The Office of Innovation, Alignment, and Accountability

DCYF FAMILY FIRST SERVICES NEEDS ASSESSMENT

Washington State Department of CHILDREN, YOUTH & FAMILIES

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July 2022
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Office of Innovation, Alignment, and Accountability | OIAA@dcyf.wa.gov

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Summary Table of Key Findings and Recommendations

	Key Findings	Recommendations	Key Steps
1	Families with young children in the child welfare system are in the greatest need for prevention services	Connect parents in the child welfare and juvenile justice systems who have young children to prevention services	✓ Institutionalize and scale DCYF's Child Welfare-Early Learning Navigators ✓ Expand FFPSA-approved evidence-based home visiting programs that serve young children ✓ Coordinate linkages to the ESIT services for child welfare-involved families with young children
2	Child welfare-involved families are likely to be economically disconnected	Work closely with child/family serving agencies to address the financial needs of families at the earliest stages of their involvement in the child welfare system	✓ Promote access and continued engagement in social safety net programs ✓ Identify family participation status in social safety programs ✓ Connect families with housing assistance
3	Parents involved in child welfare are more likely than their peers to have significant behavioral health and substance use treatment needs	Coordinate services with Health Care Authority to better identify and address behavioral health and SUD treatment needs of child welfare-involved families	✓ Create behavioral health liaison positions in regional offices ✓ Identify and support potential substance use treatment provider organizations/tribes to expand services for child welfare-involved caregivers ✓ Expand integrated services of parental SUD treatment and infant social-emotional development for child welfare-involved parents and their infants such as Pregnant and Parenting Women (PPW) program and the Family Based Recovery (FBR) Program

Key Findings

Key Finding 1: Families with young children in the child welfare system are in the greatest need for prevention services. The findings of this report show that three-quarters of all children in foster care placement are under age 11, and one-third are infants. While the identification of social-emotional needs of children is often challenging (Baggett et al., 2007), both the Washington State Department of Children, Youth, and Families' (DCYF) assessment data and Health Care Authority's (HCA) data show that the majority of child welfare-involved young children under age 5 are healthy overall; while they are likely to develop significant health or behavioral health challenges as they get older. In particular, youth in foster care are likely to have high mental health and substance use disorder (SUD) needs, and more likely to experience teenage pregnancy than other low-income youth (Aratani et al., 2021). Research shows that the children of adolescent mothers are more likely to have a higher risk of infant mortality, child maltreatment, or poor behavioral health (Svoboda et al., 2012).

Key Finding 2: Child welfare-involved families are likely to be economically disconnected. The findings of this report reveal that a large share of biological parents have no earned income and biological parents of children involved with child welfare have limited engagement in social safety net programs. Further, at least a quarter of biological mothers of child welfare-involved children experience homelessness or housing instability, and/or are involved in the criminal justice system. Thus, parents of child welfare-involved children face tremendous challenges in providing safe and healthy living environments for their children.

Key Finding 3: Parents involved in child welfare are more likely than their peers to have significant behavioral health and substance use treatment needs. The data point to gaps in mental health treatment and particularly severe gaps in SUD treatment of child welfare-involved caregivers. Further, caregivers of color may be less likely to receive behavioral health services due to stigma and limited access (Alegría et al., 2016); therefore, state administrative records may have limitations in reflecting their needs. As a large proportion of parents and caregivers involved with child welfare have behavioral health conditions, and consequently compromised well-being, children's health and mental health often are detrimentally affected (Deave et al., 2008; Parfitt et al., 2013).

Introduction: Understanding the Needs of Children and Families in Child Welfare

The Family First Prevention Services Act (FFPSA) of 2018 provides DCYF an opportunity to better address the needs of families when they come into contact with child protective services (CPS). FFPSA allows states to spend Title IV-E funding on provision of services to prevent children from being placed in out-of-home care. The overall goal of this report is to guide the creation of a DCYF child welfare preventive services array that is systemically responsive to the underlying needs of the clients and families served by child welfare. Aligned with Washington's FFPSA Prevention Services Plan and legislative mandates, DCYF's work toward creation of a preventive services array for child welfare supports both DCYF's work in Performance-Based Contracting (PBC), which requires that supportive services be effective, and the agency's mandate to identify ways to avoid clients' further penetration into the system.

Families who come into contact with CPS are more likely to be composed of Black, Indigenous, and People of Color (BIPOC) living in poverty and experiencing family economic insecurity than the general population (Barth et al., 2006; Bennett et al., 2020; Fong, 2017; Marcenko et al., 2012). A 2008 survey of over 800 Washington parents with recent child welfare involvement by Partners for Our Children (P4C) shed light on the financial hardships that many of Washington's child welfare-involved families face (Marcenko et al., 2009). The survey found that 47% of the parents reported a total household income of less than $10,000 a year, and 69% reported incomes of less than $20,000 in 2007 (when the federal poverty line was just $13,690 for a family of two and $17,170 for a family of three). Two-thirds of the respondents reported being unemployed. Furthermore, 73% of parents in the past 12 months were unable to pay an important bill, buy needed clothing, or pay their rent/mortgage, went to a food pantry, moved in with friends or family, or became homeless. Additionally, about 20% of the families involved in Washington's child welfare system are "economically disconnected," meaning that they were not currently employed but reported not receiving any governmental cash benefits, including Temporary Assistance for Needy Family (TANF), Supplemental Security Income (SSI), General Assistance (GA), and unemployment insurance (UI), and not having partners to support them (Marcenko et al., 2012).

Strongly associated with such financial hardships, when a child's basic needs are not met to the extent that it influences child development and well-being, neglect may come to the attention of teachers, police officers, health care professionals, and others who, by state law, are mandated to report to the state child protection workers (Bennett et al., 2020). The majority of CPS cases are indeed categorized as *neglect* rather than abuse in Washington State and beyond. Previous research has shown a close association between poverty and child maltreatment (Conrad-Hiebner & Byram, 2020; Paxson & Waldfogel, 2002), and there are two main models used to explain the association (Conrad-Hiebner & Byram, 2020). The first model is the *family stress model*, which argues that economic stress leads to parental depression and emotional distress, which adversely affect parents' child-rearing behaviors (Conger et al., 1992). The second model is the *ecological model*, according to which predisposing risk factors interact with contextual factors to increase the probability of child maltreatment (Belsky, 1993; Conrad-Hiebner & Byram, 2020). Despite the higher risk of maltreatment attributed to poverty, not all children living in poverty are victims of child maltreatment nor do they become involved with child welfare. As the ecological model suggests, increased child maltreatment among the poor may result from other risk factors *associated* with poverty, including domestic violence, substance use, parental mental illness, disability, and criminal justice involvement (Bennett et al., 2020; Fong, 2017). Using these frameworks, this report highlights key characteristics and current needs of families involved in DCYF's child welfare system, based upon recent state administrative records (SFY 2016-2019) and DCYF data on the needs of children, youth, and families in the child welfare system.

Washington's FFPSA candidacy groups include children, youth, and families in the following services:

- CPS family assessment response (FAR)
- CPS investigation
- CPS family voluntary services
- Trial return home
- Adoption displacement
- Family reconciliation services
- Pregnant women with an indication of substance use disorders
- Pregnant or parenting youth in foster care
- Pregnant or parenting youth in state Juvenile Rehabilitation (JR)
- Youth who are discharged from JR

As such, this report focuses both on overall needs of children, youth, and families with any DCYF child welfare involvement and those in the specific FFPSA candidacy groups.

The report comprises three sections, successively addressing the following questions related to the child welfare client population in Washington State:

1. What are the key characteristics and needs of children and youth involved in child welfare?
2. What are the socio-economic needs of families involved in child welfare?
3. What are the health and behavioral needs of child welfare-involved parents and caregivers?

This report in part is based upon analyses of child welfare, early learning, and JR data by DCYF's Office of Innovation, Alignment and Accountability (OIAA), as well as results of analyses of Integrated Client Database (ICDB) data presented in reports of the Department of Social and Health Services (DSHS)/Research and Data Analysis (RDA) division. Following this report's findings, we offer policy recommendations and next steps for research and evaluation to inform the implementation of Washington's FFPSA.

Population Definitions

Any child welfare involvement: Children, their biological parents, and/or caregivers who have any interaction with the child welfare system, including intakes, case management, and services.

Out-of-home/foster care placement: Children in out-of-home foster care, their biological parents, and/or caregivers regardless of duration of the stay.

Low-income: Children with at least one month of Medicaid or State Children's Health Insurance Program eligibility (and their biological parents).

Table of Figures

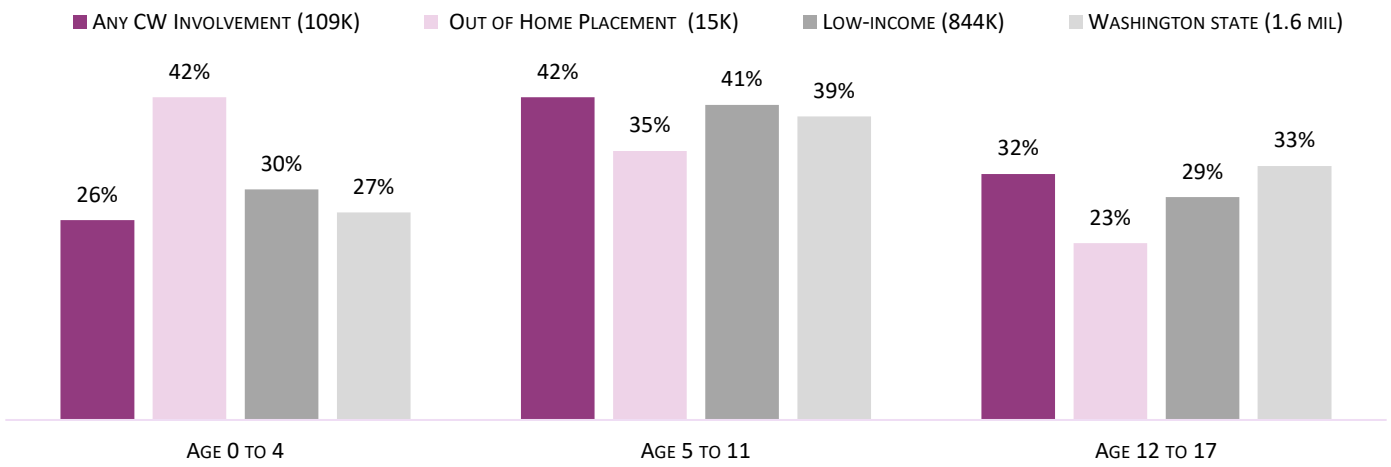
1: What are the Key Characteristics and Needs of Children and Youth Involved in Child Welfare?

In this section we highlight key socio-demographic characteristics and health and behavioral health needs of child welfare-involved children and youth. The figures and findings are based on DSHS/RDA's analysis of children and youth who were involved in any DCYF child welfare program, out-of-home foster care placement, and publicly funded health insurance programs (defined as low-income) in SFY 2016, using the Integrated Client Database (RDA, 2019) as well as OIAA's analysis of DCYF program data from child welfare, early learning, and JR.

Child Age

Younger children are overrepresented in DCYF child welfare programs, in particular out-of-home foster care placement. In 2016, children under the age of 5 comprised 27% of Washington State's young population (i.e., those less than 18 years old) and 30% of low-income families; however, they constituted 42% of the children in foster care out-of-home placement (Figure 1). Moreover, the association of young age with being placed into foster care is most evident for infants; according to an analysis of 2020 FamLink data (Ybarra, 2020), 30% of all children in out-of-home foster care placement were infants (under the age of 1) while only 10% of Washington State's population under age 18 were under the age of 1. In fact, Washington is among the four highest states in the nation in terms of the portion of children in out-of-home care who are infants (Children's Bureau, 2022).

FIGURE 1: AGE OF CHILD WELFARE-INVOLVED CHILDREN, SFY 2016

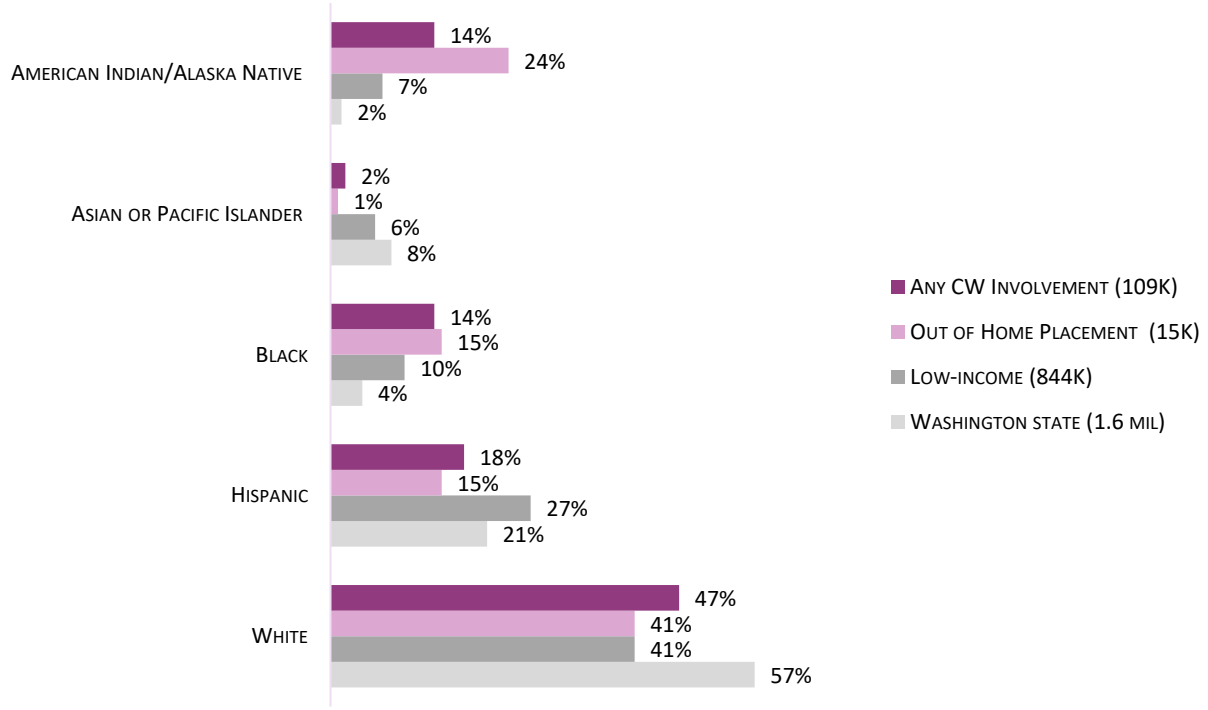


Data sources: RDA, 2019; OFM, 2021

Race/ethnicity

American Indian/Alaska Native (AI/AN) and Black children were disproportionally represented in the child welfare system in SFY 2016, as each of the two groups' share among children with any child welfare involvement was 14%, though they represented only 2% and 4%, respectively, of the child population in Washington State (Figure 2). Moreover, those two groups also are overrepresented among children in out-of-home placement (24% AI/AN; 15% Black). Hispanic children are overrepresented in low-income families (27% vs. 21% state) while underrepresented in the child welfare population.[1]

FIGURE 2: RACE/ETHNICITY OF CHILD WELFARE-INVOLVED CHILDREN, SFY 2016



Data Sources: RDA, 2019; OFM, 2021

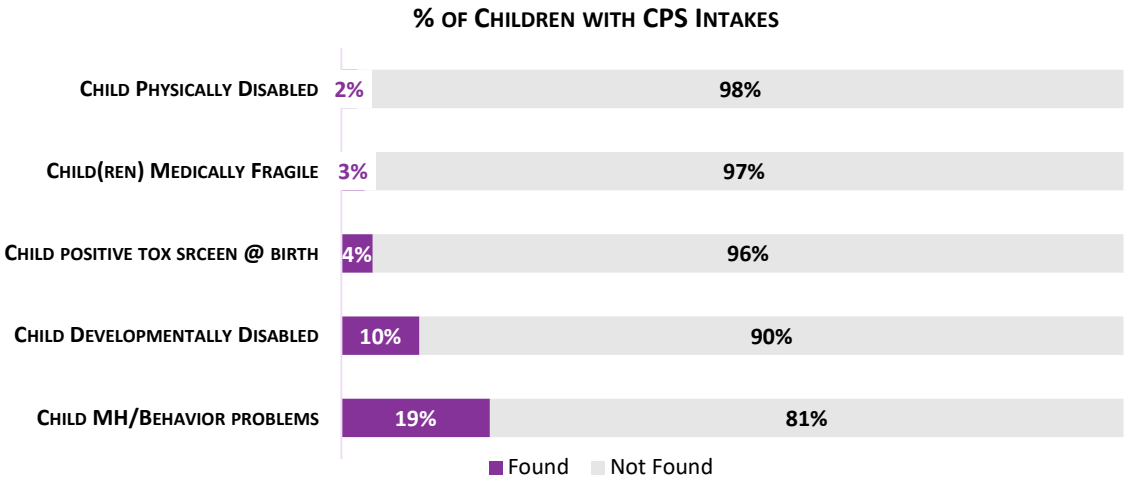
Children's Physical Health

Based on the Structured Decision-Making® (SDM) assessment, which is conducted at household level, a small percentage of households of CPS investigation and CPS-FAR intakes had child/ren with physical health conditions that needed assistance such as disability (2%), medically fragile (3%), and/or positive toxicology screen (4%) (Figure 3). Additionally, 10% of children were identified as being developmentally disabled, which is similar to estimates based on medical diagnoses received among the broader population of Washington's children, according to RDA's analysis of HCA's P1 data.[2] About 20% of the households had children identified as having mental health or behavioral health conditions.

[1] "Other" and unknown race are not included in the graph; therefore, it will not add up to 100%. The way race/ethnicity is measured is not across data sources; therefore, the direct comparison may be limited.

[2] Specific developmental disorder or intellectual disability of children with any child welfare involvement is 11%.

FIGURE 3: HEALTH STATUS OF CHILDREN WHO WERE SCREENED FOR REFERRALS TO CHILD WELFARE, CY 2016

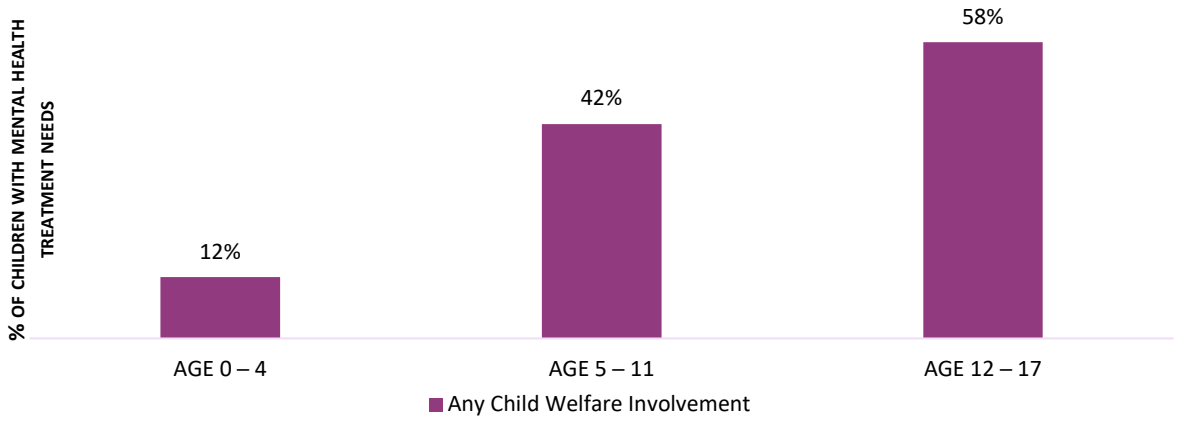


Data Source: OIAA, 2021a

Children's Mental Health Treatment Needs by Age

Children with child welfare involvement have twice the rate of having identified mental health treatment needs than low-income children (39% vs. 20%) based on RDA's analysis of HCA's P1 data (Aratani et al., 2021). The share of children with mental health needs varies considerably by age group.[3] Among the youngest children (under age of 4), only 12% of those with any child welfare involvement were identified as having mental health needs (as indicated by a mental health diagnosis, mental health-related prescription, and service utilization), but school-age children, adolescents, and young adults with child welfare involvement have much higher rates of mental health treatment needs, with 42% of children aged 5-11 and 58% of youth aged 12-17 being identified with such a need (Figure 4).

FIGURE 4: MENTAL HEALTH TREATMENT NEEDS AMONG CHILDREN WITH ANY CHILD WELFARE INVOLVEMENT BY AGE, SFY 2018



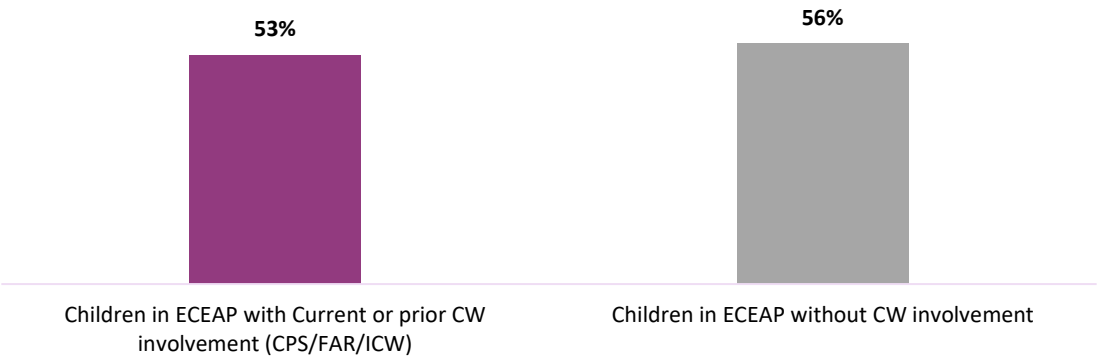
Data Source: Aratani, Pavelle, Lucenko, and Felver, 2021

[3] The analysis is limited to children/youth with publicly funded medical insurance.

Social-Emotional Development of Children in Child Welfare and Early Learning Program

Among children in Early Childhood Education and Assistance Program (ECEAP) (N=10,338, Fall 2018-Spring 2019), one-tenth self-reported current or prior child welfare involvement that included CPS, FAR, and/or Indian Child Welfare (ICW). **ECEAP data reveal that more than half (53%) of children with any child welfare involvement who were in ECEAP met or exceeded widely held expectations (WHE) in social-emotional functioning at fall baseline, which is comparable to children in ECEAP without child welfare involvement (56%; Figure 5).**[4]

FIGURE 5: SOCIAL-EMOTIONAL FUNCTIONING OF CHILDREN IN ECEAP AND CHILD WELFARE, FALL 2018



Data Source: OIAA, 2021b

Teenage Pregnancy Among Youth/Young Adults in Foster Care and Juvenile Rehabilitation

Expectant youth in foster care or JR are in the FFPSA candidacy groups, and 50 per 1,000 females in foster care aged 10-19 were pregnant or had a newborn in SFY 2018.[5] The teen pregnancy rates among youth in foster care were higher than that of their low-income counterparts (34 per 1,000 among females aged 10-19) and the rates were particularly higher among those with SUD treatment need (Aratani et al., 2021). Additionally, 70 youth, or 8% of all male and female youth in JR, were pregnant or parenting in SFY 2019 (DCYF, 2020). While we do not have data on behavioral health needs of expectant youth in foster care and JR, it is known that youth and young adults aged 12-21 in foster care and JR have overall particularly high behavioral health treatment needs (Aratani et al., 2021).

FIGURE 6*: TEEN PREGNANCY RATES AMONG YOUTH AGE 10-19 IN FOSTER CARE PLACEMENT, SFY 2018*

Data Source: Aratani, et al., 2021

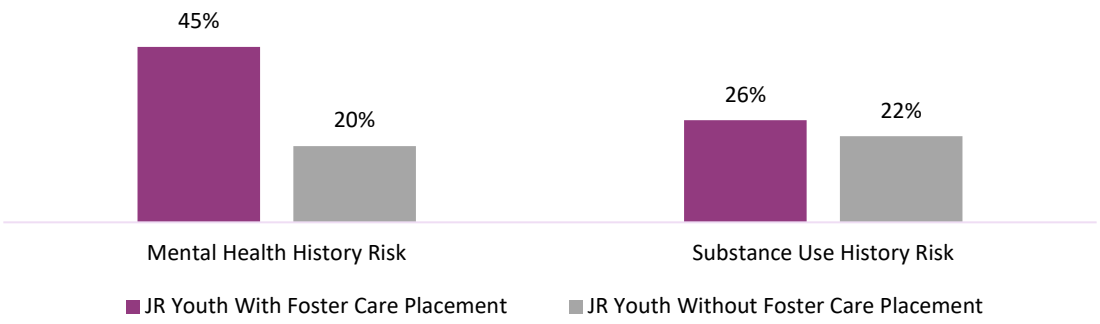
[4] This self-report may be underreported as RDA's study (Patton, Qinghua and Felver, 2018) found that a quarter of DCYF early learning program clients were involved in child welfare over 4 year period.

[5] The analysis is limited to youth with publicly funded medical insurance.

Behavioral Health Needs of Child Welfare-Involved Youth in Juvenile Rehabilitation

Youth exiting DCYF's JR facilities are another FFPSA candidacy group, and about a quarter of youth who are admitted to JR also had a prior foster care placement (OIAA, 2020). Based on OIAA's analysis of integrated treatment assessment (ITA) data for all youth admitted to JR from 2016 through 2018 (n= 1,552),[6] JR youth with prior foster care placement had significantly higher historical mental health risk[7] compared to their JR counterparts without prior foster care placement (Figure 7). More specifically, 45% of youth in JR who had a prior foster care placement were assessed as high mental health risk, compared to 20% of youth who did not have a prior foster care placement. Additionally, JR youth with a prior foster care placement had higher historical substance use risk[8] than those youth who did not experience a foster care placement; however, neither of these differences were statistically significant. On the other hand, ITA data seem to underestimate the prevalence of behavioral health treatment needs among youth in JR, compared with HCA's P1 data (which revealed 67% of youth in JR having mental health treatment needs and 53% having SUD treatment needs (Aratani et al., 2021).

FIGURE 7: BEHAVIORAL HEALTH RISK FACTORS AMONG YOUTH IN JR BY PRIOR FOSTER CARE PLACEMENT, SFY 2016-2018



Data Source: OIAA, 2021c

2: What Are the Socio-economic Needs of Families Involved in Child Welfare?

In this section, we illuminate socio-economic needs of children with any child welfare involvement, and their biological parents and/or caregivers, prior to and during the involvement in the child welfare system in SFY 2015-2016. We drew data from RDA's Integrated Client Database that included HCA's Medicaid data, DSHS Economic Services Administration (ESA) data, and Washington State Patrol's data.

Parent's Employment Status

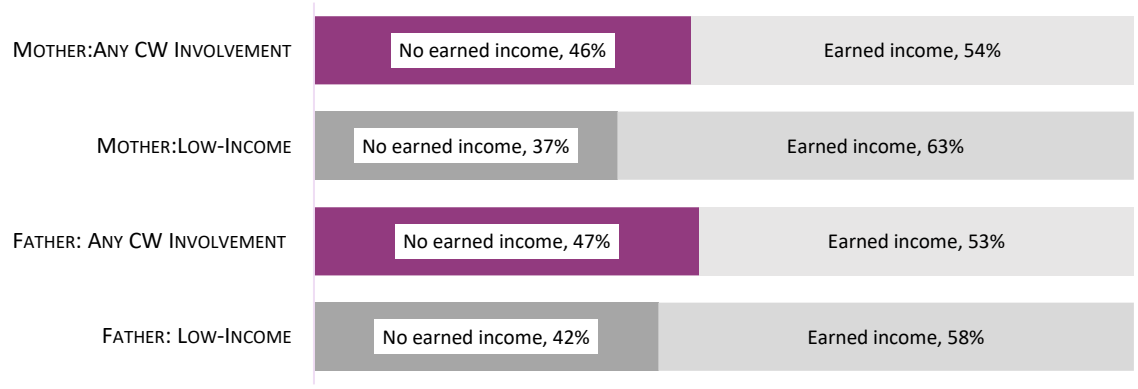
Close to half of the biological parents of children involved in child welfare in SFY 2016 had no earned income (46% of mothers and 47% of fathers), which is 5-9% higher than low-income parents (mother 37%; father 42%) (Figure 8). The relatively high percentages of the child welfare-involved parents having no earned income powerfully illuminates the extent of their economic hardships.

[6] The analysis aimed determine if there were difference between those youth with prior child welfare out-of-home placement and those who did not using a chi-square test. The two domains examined, mental health and substance use, are composite measures, constructed using items from the Integrated Treatment Assessment. Percentages in Figure 7 are the percent of youth indicated as high risk in that domain. Protective factors are measured separately but are presented in Appendix D.

[7] Historical mental health risks were created from composite scores based on youth's history of suicidal behavior, self-harm behavior, child maltreatment, having attention-deficit/hyperactivity disorders, other mental health problems, and/or health insurance.

[8] Historical drug/alcohol risks were measured by youth's history of alcohol and/or drug use and referrals for alcohol/drug assessment, attending alcohol/drug education classes, treatment program or whether they used alcohol or drugs during the previous 4 weeks at the time of assessment.

FIGURE 8: EMPLOYMENT STATUS OF BIOLOGICAL PARENTS OF CHILDREN WITH ANY CHILD WELFARE INVOLVEMENT, SFY 2015/2016

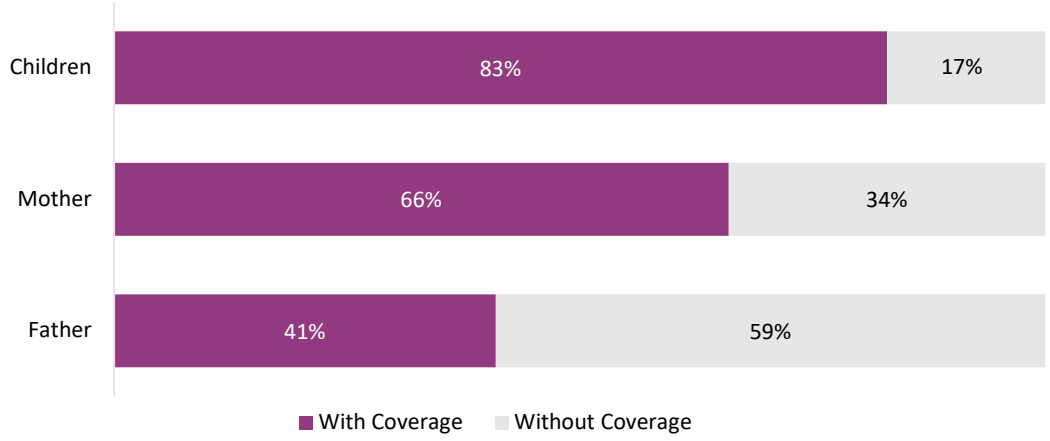


Data Source: RDA, 2019

Publicly Funded Health Insurance Coverage

The great majority (83%) of *children* involved in child welfare had publicly funded health insurance such as Medicaid and SCHIP (State Child Health Insurance Program); however, only **66% of biological mothers and 41% of biological fathers were covered by publicly funded health insurance such as Medicaid in SFY 2016 (Figure 9).** Compared to other parents, the majority of parents who were involved in the child welfare system were un- or under-employed (Figure 8), and as employment is associated with access to private health insurance, these parents likely depend on publicly funded health care coverage; without publicly funded health care coverage they are likely to be uninsured. However, HCA's provider-one (P1) data lack information regarding those with *private* insurance; hence, it is difficult to know the exact percentage of parents/caregivers without health insurance of any type.

FIGURE 9: PUBLICLY FUNDED MEDICAL INSURANCE COVERAGE AMONG FAMILIES WITH ANY CHILD WELFARE INVOLVEMENT, SFY 2015/2016



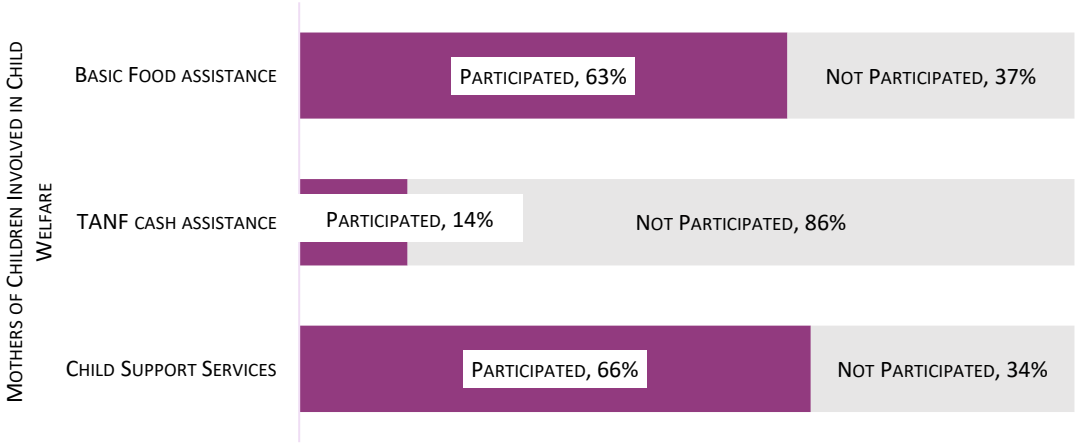
Data Source: RDA, 2019

Social Safety-Net Program Participation

Almost two-thirds of biological mothers of child welfare-involved children participated in Basic Food assistance (63%) or child support program (66%). On the other hand, despite a higher share of mothers with no earned income, only

14% of mothers participated in TANF cash assistance program (Figure 10). Research shows that increased cash benefits and better access are associated with reduction in physical abuse, and generous TANF benefits and a reduced time limit can prevent child maltreatment (Spencer et al., 2021).

FIGURE 10: SOCIAL SAFETY-NET PROGRAM PARTICIPATION AMONG BIOLOGICAL MOTHERS OF CHILDREN WITH ANY CHILD WELFARE INVOLVEMENT, SFY 2015/2016



Data Source: RDA, 2019

Housing Status

A quarter (25%) of biological mothers of children involved in the child welfare system were identified as homeless or unstably housed (Figure 11).[9] Among child welfare-involved families, homelessness/housing instability is much higher (25% mothers, 19% fathers) than their low-income counterparts (11% mothers, 9% fathers). However, the rate of homelessness/housing instability is more likely to be underestimated for the former, since the data were only available for child welfare-involved families at the time of application if they applied for public benefits in Washington State.

FIGURE 11: HOUSING STATUS OF BIOLOGICAL PARENTS OF CHILDREN WITH ANY WELFARE INVOLVEMENT, SFY 2015/2016

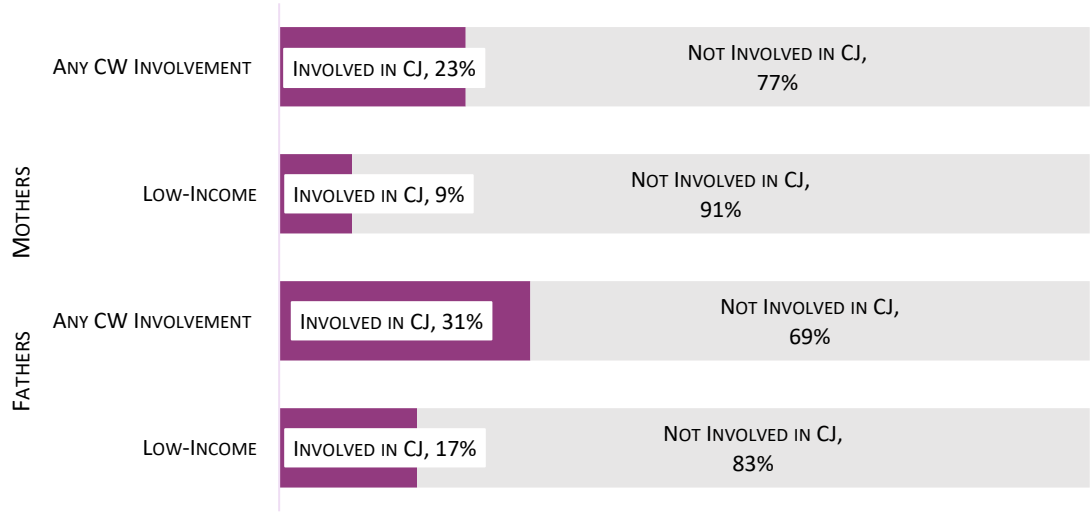
Data Source: RDA, 2019

[9] Homelessness and/or unstable living situations are identified by ESA to determine eligibility for public benefits; therefore, the housing status of those who did not apply for public benefits are unknown.

Parent's Recent Criminal Justice Involvement

Less than one-third of biological parents of children with child welfare involvement had criminal justice (CJ) involvement (23% among biological mothers, 31% among biological fathers) in SFY 2015 or 2016 (Figure 12). However, these were more than two times higher rates of CJ involvement compared with parents of low-income children (9% of mothers; 17% of fathers). Research shows that children of parents with CJ and child welfare involvement are at higher risk of living in extreme poverty, being exposed to parental SUD, and exposed to domestic violence than are children of CJ-involved parents without child welfare involvement (Phillips & Dettlaff, 2009).

FIGURE 12: CRIMINAL JUSTICE INVOLVEMENT AMONG BIOLOGICAL PARENTS OF CHILDREN WITH ANY WELFARE INVOLVEMENT, SFY 2015/2016



Data Source: RDA, 2019

3: What Are the Health and Behavioral Needs of Child Welfare-Involved Parents and Caregivers?

In this section, we show overall physical health and behavioral health service needs of biological parents and/or caregivers involved in child welfare, prior to and during the involvement in the child welfare system in SFY 2015/2016. We drew findings from RDA's analysis of HCA's P1 data and OIAA's analysis of DCYF assessment data.

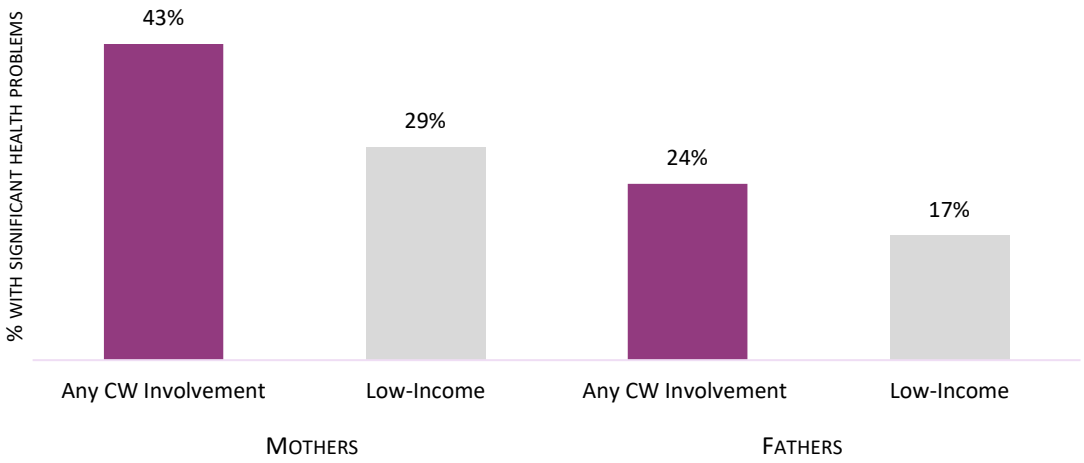
Parent Health Status

Over 40% of biological mothers with children involved in the child welfare system had significant health problems, which is a rate much higher than that of their low-income counterparts (43% vs. 29%; Figure 13).[10] Significant health problems are defined as having an identified diagnosis and prescriptions which involve costly medical expenses.[11] About a quarter of biological fathers of child welfare-involved children also had identified significant health problems. The corresponding rates for low income fathers were less (17%), but far from negligible.

[10] The analysis is limited to parents with publicly funded medical insurance.

[11] This is calculated based on the Combined Diagnostic and Pharmacy Based Risk Adjustment Model by US San Diego.

FIGURE 13: SIGNIFICANT HEALTH PROBLEMS IDENTIFIED AMONG BIOLOGICAL PARENTS OF CHILDREN WITH ANY CHILD WELFARE INVOLVEMENT, SFY 2015/2016

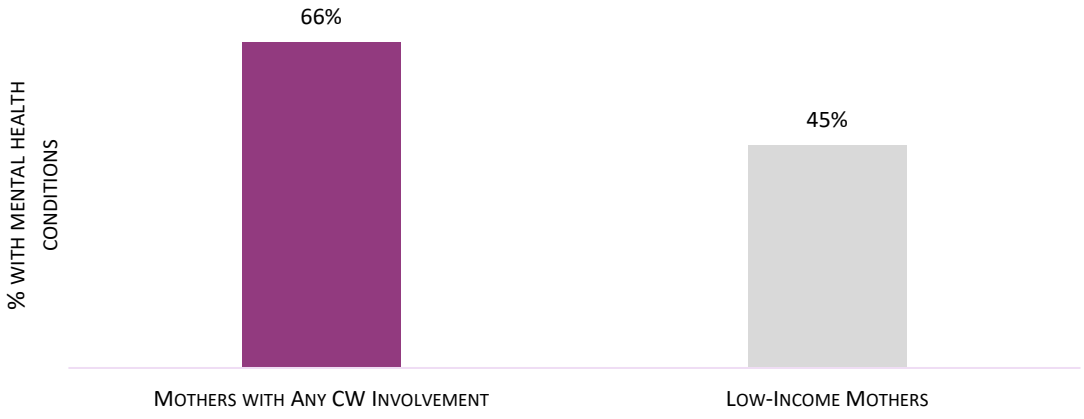


Data Source: RDA, 2019

Mother's Mental Health Conditions

Almost two-thirds of child welfare-involved mothers had mental health conditions identified that require treatment in SFY 2015/2016.[12] Based on HCA's P1 data, among biological mothers of children involved in child welfare, 66% had mental health treatment conditions identified (defined as having a mental health diagnosis in the year of child welfare involvement or the prior year). Based on analysis of the SDM, most of these needs were *not* identified by caseworkers (the data are shown in Appendix A), indicating that research is needed to learn how caseworkers can best identify the mental health treatment need among parents/caregivers of children involved in child welfare. Mental health treatment needs among uninsured mothers are unknown based on HCA's P1 data, yet the needs of uninsured mothers likely are even more pressing given that they are known to have many mental health needs that are unmet due to the high cost of care (Mcmorrow et al., 2020).

FIGURE 14: MENTAL HEALTH CONDITIONS OF BIOLOGICAL MOTHERS OF CHILDREN WITH ANY CHILD WELFARE INVOLVEMENT, SFY 2015/2016



Data Source: RDA, 2019

[12] The analysis is limited to mothers with publicly funded health insurance.

Mother's Substance Use Disorders

Among child welfare-involved mothers, 40% had SUD diagnoses recorded in HCA's P1 data, while only 16% of low-income mothers had SUD diagnoses (Figure 15), over twice as high a rate.[13] As with mental health treatment needs, most parental SUD needs are *not* identified by caseworkers (this conclusion is based on analysis of the SDM; shown in Appendix B). This finding indicates that research is needed to determine how caseworkers can best identify the SUDs and correspondingly appropriate treatments for parents/caregivers of children involved with child welfare.

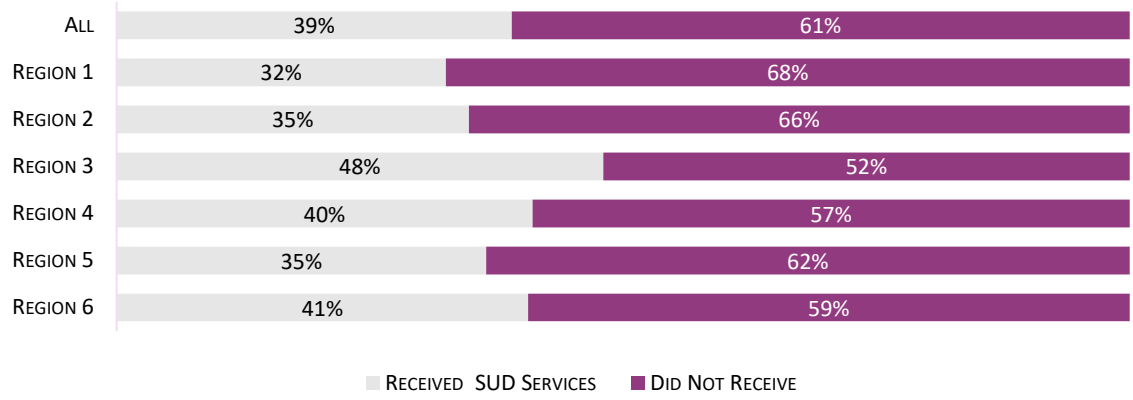
FIGURE 15: SUBSTANCE USE DISORDERS AMONG BIOLOGICAL MOTHERS OF CHILDREN WITH ANY CHILD WELFARE INVOLVEMENT, SFY 2015/2016

Data Source: RDA, 2019

Substance Use Treatment Rate Among Child Welfare-Involved Caregivers

Among caregivers with SUD treatment needs,[14] **only 39% of caregivers with any child welfare involvement and barely half (49%) of caregivers whose children were in out-of-home placement received publicly funded SUD treatment.** According to a recent RDA study (2020), in all regions of the state, the majority of child welfare-involved caregivers with an indication of a SUD did not receive publicly funded SUD treatment in the 12 months following the CPS intake or child removal. Additionally, there was regional variation in the rate of SUD treatment. Less than one-third of caregivers with an indication of a SUD received SUD treatment in Region 1 (32%), while close to half of caregivers with SUD received treatment in Region 3.

FIGURE 16: SUBSTANCE USE TREATMENT PENETRATION AMONG CAREGIVERS IN CHILD WELFARE SYSTEM, SFY 2015-2018



Data Source: Patton, Kersten, Liu et al, 2022

[13] The analysis is limited to mothers with publicly funded health insurance.

[14] The analysis is limited to mothers/caregivers with publicly funded health insurance.

Recommendations

The following recommendations are developed based on each of the key findings.

Recommendation 1: Connect parents in the child welfare and juvenile justice systems who have young children to prevention services. The majority of infants and young children of parents/caregivers involved in child welfare or in juvenile justice system will benefit from FFPSA preventive services as well as DCYF's Early Learning programs, which can help identify and address social-emotional needs of young children and promote healthy child development. DCYF's ECEAP data reveal that over 50% of child welfare-involved children in ECEAP met or exceeded widely held expectations in social-emotional functioning, comparable to children without child welfare involvement. Thus, existing DCYF programs and service expansions can be leveraged.

- **Institutionalize and scale DCYF's Child Welfare-Early Learning Navigators**. Currently under a grant-funded pilot, DCYF Child Welfare-Early Learning Navigators collaborate with the CPS caseworkers to help families with young children connect to high-quality early learning and family support programs across three DCYF regions (including South King, Grays Harbor, Mason, Pacific and Yakima Counties).
- **Expand FFPSA-approved evidence-based home visiting programs that serve young children.** These include Incredible Years, Parents as Teachers, Nurse Family Partnership, Family Spirit, and other culturally inclusive home visiting programs. These programs are designed to better identify and address the needs of young children and support their safety and healthy development, which can help link families to the needed services and ultimately to prevent children from being placed in out-of-home foster care.
- **Coordinate linkages to the Early Support for Infants and Toddlers (ESIT) services for child welfare-involved families with young children.** ESIT is an early intervention service designed to address developmental disabilities during the birth-to-three period, and is already a resource for child welfare-involved families.

Recommendation 2: Work closely with Washington State's child/family serving agencies to address the financial needs of families at the earliest stages of their involvement in the child welfare system. A wealth of research has demonstrated that social safety net programs such as TANF, SNAP Basic Food program, child care subsidies, the earned income tax credit (EITC), and housing assistance provide critical support for low-income families and contribute to reducing parental distress and preventing child maltreatment (Berger et al., 2017; Latzman et al., 2019; Maguire-Jack et al., 2021)**.**

- **Promote access and continued engagement in social safety net programs.** The continuing collaboration with DSHS is critical to address the financial hardships of families involved in the child welfare system. DCYF can work closely with DSHS to support and help families access and stay in social safety net programs, as research based on Washington's integrated database suggests that child welfare-involved households who lose TANF benefits are less likely to be reunified (Kang et al., 2016).
- **Identify family participation status in social safety programs.** Through accessing the Economic Services Administration (ESA)'s Automated Client Eligibility System (ACES), caseworkers could identify the family participation status in social safety programs (including TANF, state and federal cash programs, the Federal SNAP Basic Food Program, state funded food programs, Medicaid, and state medical programs) of families who come into contact with CPS. When the families meet eligibility criteria yet are not participating in a program, caseworkers could connect them to ESA. Research has shown that even a $100 increase in TANF benefits can contribute to the prevention of child maltreatment among low-income families (Spencer et al., 2021). By understanding the degree of a family's social safety net engagement, DCYF can plan and manage the provision of concrete services to optimize the benefit of existing social safety net programs, thereby enhancing economic supports for child welfare-involved families.
- **Connect families with housing assistance.** Connecting families to housing assistance is critical for the prevention of child maltreatment (Aratani et al., 2017). DCYF currently is collaborating with local housing authorities as a part of **the Family Unification Program (FUP),** funded by the U.S. Department of Housing and Urban Development, to provide housing assistance to families who are at imminent risk of out-of-home placement(s)

or delay in the discharge of the child/ren from out-of-home care due to housing instability. While the impact of FUP are currently being evaluated and yet to be known, FUP is offered in selected regions, and DCYF can expand collaboration with the Department of Commerce and local housing authorities across the state to widely provide housing assistance to child welfare-involved families.

Recommendation 3: Coordinate services with HCA to better identify and address behavioral health and SUD treatment needs of child welfare-involved families. As FFPSA aims to promote preventive services for both children and family members, it is important to further strengthen behavioral health supports for parents/caregivers as soon as they first come into contact with CPS. Children are more likely to thrive and remain healthy and safe in their home environments when the behavioral health treatment needs of parents are fully met, or at least effectively addressed. While HCA funds an array of behavioral health services, there is currently a large treatment gap between substance use treatment that child welfare-involved caregivers need and what is available in local communities. Additionally, DCYF caseworkers currently have limited capacity and resources for connecting families to HCA funded services. This is an area of potential improvement.

- **Create behavioral health liaison positions in regional offices.** A behavioral health liaison, staffed by a person knowledgeable about available behavioral health services can work closely with caseworkers in providing child welfare-involved families with a "warm handoff" to behavioral health treatment providers.
- **Identify and support potential substance use treatment provider organizations/tribes to expand services for child welfare-involved caregivers.** Given the large and long-standing gap between substance use treatment needs for child welfare-involved caregivers and the supply of needed treatment, more treatment capacity is needed for DCYF clients. While most clients are Medicaid eligible and will qualify for Medicaid funded treatment once it is available, clearly more investments are needed in building the treatment capacity necessary to serve them.
- **Expand integrated services of parental SUD treatment and infant social-emotional development for child welfare-involved parents and their infants.** This allows parents to receive substance use treatment services while children can safely stay with their parents while receiving preventive support for promoting healthy social-emotional development.
    - **Consider the expansion of Pregnant and Parenting Women (PPW) program.** It provides outpatient treatment services and residential treatment services, as well as housing support services, for women and their children under age 6, for up to six months.
    - **Consider in-home SUD/infant mental health services such as the Family Based Recovery (FBR) Program.** FBR provides in-home SUD treatment by integrating SUD treatment for parents and an infant mental health intervention, with the goals of preventing child maltreatment and family disruption (Hanson et al., 2015, 2019).

Limitations and Future Directions for Assessing FFPSA Service Needs

There are a few limitations to this report to note. First, as this service needs assessment report compiles results from multiple data sources, different time periods, and different populations, the findings are not all directly comparable.

Second, behavioral health treatment needs of children with any child welfare involvement and their parents need further investigation, because the findings based upon RDA's analysis of integrated administrative data (ICDB) and upon OIAA's analysis of DCYF assessments varied considerably. The results based upon the ICDB are limited in that its data include only clients who had access to publicly funded health insurances (such as Medicaid or SCHIP) *and* have accessed services. The health insurance status of parents/caregivers understandably will affect their likelihood of receiving adequate health and mental health care, and if clients did not utilize publicly funded services, their needs for these types of services were not identified in the ICDB. However, that does not mean that those clients did not have behavioral health conditions that required care. On the other hand, DCYF's SDM, Child and Adolescent Needs and Strengths (CANS),

and Integrated Treatment Assessment (ITA) tools may be underestimating the behavioral health needs of parents/caregivers and youth.

Third, children and youth in the category *with any child welfare involvement* comprise diverse groups (and their parents/caregivers) who were involved in child welfare at different stages, including CPS intakes, out-of-home placement, adoption, and other child welfare services and with varying types of needs. In order to better inform Washington's FFPSA implementation, further investigation is needed to understand the distinctive characteristics and needs of each of the FFPSA candidacy groups.

Finally, we have particularly limited information regarding the housing status of child welfare-involved families, their health insurance, and the physical/behavioral health status of parents/caregivers who did not have Medicaid coverage, as well as important contextual factors such as regional differences and service availability. These data are to be examined in future Family First service needs assessment reports.

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The Office of the Innovation, Alignment and Accountability (OIAA). 2021a. Analysis of Structural Decision Making (SDM) Assessment Data: Client Characteristics and Needs by Out of Home Placement Status, CY 2016 (Appendix A)

The Office of the Innovation, Alignment and Accountability (OIAA). 2021b. Analysis of ECEAP Data Based on Parent Report of CW Involvement (Appendix B).

The Office of the Innovation, Alignment and Accountability (OIAA). 2021c. Analysis of Integrated Treatment Assessment (ITA) Data: The Risk and Needs for Youth in JR by Prior Foster Care Placement Status, CY 2016-2018. (Appendix C).

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Appendices

Appendix A: Client Characteristics and Needs by Foster Care Placement Status, CY 2016

Table A1: Child and parent characteristics by foster care placement status

	All Households with SDM Assessment, CY 2016	Household with No Foster Care Placement within 180 Days, CY 2016	Household with Foster Care Placement within 180 Days, CY 2016
Population Size	20,458	18,668	1,790
Child Characteristics			
Child MH/behavior problems	19%	20%	18%
Child developmentally disabled	10%	10%	10%
Child positive tox screen @ Birth	4%	3%	15%
Child delinquency history	3%	3%	5%
Child(ren) medically fragile	3%	2%	6%
Child physically disabled	2%	2%	2%
Child MH/Behavior problems	19%	20%	18%
Household Characteristics			
Youngest child under 2	30%	29%	47%
Four plus children in the home	12%	12%	13%
Housing instability (homelessness)	5%	4%	17%
Housing is unsafe	1%	1%	6%
Primary conviction prior to past year	14%	13%	25%
Primary conviction past year	2%	2%	8%
Two or more domestic violence in the past year	7%	6%	18%
Parent-child relationships			
Primary lack parent involvement	5%	4%	18%
Primary harmful relationship (none scoring item)	10%	8%	31%
Primary caregiver justifies maltreatment	4%	3%	15%
Primary caregiver blames child	3%	3%	9%
Primary lacks parenting skills (none scoring item)	22%	18%	54%
Primary caregiver is domineering	2%	1%	4%
Primary caregiver rejects child	1%	1%	5%
Primary caregiver apathetic (none scoring item)	4%	3%	11%
Primary caregiver excessive discipline	3%	2%	8%
Parent behavioral health needs			
Mental health problems	22%	21%	37%
Substance abuse problem: Drug	12%	9%	40%
Substance abuse problem: Alcohol	5%	4%	14%

Source: OIAA Analysis of DCYF SDM Assessment Data

Technical Note: The SDM analysis includes about 20,500 who had a screened in referral to child welfare in 2016 and who had an SDM completed within 100 days of this screened in referral. The SDM results are shown for the whole group as well as separately for those families with a placement episode within 180 days of the reference referral.

Appendix B: Parent Reported Risk Factors and Child Outcomes among ECEAP Clients by Child Welfare Involvement Status, CY 2018-2019

Table B1: Parent reported risk factors and child teaching strategies GOLD outcomes, comparing those with current/prior CPS/FAR/ICW involvement and those without (ECEAP CY 2018-19)

	Children with Current/Prior CPS/FAR/ICW, CY 2018-2019	Children without Current/Prior CPS/FAR/ICW, CY 2018-2019	Significance
Population Size	**1,766**	**13,750**	
Child Characteristics			
Child has IEP	14.1%	12.1%	0.016
Child has been expelled	2.9%	0.7%	0.000
Child low birthweight	9.7%	6.3%	0.000
Household/Parent Characteristics			
Percent Federal Poverty Line (avg)	60.0%	83.0%	0.000
Family on TANF	11.8%	4.5%	0.000
Current or prior homelessness	25.1%	12.0%	0.000
Teen parent	4.3%	2.5%	0.000
Parent with no diploma	20.9%	25.0%	0.000
Parent deployed	1.4%	1.1%	0.391
Parent incarcerated	18.8%	3.4%	0.000
Parent is migrant worker	3.3%	8.9%	0.000
Parent speaks English	94.1%	64.7%	0.000
Isolated	12.0%	13.4%	0.108
Domestic violence in home	46.4%	8.9%	0.000
Parent health/behavioral health needs			
Disabled parent	17.9%	6.2%	0.000
Parent mental illness	63.4%	12.7%	0.000
Parent substance abuse	45.4%	5.8%	0.000
Teaching Strategies GOLD outcomes			
Fall percent meet or exceed WHE in SE domain	53.4%	56.0%	0.094

Indicates families with CW involvement have significantly higher risk than those who did not.

Source: OIAA's Analysis of ECEAP Child-level Data

Technical Note: Child-level ECEAP data provides (1) parent-reported CPS/FAR/ICW involvement collected at ECEAP enrollment, (2) a range of child-level risk factor, demographic, and outcome information, and (3) an assessment of family need and economic stability collected through the Mobility Mentoring program. According to parent report, 11.4% of 2018-19 ECEAP enrolled children experienced current or prior CPS/FAR/ICW involvement. The results of t-tests showed that CW involved children experience significantly higher risk across a number of child and family-level factors, while there is little to no relationship between CW involvement and child outcomes (at p values < .05).

Appendix C: The Risk and Needs for Youth in Juvenile Rehabilitation by Prior Foster Care Placement, CY 2016-2018

Table C1: Risk factors and protective factors among youth in JR by prior foster care placement status

	Youth in JR with Prior Foster Care Placement, CY 2016-2018	Youth in JR without Prior Foster Care Placement, CY 2016-2018	Significance
Population Size	364	1,188	
Risk Factors			
School History Risk	37.4%	29.8%	0.000
School Current Risk	15.4%	10.9%	0.001
Free Time History Risk	8.5%	11.9%	0.075
Free Time Current Risk	1.4%	2.4%	0.000
Employment History Risk	6.0%	7.0%	0.531
Employment Current Risk	12.4%	9.3%	0.004
Relationship History Risk	17.6%	21.6%	0.095
Relationship Current Risk	5.8%	5.0%	0.584
Family History Risk	58.0%	20.1%	0.000
Living Arrangement Current Risk	22.5%	6.9%	0.000
Mental Health History Risk	44.8%	19.5%	0.257
Mental Health Current Risk	8.0%	5.1%	0.000
Drug/Alcohol History Risk	26.1%	22.0%	0.026
Drug/Alcohol Current Risk	33.2%	31.4%	0.257
Attitude History Risk	85.2%	81.1%	0.066
Attitude Current Risk	7.4%	3.5%	0.074
Aggression Risk	21.2%	15.8%	0.000
Skills Risk	26.9%	16.7%	0.003
Protective Factors			
School History Protection	5.6%	4.4%	0.356
School Current Protection	32.4%	27.2%	0.166
Free Time History Protection	65.7%	67.6%	0.497
Free Time Current Protection	45.4%	39.8%	0.112
Employment History Protection	35.6%	27.5%	0.004
Employment Current Protection	8.0%	6.9%	0.006
Relationship History Protection	20.0%	17.9%	0.324
Relationship Current Protection	35.5%	26.9%	0.009
Family History Protection	16.0%	2.8%	0.000
Living Arrangement Current Protection	52.9%	26.4%	0.000
Drug/Alcohol History Protection	81.6%	80.2%	0.344
Drug/Alcohol Current Protection	12.0%	13.2%	0.078
Mental Health History Protection	27.50%	10.40%	0.000
Mental Health Current Protection	93.10%	93.40%	0.838
Attitude History Protection	18.90%	14.80%	0.074

Youth with prior foster care placement have significantly higher risk or lower protection than those who did not.
Youth with prior foster care placement have significantly lower risk or higher protection than those who did not.

Data Source: ITA Data

Note: Table C1 shows the differences between youth with a prior out-of-home placement and those without, on domain scores in the ITA. The ITA is administered within 14 days of a residential admission, and then again prior to release. The instrument is a risk and needs assessment; however, the information has not been clearly set-up to identify specific needs. Instead, it is presented in terms of risk and protection in domains. Need can be determined based on the domain scores. For example, high risk and low protection in the Alcohol and Drug domain, would indicate a need for substance abuse treatment. All domains have both a historical and current risk and protective score. The table shows the domains and the percent of youth with either high risk or high protection, by prior foster care placement status. The significance level is presented from a chi-square test.