Harris County Protective Services
Integrated Health Care Implementation Grant

Final Evaluation Report

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The Hogg Foundation for Mental Health
Lake Austin Centre, 4th Floor
3001 Lake Austin Boulevard
Austin, Texas 78703-4200

Submitted by:
Dr. Toni Watt
Professor
Sociology Department
Texas State University
(512) 245-3287
tw15@txstate.edu

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Executive Summary

Background

Children in foster care have much higher rates of emotional and behavioral problems, physical health concerns, and developmental delays than children from similar socioeconomic circumstances. However, these children are unlikely to receive the necessary services. It has been suggested that integrated behavioral health care (IHC) is uniquely poised to address existing gaps in services for children in State custody. However, the evidence base for pediatric IHC programs is limited and there are no studies of foster children served by an integrated care model. In 2012 Harris County Protective Services received funding from the Hogg Foundation to plan and implement an integrated behavioral health program for children in State custody. The Hogg Foundation also funded an evaluation of the pilot program. This report provides the results of the evaluation, which offers an exploration of needs, processes, and outcomes.

Key Findings

The current behavioral health system for children in State custody needs improvement.

- The majority of children in kinship care in Harris County (56%) do not receive behavioral health treatment.
    - Ninety-nine percent of children age 5 and younger receive no treatment.
- Kinship caregivers report barriers to treatment and want additional support.
- Key stakeholders report that the system of care is a "broken" system.
- Several gaps in service can be addressed through integrated care.

HCPS successfully launched an IHC program for children in State custody in June 2014.

- Care management and psychiatric services are provided on-site and in collaboration with primary care.
- The IHC program served 194 unduplicated clients (6/14-9/15).
- HCPS clinic and IHC visits have increased substantially over time.
- Caregivers and stakeholders report that the program fills important service gaps (e.g. care management and psychiatric services).

Preliminary evidence suggests the HCPS IHC program is benefiting children and families.

- Children served by the program experienced significant improvements in well-being, particularly in terms of interpersonal strength and family involvement.
- Caregivers reported that the IHC services helped them confront the strains of caregiving. Thus, IHC programs could contribute to placement stability.

Opportunities exist for program development.

- HCPS's therapeutic component requires strengthening for IHC model fidelity.
    - Few clients utilize or can access the contractual on-site therapist.
    - Approximately 89% of the children served by the IHC program are on medication relative to 37% for Harris County

- Existing IHC models are not designed to meet the needs of young children.
    - Children age 5 and younger represent 47% percent of children in care but only 14% of children served by the IHC program. This is an improvement relative to Harris County (2%), but still warrants improvement.
    - Caregivers of young children report a lack of services.
        - Standard IHC treatments (e.g. talk therapy, medication management) are not appropriate for children age 5 and younger.
- Existing IHC models do not formally address trauma.
    - There is a need to measure and communicate information about trauma.
    - Trauma-services should be offered (e.g. therapies, training for caregivers).

Conclusions and Recommendations

HCPS has taken on the pioneering work of developing an integrated behavioral health care model for children in State custody. They have made impressive progress. The IHC program has served a large number of children and families by offering psychiatric services and care management on-site and in collaboration with primary care. Caregivers and stakeholders see great value in the new program and the children served are experiencing significant improvements in well-being. HCPS is the first agency to offer IHC to children in State custody, to track child well-being, and to demonstrate improved outcomes and client satisfaction. We encourage HCPS and potential funders to continue this initiative. We also suggest that HCPS work to strengthen the therapeutic component, explore strategies for serving young children, and formally incorporate trauma into the existing treatment protocol. Some of these suggestions aim to move the HCPS program closer to standard IHC practice (e.g. therapy) while others (e.g. early intervention and trauma) require a new conceptualization of integrated care. At this stage HCPS have the staff, feedback loop, and commitment to create a new system of care that improves outcomes for children experiencing maltreatment and family disruption. They are well poised to educate others on model implementation and to spearhead the evolution of the IHC model so that it can serve the unique needs of this vulnerable and deserving group of children.

Introduction

Children in foster care have much higher rates of emotional and behavioral problems, physical health concerns, and developmental delays than children from similar socioeconomic circumstances.[1] However, these children are unlikely to receive the necessary services.[2] In addition, the health care that is provided is often substandard, characterized by a lack of coordination of services, poor communication by providers, an overreliance on psychotropic medications, and failure to include biological family members.[3-6]

It has been suggested that integrated behavioral health care (IHC), with its emphasis on collaboration, continuity, and comprehensive care, is uniquely poised to address the limitations outlined.[6] Integrated care has been found to improve mental and physical health of adults more than usual care alone.[7] However, the evidence base for children is very limited and there are no studies of foster children served by an integrated care model.[8,9] Further, there is reason to believe that integrated care may not transfer seamlessly from the adult to the foster care population. IHC interventions targeting foster care need to distinguish between different types of placements (e.g. kinship care, foster care) and to disentangle the child's reaction to the new placement from mental health disorders.[10] The history of trauma also complicates mental health diagnoses.[11] And, despite frequent calls to do so, CPS has never systematically measured child well-being.[12]

Harris County Child Protective System is currently taking on these challenges. They received an integrated health planning and implementation grant from the Hogg Foundation in 2012. The Hogg Foundation also funded an external evaluation of the initiative to be conducted by Texas State University. HCPS launched their pilot program in June of 2014. A mid-course evaluation report (distributed March 2015) provided a detailed needs assessment and formative evaluation of the first nine months of program operation. This final evaluation report provides an assessment of program activities and outcomes for the full grant period, which includes approximately a year and three months of program services (2014-2015).

Relevant Literature

It is estimated that 40-60% of children in State care have behavioral health problems, which often are accompanied by physical health concerns as well.[13-16] These concerns challenge foster and kinship caregivers and undermine children's long-term outcomes. In addition, they strain existing State support systems. For example, children in foster care represent 3% of the Medicaid child population but account for 29% of Medicaid expenditures for behavioral health services.[16] Thus it is important to create an effective and efficient system for connecting children in State care with high quality behavioral health services.

Studies find that 25-80% of children in State care with an identified need receive behavioral health services.[13,17,18] These estimates vary widely, in part, because behavioral health access is affected by a number of variables such as race/ethnicity, insurance,

geographic region, living arrangements, and socioeconomic status.[13,19, 20] One factor which affects treatment receipt is whether the child is placed into a foster home or with kinship caregivers. Since the Adoption and Safe Family Act of 1997, Child Protective Services has been encouraged to seek out kinship care placements, leading to increases in these placements.[21,22] Kinship care placements have been found to have advantages over traditional foster placements in terms of stability and preserving family and racial/ethnic identities.[23-26] However, kinship caregivers tend to be older and low-income and receive fewer support services than foster families.[23-24,27] Thus it has been noted that kinship caregivers may have more difficulty accessing behavioral health treatment. For these reasons, several interventions designed to offer additional support to kinship caregivers have been piloted. Lin provides a review of the evidence base for these sorts of programs (2014).[28] This review found that support services can benefit kinship caregivers, particularly those offered by peers. However, Lin also notes that the study research designs were often weak and that more rigorous evaluations of support programs are needed. In sum, interventions are needed which increase access to behavioral health care, particularly those that assist kinship caregivers.

An additional area of concern is the quality of behavioral health care provided to children in State care. Researchers have lamented the narrow treatment protocol, which typically includes only traditional talk therapies, psychotropic medication, or some combination of the two. There are compelling arguments that talk therapies (e.g. cognitive behavioral therapy) were not designed for, and thus do not work well with children.[29] In addition, psychotropic medication is often the only form of treatment that children in foster care receive and they are four times more likely to receive it compared to other children on Medicaid.[16] While medication is an accepted evidence-based practice in the short-term, research reveals that many psychotropic medications routinely given to children are ineffective and/or harmful in the long-term.[30-35] For these reasons, the American Psychological Association recommends that psychotropic medication not be the first course of treatment for children, but used after other types of treatment have proven ineffective.[36]

The Center for Health Care Strategies, Inc. offered a number of suggestions to better meet the behavioral health needs of children in State care.[16] Two of their recommendations were to a) increase access to behavioral health treatment and b) create systems of care that involve coordination and collaboration between providers. These directives can be accomplished through the adoption of integrated behavioral health care, also referred to as collaborative care. Integrated care has been shown to increase access to behavioral health services and improve both physical and behavioral health outcomes beyond that typically accomplished with usual care alone.[7] These models have a strong evidence base with numerous randomized controlled trials and community evaluations. However, the vast majority of the research on these models has been conducted with adult populations. A few investigations have been conducted of their efficacy with children and adolescents.[8,9] However, there have been no documented integrated behavioral health care programs offered to children in State custody.

Harris County Protective Services' IHC Pilot Program

Harris County Child Protective Services is committed to improving the outcomes for children in State care. HCPS recognizes the unmet needs for mental health services, the connection between mental and physical health, and the promise of integrated care. Consequently, they applied for and received funding from the Hogg Foundation to adopt integrated behavioral health care. In 2012 they received a two year planning and implementation grant for IHC. They eventually requested a no-cost extension to continue the pilot and evaluation through 2015. As discussed, there is no documentation of IHC programs offered to children in the child protective system, and thus HCPS is entering uncharted territory with this new initiative.

They completed their planning cycle and launched the new program in June of 2014. Initially, they planned to target only children in kinship care, proposing to serve 100 children placed in kinship care between April and July of 2014. However, shortly after the program launched, they learned that the number of children in kinship care attending the clinic was limited and that there were other targets with pressing mental health needs. Thus they expanded the project to also include children in foster care with significant behavioral health concerns and children in need of behavioral health services who are residing in the on-site children's shelter. HCPS hired Shelly Wilson-Scott as a full-time care manager (MSW) and secured Dr. Oscar Bukstein, a Depelchin child psychiatrist, on-site for 5 hours every other week. Ms. Wilson-Scott and Dr. Bukstein began seeing children in June of 2014. HCPS experienced delays in adding a therapist. However, in January of 2015 they were able to develop an agreement between a HCPS therapist who practices in the same building as the IHC program. This therapist now accepts referrals for IHC clients. HCPS also added two peer navigators in the first quarter of 2015 to provide caregivers with a connection to other families who have been through the system and can offer support and guidance.

Evaluation

The evaluation used mixed methods to assess existing needs and program processes and outcomes. It was developed as a collaborative effort and thus reflects the research needs identified by the evaluator, the Hogg Foundation, HCPS staff, HCPS consumers, and representatives from the state office of DFPS. Approval for all evaluation activities was obtained from the state office of DFPS and from the Texas State Institutional Review Board. The following outlines the detailed goals/objectives and methods used in the evaluation.

Evaluation Goals and Objectives

- Describe the HCPS health care service model before and after integration
- Explore whether the integrated care model incorporates the Hogg Foundation emphasis on recovery (consumer empowerment and trauma-informed).
- Determine if outcomes for children improve significantly and substantively with the integrated behavioral health care model.

Evaluation Data and Methods

The evaluation provides a triangulated approach, utilizing quantitative and qualitative methods and data sources. For the quantitative data we obtained information from HCPS clinic staff on the kinship care cases that came to the clinic pre/post intervention. Clinic staff provided information on the number of cases, demographics, and the PEDS/PSC screening assessments. The care manager collected data post intervention on all children served by the IHC program (kinship, shelter, and foster care). These data contain reason for the referral, visits, and case notes from visits with the psychiatrist. The care manager also collected initial and follow-up BERS-2 (Behavioral and Emotional Rating Scale) to measure child well-being. The BERS-2 is a reliable and valid instrument designed to measure the emotional and behavioral strengths of children and adolescents. The 52 items in the BERS assesses five areas of childhood strength: Interpersonal Strength, Family Involvement, Intrapersonal Strength, School Functioning, and Affective Strengths. The care manager administered the BER-2 at intake and 3 months follow-up. The BERS-2 can be completed by any adult familiar with the child (at least 30 days) or can be self-administered by adolescents.

We also obtained quantitative health data (Superior Health) to measure pre/post integration change of the number of clients in the target served at the Chimney Rock HCPS location, their rate of behavioral health access, and the types of treatment received. However, the sample sizes for the clients seen at the HCPS clinic were so small in this database that a pre/post analyses of clinic service data was not possible. However, the Superior Health data provide a rich source of information on all of the children in Harris County in kinship care. Thus we use these data to offer a needs assessment and comparison group for the children served in the HCPS IHC program.

For the qualitative data, we conducted in-depth interviews pre and post intervention with HCPS staff, program stakeholders (e.g. DFPS staff, IHC steering committee members) and consumers participating in the program planning. We also interviewed 8 kinship caregivers, some receiving services before the IHC program launch and others after participating in the new pilot program. For our qualitative analysis we looked for themes in terms of program strengths and unmet needs. We also utilize these data to elaborate on our quantitative findings.

Findings

HCPS Integrated Behavioral Health Program: Process

The mid-course evaluation report identified numerous gaps in behavioral health services for children in State custody. Superior Health data revealed that the majority of children in kinship care in Harris County did not receive mental health services (56%) and this was particularly striking for children age 5 and younger (99% receive no behavioral health treatment). We also learned that there are numerous barriers to service utilization experienced by caregivers (e.g. long travel times, difficulty locating services). Thus there was a clear need for an integrated behavioral health model to increase access to behavioral health services. The following section provides a summary of HCPS's implementation of their new IHC model.

Successful Program Launch

In the first year of grant funding HCPS engaged in the IHC planning process. This was a uniquely complex process for an IHC program as the number of agencies and stakeholders is large. HCPS created a steering committee that included representatives from HCPS, the State DFPS office, providers, collaborative agencies, and consumers. The committee met regularly to help design the program, to create buy-in across systems, and to establish a referral network. The planning process was challenging but resulted in a cohesive collaborative network and a successful program launch.

From June 2014 through September of 2015, the new IHC pilot program served **194** unduplicated clients. Clients visited from 1 to 10 times with an average of approximately 2 visits per client. While initially targeting kinship care, the program is more broadly serving children in kinship care (43%), foster care (38%) and the HCPS shelter (20%). Figures 1 and 2 also reveal that the program has been growing over time.

Figure 1: Number of IHC Clients Served Over Time

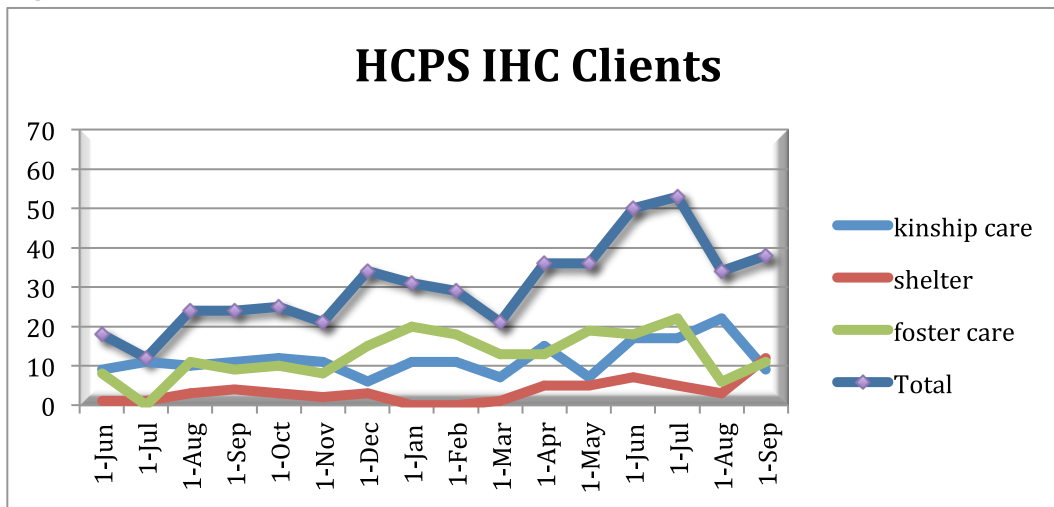


Figure 2: Average IHC Visits Per Month: Launch and One Year Later

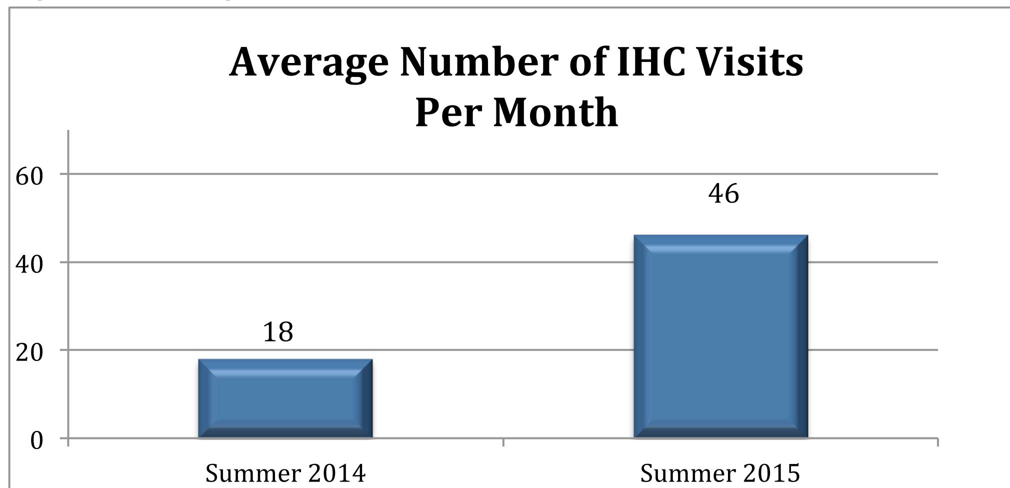


Figure 1 shows the upward trajectory of the IHC visits over time. Figure 2 further reveals that the average number of visits in the summer months immediately after program launch increased in the next year by **156%** (from 18 to 46 per month).

In addition to increasing access to behavioral health services, one of the goals of the IHC program was to increase utilization of the HCPS primary care clinic. Figure 3 documents these trends in clinic traffic over time.

Figure 3: HCPS Primary Care Visits Over Time

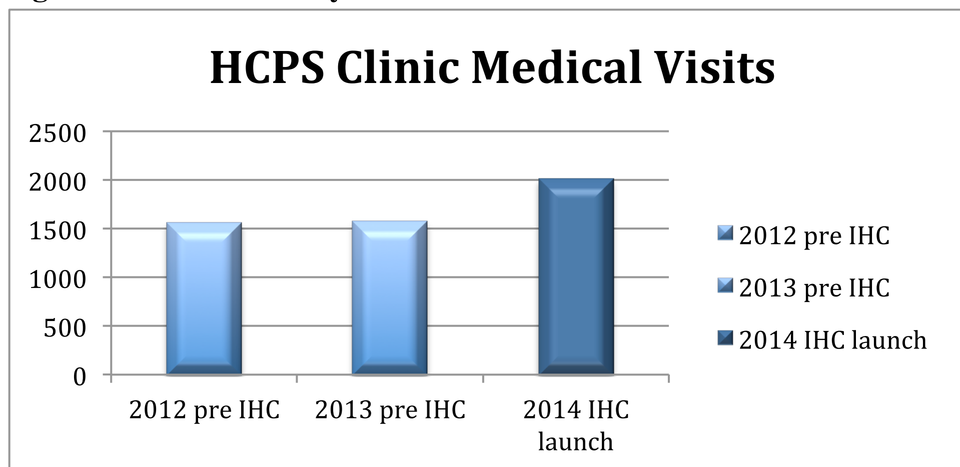


Figure 3 reveals less than a 1% change in clinic visits from 2012-2013, the pre IHC period. However, the launch of the IHC program in 2014 was associated with a **28% increase** in visits. While we cannot conclusively attribute the increase to the program, staff report that this is a unique increase tied to the new program, since the enhanced services increase the attractiveness of the clinic for families and providers making referrals.

Table 1 provides the demographic characteristics of the children participating in the IHC program and how it compares to the baseline data for Harris County.

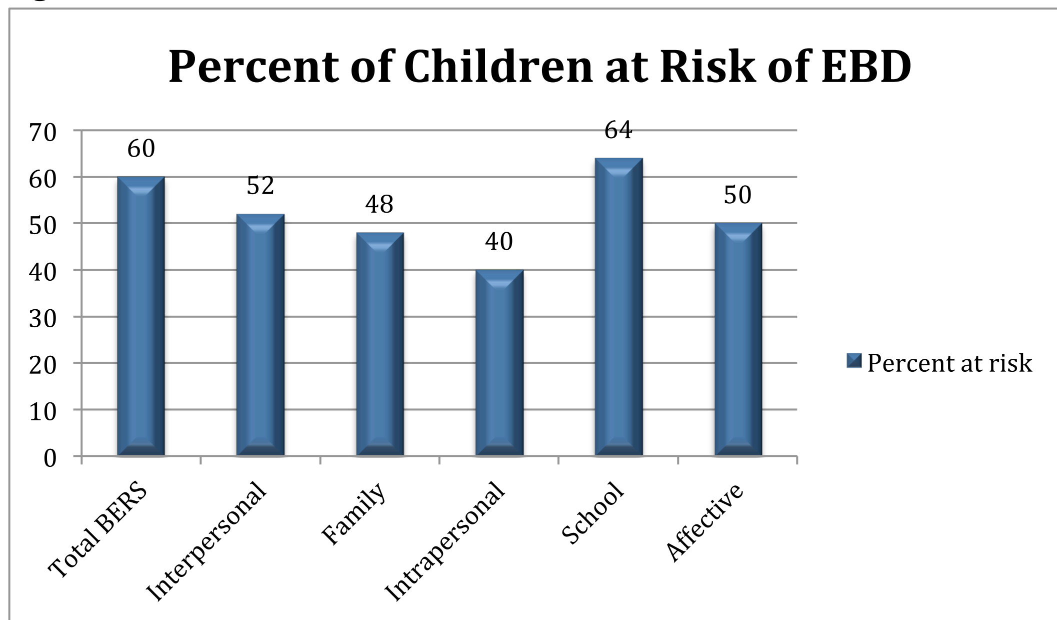
Table 1: Descriptive Profile of Children Served

	Harris County PC or BH Services %	Harris County BH Services %	HCPS IHC BH Services %
Sex			
Male	49	48	56
Female	51	52	44
Age			
<=5	47	2	14
6-11	33	61	53
12-17	20	38	33
Race/Ethnicity			
White	21	19	23
African-American	49	51	48
Hispanic	30	29	27
Other	1	1	2

Column 1 reveals the demographic profile of children in kinship care in Harris County who received any health care services (primary and/or behavioral health care). This offers a reasonable estimate of the characteristics of children in State care. Column 2 provides the profile of children in kinship care in Harris County who have received behavioral health services. Finally, column 3 provides the profile of the children receiving behavioral health services through the HCPS IHC program. The results reveal that with regard to sex and race/ethnicity, there is no subgroup over/under-served by the IHC program. However, there are significant differences with regard to age and receipt of services. As discussed, children age 5 and younger are under-served by the behavioral health system. While 47% of children are in this age group, they constitute only 2% of children receiving behavioral health services in Harris County. The HCPS IHC program does a better job of serving these children as they represent 14% of children served (and this is an increase from the mid-course evaluation of 5%). However there is still a need to increase the percentage of young children served.

Children referred to the IHC program were administered the BERS-2, a strengths based measure of social and emotional well-being. A rubric allows the provider to place the child into categories of extremely low, very low, low, high, or very high risk of an emotional or behavioral health disorder (EBD). Approximately 50 of the 194 children served by the program have BERS-2 surveys completed at or around the time of intake. Thus these data are only for a portion of the children served by the program. The care manager found it sometimes challenging to administer the BERS-2 as it requires at least a month of close contact with the child in order to offer an assessment. Figure 4 provides a summary of the BERS-2 scores for all children (kinship, foster care, shelter) when they initially began receiving HCPS IHC services.

Figure 4: BERS-2: Risk of an Emotional or Behavioral Health Disorder



For the children receiving this assessment, 60% profile as high or very high risk of an emotional or behavioral health disorder. This suggests that the majority of the children referred to the program are an appropriate target for program services. However, in the mid-course evaluation, this figure was considerably higher (89%). It may be that children are coming in with stable symptoms due to previous medication/treatment. However, it will be important to consider these initial BERS-2 scores in conjunction with other assessment tools. The individual component results suggest that children's greatest risk is in their school performance. Interestingly, the least problematic area is intrapersonal strength, a child's self-confidence and enthusiasm for life.

IHC Services Received

All children/adolescents served by the IHC program had at least one visit with the care manager. The care manager assists clients in a number of areas. She provides help in making referrals to the internal behavioral health staff. When the child's needs involve other health issues requiring a specialist (e.g. cardiologist, neurologist) the care manager assists the caregivers with those referrals. The care manager also collects data on the child/families at intake and follow-up and offers social support to the clients. The on-site psychiatrist conducts assessments and provides medication management. In early 2015 HCPS contracted with a therapist to provide counseling/therapy to children served by the IHC program. In addition, two peer navigators were added in 2015. Table 2 provides a descriptive profile of the types of services the children and families received through the IHC program.

Table 2: IHC Services

	%	n
Referral Type		
On-site psychiatric services	86	166
Other specialty services (e.g. speech)	17	33
Behavioral Health Services		
Medication	89	109
Therapy		
Referral for therapy	18	22
Follow through on therapy	63	14
No follow through on therapy	37	10

Table 2 reveals that the majority of the clients seen by the care manager received a referral specifically related to behavioral health needs and then were scheduled to meet with the IHC psychiatrist on-site. Approximately 17% of clients were in need of other specialty services due to physical or developmental issues (e.g. audiology, autism).

Among the IHC clients, approximately 89% are on psychotropic medication. In Harris County, the percentage of children on medication was much lower than the HCPS IHC program (37%). The HCPS IHC data include kinship care, foster care, and shelter children whereas the Superior Health data were only of kinship care children, who have been shown to have less severe behavioral health problems than children in foster care. However, we reanalyzed the HCPS kinship care cases separately and found that approximately 81% were on medication. One explanation for the difference in medication use rates is the type and severity of the cases served by the HCPS IHC program. Staff reported that there is a severe lack of psychiatric services in Harris County. Thus, by providing medication management/psychiatric services, the IHC program is attracting clients with a particular unmet need for this service. However, it is also possible that the current HCPS IHC model shifts the treatment protocol towards medication management and away from therapy. Table 2 reveals that very few children receive therapy on-site (approximately 11%). Staff reported that many children already had a therapist and a few did not need/want therapy. However, our qualitative data also indicate that the therapeutic component of the program was weak. The therapist was not part of the program until 2015, is not supported by IHC funds, and is not well integrated into the current IHC team. In addition there have been consumer complaints that it was difficult to schedule an appointment with the therapist, and I was unable to reach the therapist to discuss her role in the program (despite several attempts).

HCPS Integrated Behavioral Health Program: Outcomes

Our initial evaluation plan included several outcome measures. Because the clinic routinely screens patients using the PEDS and PSC, we hoped to obtain follow-up PEDS/PSC assessments for the baseline (pre IHC) period and compare them to the follow-up PEDS/PSC scores after the IHC program had been adopted. However, in our analysis of the baseline data we learned that children rarely return for follow-up

assessments. While this provided us with less data than we had hoped, it offered additional justification for an IHC program that tracks patients over time. Thus, the addition of a care manager who can track patients using a broader strengths-based measure of well-being (BERS-2) became important not only as a service characteristic but essential to evaluation efforts as well. Consequently, our outcome evaluation focuses on the pre/post change in the BERS-2 measure.

The BERS-2 was re-administered by the care manager at 3 months follow-up. Of the children with an initial BERS-2 (26% of all children) with sufficient time for follow-up, the BERS-2 was re-administered to 61%. While our sample sizes with initial and follow-up BERS-2 is small at this point in the pilot, we are able to present our preliminary findings on the pre/post changes in this outcome measure. However, caution should be used as these outcomes do not represent the majority of children served. Table 3 provides a summary of the statistical tests for significant changes in the mean scores on the BERS-2 (paired sample t-tests). It also provides the effect sizes for these changes, reported as Cohen's d. Effect sizes are a standardized measure of change which tell us whether the changes observed are small (d=.2), medium (d=.4) or large (d=.8).

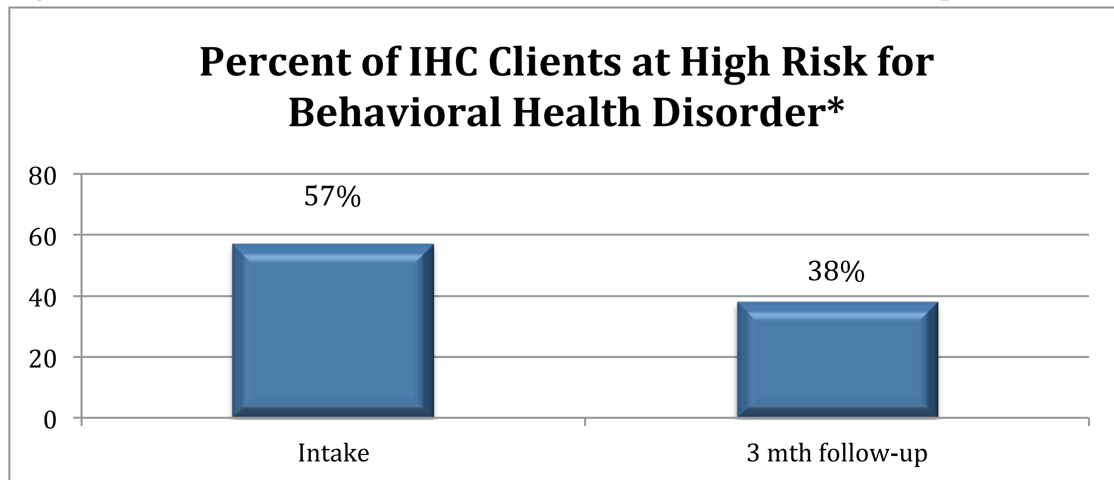
Table 3: Child/Adolescent Well-Being (BERS-2) at Intake and 3 Months Follow-up

BERS-2 Component	*Intake*	*Follow-up*	*Change*	*Effect Size (d)*	*n*
Interpersonal Strength	7.91	9.41	1.50***	.46	22
Family Involvement	7.91	8.82	.91*	.32	22
Intrapersonal Strength	8.73	10.0	1.27[d]	.35	22
School Functioning	7.18	8.00	.82	.26	22
Affective Strength	8.45	9.36	.91[d]	.25	22
Total BERS-2 Index	83.32	90.55	7.23	.27	22

***p<=.001, **p<=.01,*p<=.05, [d]p<=.10

Results reveal that children experienced statistically significant improvements in their well-being in the first three months of receiving HCPS IHC services. This change was driven primarily by significant improvements in interpersonal strength, suggesting children are better able to interact appropriately in a social environment. There were also significant improvements in family involvement. There were improvements approaching significance in the areas of intrapersonal strength (self-confidence and enthusiasm) and affective strength. The largest effect (approaching a medium effect size) was in interpersonal strength. The other changes are considered small effects. This is an excellent start for a new program. However, there is room for improvement in the effect sizes, which may occur as the program expands to include new services (therapy and peer navigators). Figure 5 examines BERS-2 outcomes in terms of the percentage of children profiling as at high risk of having a behavioral health disorder, looking at intake and at 3 months follow-up.

Figure 5: Risk of Behavioral Health Disorder at Intake and Follow-up



*Results are for children with a BERS-2 at intake and follow-up

Figure 5 reveals that 57% of children served profiled as high risk at intake but only 38% were high risk at follow-up.

IHC Program Strengths and Opportunities for Growth

There are no documented integrated behavioral health programs offered to children in State custody. It has been suggested that IHC is well suited to remedy some of the most significant gaps in the current system of care for these children. However, it has also been noted that IHC models were not designed for this particular target and may not be able to address the complex needs of these children. In the evaluation we found support for both of these positions. Our focus in this section is to merge all of the quantitative and qualitative data sources in order to identify the most striking benefits and limitations of the IHC program. This presents a snapshot of how IHC may be able to benefit children in State care and how it must evolve to serve this particular target population.

Program Strengths

Integrating Complex Systems

HCPS has taken a leadership role in integrating not only mental and physical health care providers but in bringing together the many complex systems that encompass child welfare. HCPS hosted integrated care meetings that included representatives from HCPS, the State office of child protection (DFPS), community agencies serving children in State care (e.g. Child Advocates), mental health systems, primary care systems, and consumers. This complex system, which has been described as a "labyrinth", is a disjointed system filled with many gaps. The most common phrase heard in the in-depth interviews is that "the system is broken". HCPS is working to pull some of the pieces together and to break down siloes within siloes. This is a key part of what needs to happen if IHC programs are going to be offered to children in State custody. And HCPS did an excellent job of

investing the time and energy into developing a more collaborative and integrated model for serving children in State care. The following outlines some of the benefits (described in the in-depth interviews) of developing these connections and partnerships across various stakeholders:

- Consumers felt that their voices were heard in developing the program components, particularly the peer navigator piece of the intervention.
- HCPS's connections with DFPS and CASA helped to create awareness of and referrals to the integrated care program.
- The care manager role was designed in a way that could fill some of the gaps in support services for kinship caregivers that exist within primary care, behavioral health, and child protective services.

Given this collaborative environment and the successful launch of the program, key stakeholders were unanimously in support of the new program, stating:

> *"The program is outstanding"*
>
> *"I've been extremely pleased with the process. Hats off to the staff in terms of how well they have been able to pull this together, and so effectively."*
>
> *"I'm really impressed with the program. This is something that we need …….. There should be several clinics like this in Harris County."*

Meeting the Need for Psychiatric Services

As noted in the process findings, a significant portion of the children served by the pilot program are taking psychotropic medications. Staff and caregiver interviews suggest that this reflected an existing need in the target population, either for prescriptions for medication or medication management. Kinship caregivers noted that therapists typically can't prescribe medication and there are a shortage of psychiatrists. Primary care providers can fill this need, however, they are often hesitant to do so or not experienced enough with these medications to conduct appropriate follow-up and/or medication management. The addition of psychiatric services on-site was particularly helpful in filling this need. The model represented a psychiatric consultation model which was well-suited for patients in need of triage and timely assistance. It is also a cost-effective approach for serving a large high need population. The caregivers and staff were pleased with the psychiatric services provided. One stakeholder stated:

> *"Some of these kids weren't receiving services before, especially the psychiatric services. That was the service that nobody was getting. Those kids are getting world class psychiatric services and they used to not be getting any."*

Caring for the Caregiver

Our findings reveal that caregivers are strained and have difficulty accessing services. Caregivers and DFPS staff noted that the child protective system is a complex system that is stressful to navigate. Caregivers stated they frequently asked DFPS for help in accessing mental health services but did not receive any assistance. This experience creates frustration and at times, an adversarial relationship between the caregiver and DFPS. Caregivers stated:

> *"I have three jobs. I'm trying to go, but help me with something! Do Something!"*
>
> *"If I need help, I need help. Don't make it hard when it doesn't have to be"*
>
> *"I stepped up, but you didn't do anything!"*
>
> *"trying to get services was just a mess….I had to search for a therapist and a psychiatrist and didn't even know where to start from. A lot of parents like me that don't know where to start from. They say 'go to the internet'. But what if I don't have internet?"*
>
> *"Why should I do anything (get services) if they (DFPS) are just going to yank them?"*

A DFPS worker confirmed that the system "exhausts the caregiver" by setting high standards for the care of the children but with few resources offered. Caregivers and DFPS workers stated that caregivers were " "stressed to the max" and don't "have control". A caseworker stated:

> *"There is no system that incorporates that caregiver, talking to them as a person, as opposed to telling them what to do."*

However, we found that the integrated care model addresses the need to better "care for the caregiver" by offering co-located services and care management. Staff and caregivers seemed particularly pleased with the IHC care manager:

> *"She is super nice all the time. She's always asking 'how are you doing?' That's a value. You never know how stressed that caregiver is. Maybe someone calling to see how you are doing, that can make someone's day go by great."*
>
> *"I love her (Care Manager). She is the only reason I go down there. She is fantastic. She is very engaging. She takes the time to get to know everyone. She's been very helpful…. She does everything possible to make it an easy experience…..I think she really sincerely cares. ….In our situation, we're so rattled, here we were almost empty nesters, and then we were just in this situation. Every contact (with her), it matters more to me than the case workers."*

> *"Shelly does an outstanding job. She really makes it work."*

The HCPS IHC care manager also tracks child well-being. This is a key component of integrated care, and something that has been lacking in the child welfare system. It empowers and encourages caregivers by sharing their child's progress with them. In the in-depth interviews caregivers relayed that this type of service reduces stress and can improve the quality and stability of the placement:

> *"On a bad week you think, I can't do this. I'm a failure…..Just knowing that she (the Care Manager) is there, and she gives you positive reinforcement…. It does make you feel good when a therapist or the care manager says you are doing good. It gives you strength to go on. Hearing that the outcomes are improving."*

Program Opportunities

Moving from Coordination to Collaboration

Most new IHC programs accomplish co-location and coordination with little difficulty. However, moving to those higher levels of integration through collaboration is typically more challenging. Few models or evaluations articulate exactly how to achieve a true collaborative model. HCPS faces similar challenges. The clinic has clearly accomplished co-location and coordination. And there is much evidence that a collaborative team is emerging between mental health providers. However, our qualitative data suggest that the program can benefit from more collaboration between primary care and mental health services, particularly for prescribing and managing psychotropic medication. This might involve more training for primary care providers in psychotropic medication, regular team meetings to discuss patients, and/or refinement of the logic model to clarify specific roles for providers regarding responsibilities for treatment plans involving medications.

HCPS is currently coordinating with DFPS, which is a unique accomplishment in and of itself. However, it was suggested that children/families would benefit from increased collaboration. HCPS and DFPS could work together on community outreach in order to increase caregiver awareness of the program. There are also opportunities for DFPS to help HCPS with barriers to program participation. For example, it was suggested that DFPS might be able to assist caregivers with transportation to the clinic. The partnerships that have been developed are clearly beneficial and if they continue to grow, children and families will benefit.

Strengthening the Therapeutic Component

Approximately six months after the program launched, HCPS was able to offer referrals to a therapist located in the attached youth shelter. However, once the therapist was added, there were mixed views on this program component. Some suggested that most children coming to the clinic did not utilize the services available because they already had a therapist. Consistently, our quantitative data show that most children did not receive a referral to the on-site therapist for this reason. Thus, some staff felt that the current

therapy arrangement was sufficient to meet the needs of the clients. However, other staff felt that the IHC program would have more fidelity to existing IHC models if the program housed it's own therapist (part-time or full-time) within the HCPS clinic as a clearly defined member of the IHC team. In addition, interviews with kinship caregivers suggest a need for a stronger therapeutic component. Caregivers interviewed before the therapist was added stated that they had a very difficult time locating a therapist and that it would have reduced their stress if a therapist had been available at the clinic. They noted that they would definitely like to be able to get all of their services at one clinic and to have a therapist that collaborated with their psychiatrist. After the therapist was added, one kinship caregiver stated that she still had trouble finding a therapist and that she was told it would be a long wait to get to see the HCPS therapist. She expressed great frustration at the lack of on-site therapy. Therapy is typically a cornerstone of IHC programs and the collaborative relationship between the therapist and the psychiatric consult is a critical component. Thus additional planning (and perhaps funding) is needed to help the HCPS IHC program become more closely aligned with existing IHC models on this component.

Expand Treatment Options for Young Children

As described, young children (ages 5 and younger) are unlikely to receive mental health services through HCPS IHC or in Harris County generally. In our in-depth interviews, behavioral health providers and kinship caregivers acknowledged that providers very rarely treat young children. Providers are reportedly hesitant to treat young children because they find it challenging to tease apart behavioral health disorders, developmental delays, and normal childhood behaviors (e.g. temper tantrums). They were concerned with misdiagnosis, labeling/stigma, and early use of psychotropic medication. Thus, the standard protocol is often to "wait and see". When disorders are later verified in a school setting, then a referral is typically made. However, several caregivers expressed concern for the young children in their care. They spoke of behavior problems (anger, fear, sleep problems, etc.). One caregiver stated:

> *"I had a hard time finding someone. I'd call 20 names on the list and they said "I don't do earlier than 7"…. They don't want to label them. They don't like ODD because once they do that the kid's been labeled……What if I have a six year old that is stabbing, kicking me, spitting on me? What, I'm supposed to wait a year?"*

In the mid-course evaluation we recommended more services for children in this age group. Since mid-course there has been a slight increase in the number of young children served (from 5% to 14%). And HCPS began exploring early childhood interventions (e.g. Triple P). However much more work needs to be done to bridge this gap.

Incorporate Trauma into IHC Models

IHC programs have not formally addressed trauma. There is little guidance available other than suggestions to be "trauma-informed". However this is a broad term with few if any specific directives. By definition all children in State Custody have experienced

trauma, and some of it occurs simultaneously with behavioral health treatment (e.g. family disruption). Thus IHC programs that are adopted for children in State Custody will need to incorporate trauma into the IHC treatment protocol. Currently there are gaps in this process.

HCPS staff lamented that there currently is no system for measuring and communicating information about trauma to mental health providers, despite its significance:

> *"We want to be able to tell the child's story. There is interview information on trauma concerns that we want to be communicated. ….We have had children who have witnessed the murder of a parent, and then been crawling all over them all night…We have children who have witnessed domestic violence multiple times.…We had a case of a child that had been starved…. These are the kinds of cases we see."*

As part of the evaluation, HCPS has been given information on tools for measuring trauma (e.g. Connecticut Trauma Screen) and staff are currently reviewing these instruments.

A second issue involves the disconnect between trauma and the DSM. Behavioral health systems rely heavily upon the Diagnostic and Statistical Manual (DSM-IV or V) to identify the behavioral health disorder, identify the appropriate treatments, and achieve reimbursement for services. However, our qualitative data revealed that this system can serve as a barrier to mental health treatment because it does not adequately address trauma. Caregivers questioned the narrowness, and potential permanence, of DSM labels for children. They discussed how these labels (and associated treatments) kept them from utilizing mental health services. Caregivers stressed that the problems these children had were not their fault and thus they were resistant to labels which locate the problem within the child. They were concerned that DSM labels pathologize a child's reaction to a highly stressful situation and do not reflect an understanding of the trauma experienced. A caregiver stated that the current system leads others to "think these kids are crazy…….a lost cause" and to be "quick to give up on them". Because caregivers felt that behavioral health providers might not adequately incorporate trauma, they were often concerned with whether the treatments administered were appropriate:

> *"Sometimes trauma presents as ADHD. …..Another reason I hate those amphetamines, their hearts are beating so fast, it scares me to death when they are sitting in my lap and I can feel their hearts beating so fast. My husband has a heart condition so genetically, I just don't like it. Then, give them something to sleep. Clonidine, that's just as scary, how good is that for their blood vessels to be speeding all day and then they are out, once you give him that medicine? It is just scary and I'd like to be sure."*

In our mid-course evaluation we found that all children receiving behavioral health services in Harris County had a DSM diagnosis and that the most common diagnosis by far was Adjustment Disorder (55%). Adjustment disorder (AD) is characterized by

significant distress and impairment as a consequence of a stressful life event. Adjustment disorder appears to offer a compromise position between the biomedical DSM approach and ecological paradigms preferred by caregivers. However, AD is an understudied and controversial diagnosis. There is no reliable and valid measurement tool for it. It conflates the etiology of the disorder with the disorder. And, it is unclear whether it reflects an abnormal reaction to a normal stressor or a normal reaction to an abnormal stressor. In particular, little data exist regarding effective treatments. For these reasons Carta et al (2009) conclude that psychotropic medication is not advised for Adjustment Disorder.[37] However, additional bivariate analyses (chi square) of the Superior Health data reveal that medication use rates did not differ between those with AD and those with other diagnoses for which medication has been more extensively studied (e.g. depression). Thus the diagnosis could still be inappropriately applied, stigmatizing (if viewed as an inappropriate response to a stressor), and lead to the unjustified use of medications. In this sense, its face validity is of little consolation to concerned caregivers.

Challenges to the DSM are beyond the scope of this evaluation and HCPS has little control over this process. However, is important for those implementing IHC programs for children in State custody to understand how caregivers perceive DSM diagnoses and associated treatments. A more formal incorporation of trauma into the IHC service model may be able to address these types of caregiver concerns.

Finally, there is a need for IHC programs to offer trauma services in addition to being trauma-informed. Trauma services are treatments specifically designed to treat the underlying trauma rather than control behavioral health symptoms. Caregivers repeatedly lamented the lack of trauma services. For younger children, play therapy and parenting interventions may need to be considered in addition to the very narrow treatment protocol of talk therapy and/or medication. Caregivers also requested trauma-services for older children. One caregiver was concerned that her therapist's behavioral therapy approach failed to treat the root cause of the behavior problems:

> *"I would like for somebody to address the issues they went through. They were treated like caged animals…someone has to address the terror they suffered….no one seems to address that these children have been traumatized."*

Caregivers also asked for assistance accessing community services such as a Big Brothers/Big Sisters program, support groups, and/or alternative treatments (e.g. equine therapy). This type of community referral could be incorporated into care management duties. In addition, the care manager could offer caregivers more formal training in how to create environments for children that mitigate rather than exacerbate trauma. The Child Trauma Academy (located in Houston) offers a number of short videos and reading materials on this issue. And the Child Welfare Trauma Toolkit may be a useful resource for training caregivers in how to respond to trauma.

Conclusions and Recommendations

We began our evaluation with a needs assessment for children in State custody in Harris County. Our data reveal a need for a new integrated model of care that can address existing gaps in access to and quality of behavioral health care. Key findings were that the majority of children in kinship care in Harris County do not receive behavioral health services (56%) and this is particularly pronounced for children age 5 and under (99%). The data also revealed that kinship caregivers find it difficult to locate mental health services (particularly psychiatric services and trauma-informed therapies) and these services are not conveniently located. In addition caregivers report needing instrumental and emotional assistance in meeting the needs of the children in their care. These findings confirm the need for an integrated behavioral health program and provide direction for model development.

In June of 2014, HCPS successfully launched its integrated behavioral health program for children in State care. They engaged in a complex planning process that required coordination and cooperation of several different entities. HCPS solicited input from DFPS, HCPS staff, consumers, and several other community agencies serving children in State care. They developed a detailed logic model and have systematically implemented the vast majority of the tasks outlined. The crux of the program has been the addition of a care manager (MSW) and a child psychiatrist (part-time) located within the HCPS primary care clinic. From June 2014 through September 2015 the HCPS program served 194 unduplicated children/youth. IHC client visits have been increasing since the program launch and overall traffic to the HCPS primary care clinic has increased substantially over time.

The care manager helps children access needed specialty services, schedules appointments for on-site psychiatric services, and makes referrals for therapy when needed. The care manager also offers children and families emotional support, guidance, and assistance obtaining other community resources. Finally, she tracks children's well-being and maintains the majority of the data collection for the initiative. The on-site psychiatrist provides further assessment and medication management. Caregivers and stakeholders reported being very satisfied with the services provided by both the care manager and consulting psychiatrist. In the second year of operation peer navigators were added to offer additional support to caregivers. While we do not have sufficient data to evaluate the peer navigator component, initial reports are that it is a valuable addition to the IHC model.

Co-location, care management, and psychiatric consultation are elements of the IHC model that have been successfully implemented in the HCPS program. While therapy is typically a core component of IHC models, this is the only piece not yet fully operational in the program. A contractual arrangement was made with an on-site therapist to accept program referrals. However, the level of access clients have to this therapist, the types of services provided, and the level of integration of this therapist into the HCPS program is unclear. The vast majority of IHC clients (89%) do not utilize the on-site therapist. In

most instances it was reported that they already had a therapist. However in other instances caregivers stated that they would prefer to have a therapist in the HCPS location but that it was difficult to gain access to the current therapist. We made several attempts to contact the therapist for an in-depth interview but were unsuccessful. Further, our findings reveal that the vast majority of children served by the IHC program are on medication (89%) a figure far higher than the average for the county (37%). This may suggest a lack of access to therapy relative to medication. It is also possible that the higher rate of medication use may represent a selection effect, that the children seeking IHC services at the clinic are those most in need of medication. HCPS staff have confirmed that the program attracts patients with more complex needs, particularly since they are one of the few sites to offer relatively quick assess to psychiatric services. However, on-site therapy may be able to draw a more diverse group of children to the clinic for IHC services. In order to have fidelity to existing IHC models and wider coverage of the program target, a stronger therapeutic piece is needed.

The ultimate goal driving all evaluations is whether program processes are able to improve outcomes for the children served. Our findings suggest that the program is having the desired impact on children. Pre/post BERS-2 scores reveal that children's well-being increased significantly with program services. The greatest increase was seen in interpersonal strength, which reflects children's ability to control their emotions and behaviors in social situations. There were also increases in family functioning, intrapersonal strength, and affective strength. These are encouraging results for a program in its infancy. Without a comparison group of children in usual care, it is difficult to attribute these changes to the IHC program. In addition, data collection was challenging and only a small sample of the children served have outcome data. However, this is the first documented attempt to track and measure well-being over time for children in State care. This, in itself, reflects a new model of care that places a high value on the child's outcomes and the need to follow them over time. And it is the first program to demonstrate improved well-being among children in State care. These are significant accomplishments.

In this evaluation we learned that the basic integrated behavioral health care model successfully addresses several of the existing gaps in services for children in State custody. Thus, the HCPS IHC program represents an innovative and improved model of care that should be expanded to other sites. However, this evaluation also revealed that the current integrated care model (initially designed for adults with depression and anxiety), needs to evolve in order to adequately serve the unique needs of children who have experienced maltreatment and family disruption. In particular, IHC programs offered to children in State care need to adopt a commitment to early intervention, particularly to serving young children before they reach school age. This will require additional discussion of screening tools for early childhood and the development of services for young children (e.g. play therapy, attachment/parenting interventions). In addition, IHC programs designed for children in State care need to formally incorporate trauma into all aspects of treatment. This will require strategies for communicating information about trauma to providers. It also requires expanding the existing treatment protocol to include interventions designed to treat trauma rather than those that merely

acknowledge it. While early intervention/prevention and trauma-services are not yet a formal part of all IHC programs, a co-located, collaborative team which includes a physician, therapist, psychiatrist, and care manager is uniquely positioned to fill these gaps. HCPS is working to address several of these evolutionary needs of the IHC model. Staff are reviewing trauma assessment tools, discussing therapeutic needs, and exploring early childhood intervention options. They are also seeking additional funding in order to sustain and expand their program. It has been written that the biopsychosocial model, with its emphasis on treating the whole person and addressing root causes, is the grandfather of integrated care. This paradigm allows us to see how expansions to include early intervention and trauma are not beyond the scope of IHC, but rather get to the heart of what the model was designed to do. As such, the challenges revealed in this study can illuminate the path proponents must take to move the IHC model forward and help to realize its full potential. HCPS has been a pioneer in developing IHC for children in State custody and is poised to be a leader in tailoring IHC programs to meet the needs of this vulnerable and deserving group of children.

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