).

At the same time, several sources identify creative methods states can use to finance mental health services (Bazelon Center for Mental Health Law, 1999a, 1999b; Cooper, 2008; Field, 2004; Webb & Jones-Harden, 2003). The largest number of options concern Medicaid. State budgets can be searched to identify more state matching funds to secure more federal Medicaid dollars (Field, 2004). Several steps can be taken to use EPSDT more effectively, including defining more clearly the services covered by the state's Medicaid plans; informing caregivers of children's rights to assessment and services under EPSDT; increasing the frequency of EPSDT screening (particularly by taking advantage of flexibility in what federal law considers screening); and training pediatricians to do effective mental health screening (see, e.g., Bazelon Center for Mental Health Law, 1999a, 1999b; Webb & Jones-Harden, 2003). States can pursue Medicaid waivers and options that allow payment for an array of community-based, nontraditional, nonoffice-based services that are now considered best practice for many youths with serious, complex mental health problems (Bazelon Center for Mental Health Law, 1999a, 1999b; Cooper, 2008; Field, 2004; Stroul, 2007). These services include, for example, wraparound services, targeted case management, respite services, family support services, and services specifically aimed to help older youths aging out of foster care. Successful use of these options could reduce the need for costly psychiatric hospitalization and residential treatment, potentially freeing up more funds for community-based services. Caution regarding this option is needed,

however, as the federal Deficit Reduction Act of 2005 is leading many Medicaid claims for these services to be disallowed in audits (Cooper, 2008).

Some states have also been able to fund some mental health services for children in foster care by taking advantage of federal child welfare funding programs that are flexible as to how money is used, though the amount of funds in these programs is typically small (Field, 2004). For example, the state of New York has been able to fund some mental health services through child welfare funds in the Transitional Assistance to Needy Families (TANF) program (Cooper, 2008; see also Webb & Jones-Harden, 2003). It is beyond the scope of this paper to make specific recommendation for Illinois to increase funding, especially since the child welfare and mental health systems are rapidly moving targets and specific options would require more in-depth study. Nevertheless, the combination of unmet need and the plethora of innovations used nationwide (see also National Conference of State Legislatures, 2005) should propel Illinois to test new financing methods to extend mental health care to a wider range of children in custody.

Recommendations

This review suggests much that advocates and professionals can do to improve mental health services for children in foster care. Advocates and professionals in Illinois could educate themselves about the various DCFS initiatives to improve mental health services for children in foster care, and do their part to help make these initiatives effective. Programs like CAYIT and resources like the state provider database depend on input from multiple professionals both outside and inside DCFS. Participating, giving feedback, using and promoting these initiatives will do a lot to enhance their quality and provide the leverage to continue funding and developing good children's mental health initiatives.

Because mental health services for children in foster care is a small niche within broader policy concerns—such as the quality of child welfare services in general, the availability of children’s mental services generally, and the viability of the Medicaid system—these advocates could form alliances with advocates for these broader policy concerns to push for change. This benefits both sets of advocates: linking the cause of mental health care for children in foster care with larger advocacy efforts increases the probability that this special population will get what it needs. Also, adding a voice for children in foster care to the efforts to change larger systems adds greater moral weight and poignancy to the case for reform. Child welfare has been an important voice within the larger Illinois Children’s Mental Health Partnership, for example, which has addressed children in foster care in his advocacy efforts, and this voice should become stronger.

Advocates for children in foster care could lobby legislators about the ethics of delaying Medicaid payments and the effects of delay on availability of services, and could further explore with state Medicaid officials creative options to augment resources for mental health care for children in foster care. Advocates in Illinois could also continue to lobby the Department of Healthcare and Family Services to reimburse social workers for mental health services for foster children, now that the law allows it to do so. Advocates could also join with health care financing experts to explore the many options states have pursued for creatively blending different state and federal monies for financing children’s mental health care, with a special focus on children in foster care.

Educational programs that train mental health professionals could play a role as well. They could enhance training on the special circumstances and needs of foster children in their curricula and develop internship and practica sites that serve these children, with the aim of increasing the base of mental health professionals who have the interest and skills to serve them. In

conjunction with increasing opportunities to educate young professionals about these children, they could develop projects to provide at least some free care to children in foster care.

Conclusion

Other states can learn from the Illinois experience. Illinois has faced an array of challenges and developed several initiatives that other states may want to study. The range of organizations involved and contributions coming from them might inspire, warn, and teach parallel organizations in other states. Although it is a state responsibility, the mental health of children in foster care is a universal issue. States can be seen as partners in a national laboratory to find better methods for addressing the mental health needs of one of their most vulnerable groups of young citizens.

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