

Preparing the Child Welfare Workforce:

WHAT IT WILL TAKE TO REACH THE NEXT 25%

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ACYF Training & Technical Assistance Venues

Children's Bureau Training and Technical Assistance Network

(www.acf.hhs.gov/programs/cb/tta/cbttan.pdf)

- National Resource Centers
- Quality Improvement Centers
- Implementation Centers
- Child Welfare Information Gateway
(www.childwelfare.gov)
- National Data Archive on Child Abuse and Neglect
- National Center on Substance Abuse and Child Welfare (SAMHSA)
- National Technical Assistance Center for Children's Mental Health
- National Technical Assistance and Evaluation Center for Child Welfare Systems of Care Grantees

National Child Welfare Workforce Institute



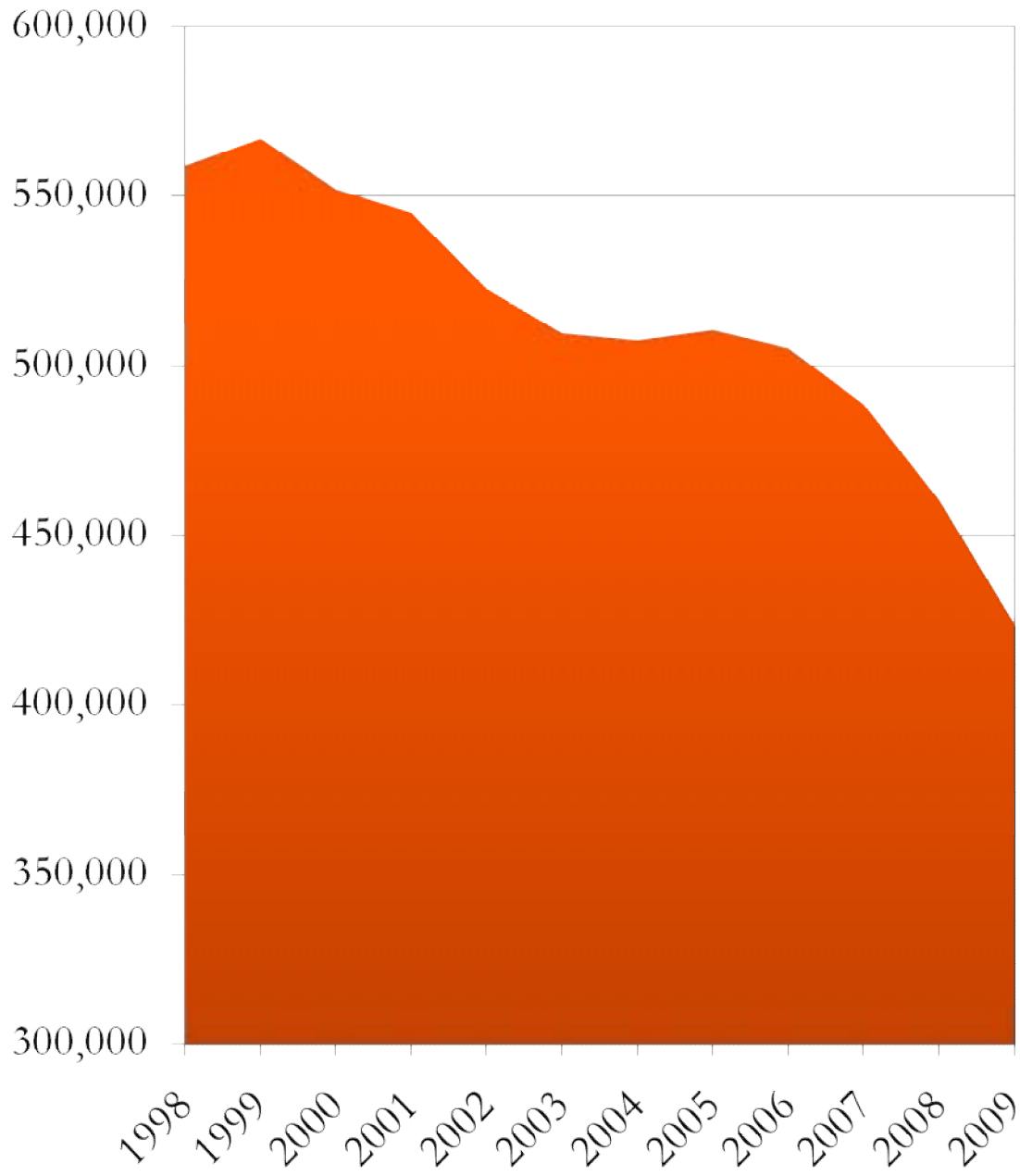
- Derives promising practices in workforce development
- Delivers child welfare leadership training for middle managers and supervisors
- Facilitates BSW and MSW traineeships
- Engages national peer networks
- Supports strategic dissemination of effective and promising leadership and workforce practices
- Advances knowledge through collaboration and evaluation

NCWWI's Leadership Academy

- Leadership Academy for Supervisors
- Leadership Academy for Middle Managers

Leadership Competency Model focuses on:

- Leading Change
- Leading in Context
- Leading People
- Leading for Results



In the 1980s and early 1990s, the child welfare system doubled in size.

In the last 13 years, it has gotten 25% smaller.

Child welfare policy reforms were the drivers behind this reduction

- The *Adoption and Safe Families Act (ASFA) of 1997*, P.L.105-89 marked the culmination of more than two decades of reforms in the child welfare field. Enacted as an amendment to titles IV-B and IV-E of the Social Security Act, ASFA has two overarching goals:
 - To move children who are languishing in the child welfare system into permanent placements
 - To change the experience of children who are entering the system today
- In 2008, the *Fostering Connections to Success and Increasing Adoptions Act*, P.L. 110-351 passed as a complement to ASFA. The goals of *Fostering Connections* include:
 - To extend care beyond age 18, up to age 21
 - To expand the Guardianship Assistance Program
 - To promote educational stability for children and youth in foster care
 - To enhance transition planning for youth aging out of care
 - To empower tribes to administer their own IV-E dollars

What will drive further reductions?

- How will we reach the next 25%
- What are the transformations required of the child welfare workforce to continue the progress of the last 13 years?

Objectives for Workforce Development

- Focus on improving child and family functioning and well-being by addressing social-emotional, behavioral, and mental health of children coming into contact with child welfare
 - Understand common disorders and sub-threshold issues for children with trauma history
- Emphasize child and family outcomes, and promote data- and outcomes-driven decision-making
- Use workforce development as an implementation tool for evidence-based practices

Young children entering child welfare have high levels of developmental risk

Developmental Risks	Level of Child Welfare Involvement			Totals
	Out of Home	In Home Active CW Case	In Home No Active CW Case	
Language and Communication level				
0–2 years	6%	17%	10%	11%
3–5 years	15%	14%	17%	16%
Social Skills				
3–5 years	8%	7%	8%	8%
Developmental/Cognitive status				
0–2 years	27%	26%	33%	31%
3–5 years	14%	10%	17%	15%
Adaptive Behavior				
0–2 years	10%	6%	6%	6%
3–5 years	33%	13%	14%	15%
Behavioral Needs§				
2 years	56%	26%	22%	26%
3–5 years	39%	26%	33%	32%

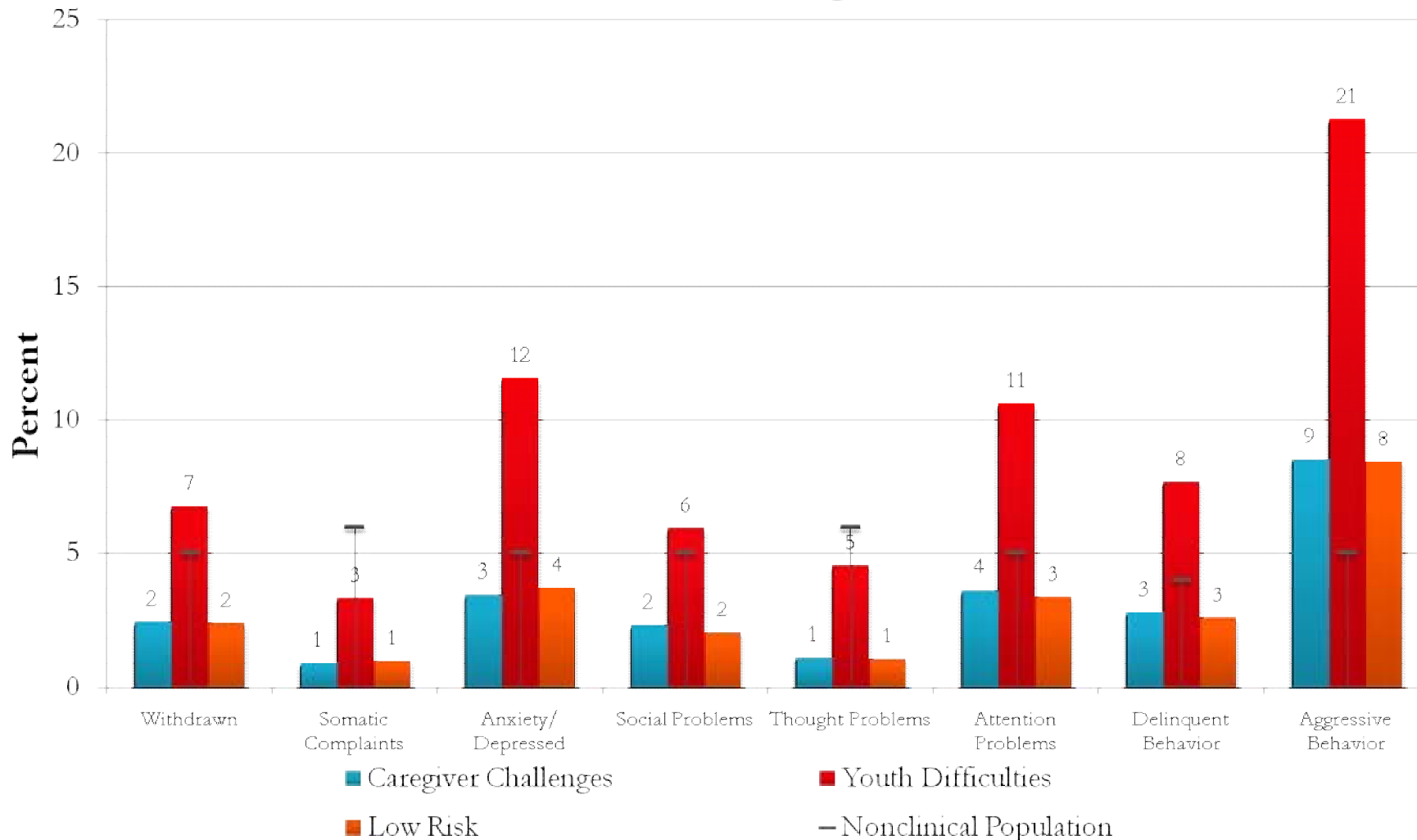
Children coming into contact with Child Welfare agencies frequently are at increased risk for poor developmental trajectories.

Specifically, 40% of infants and toddlers (0–2 years old) and 50% of preschoolers in this sample exhibited serious developmental and/or behavioral risk, with behavioral problems being the most common area of concern.

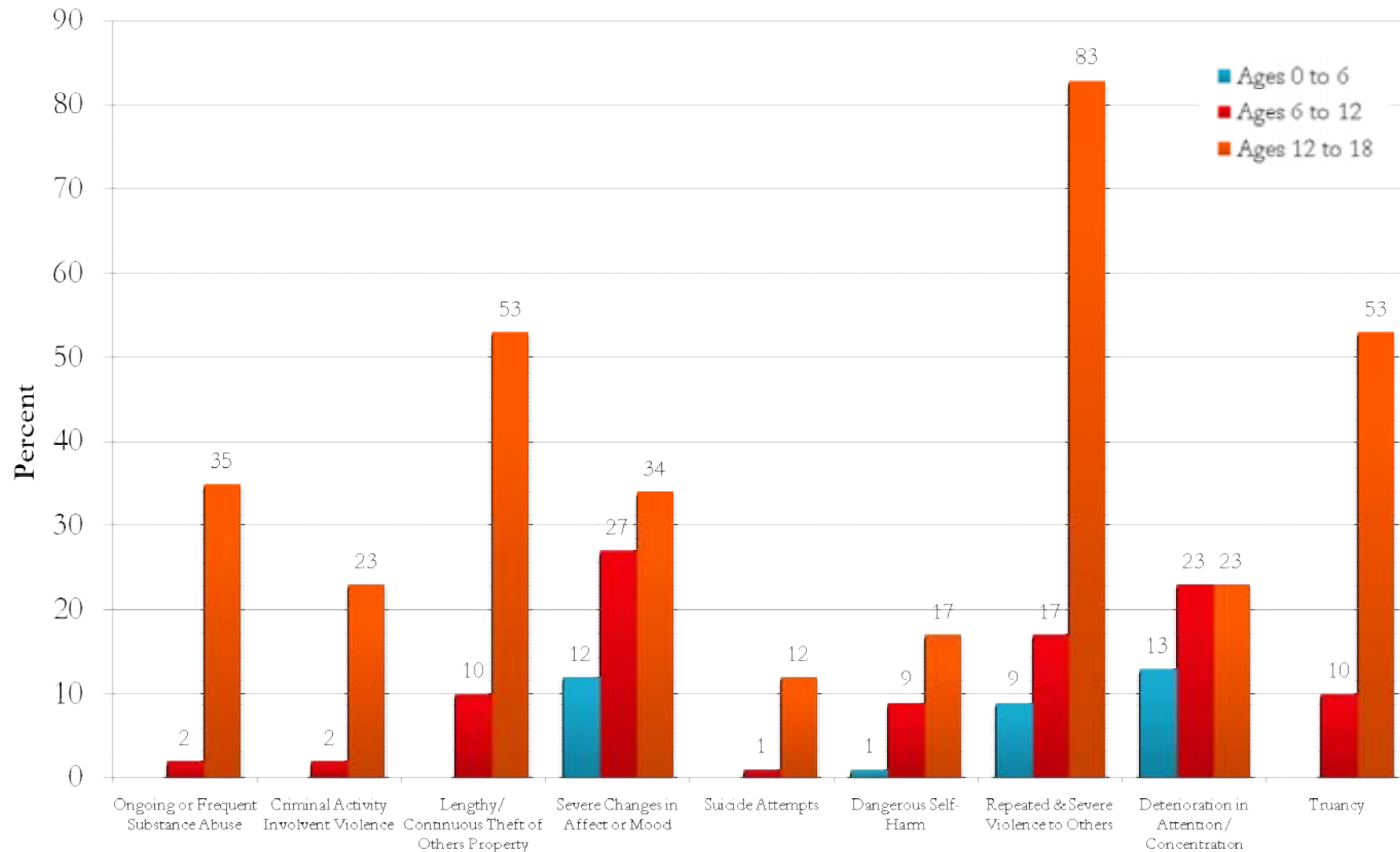
§ The CBCL 2-3 or CBCL 4-18 was used to assess behavioral issues. The CBCL is normed for children >2 years of age; therefore, children <2 years of age were not included in these analyses.

Youth involved with child welfare face social-emotional, behavioral, and cognitive challenges

Rates of Behavior Problems among Youth 11-16 in NSCAW

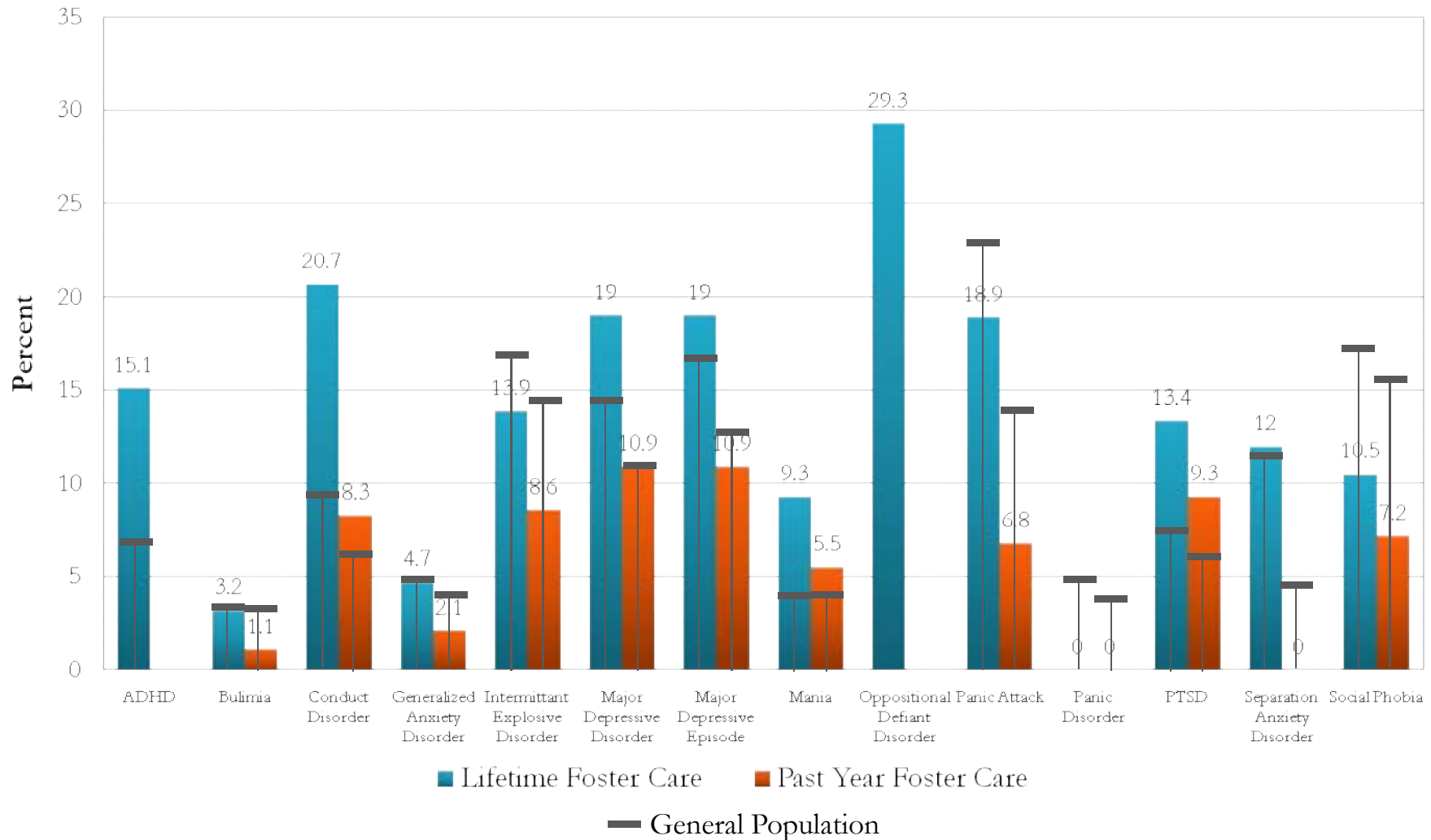


Behavioral sequelae of trauma manifest over time



Maltreatment has a distinct fingerprint on the mental health of young people

Mental Health Diagnoses among Youth 14-17



White, CR; Havalchak, A; Jackson, L; O'Brien, K; & Pecora, PJ. (2007). Mental Health, Ethnicity, Sexuality, and Spirituality among Youth in Foster Care: Findings from The Casey Field Office Mental Health Study. Casey Family Programs.

Mental health disorder prevalence is high among children who have been in foster care

Onset and Prevalence of Major Psychiatric Disorders for the Past Year, Lifetime, and Before Entrance into the Foster Care System (N=373)

Psychiatric Disorder	Lifetime			Past Year
	Ever	Before Foster Care Entry	Age at Onset	
Posttraumatic Stress Disorder (PTSD)	14%	42%	10.48	18%
Attention-Deficit/Hyperactivity Disorder (ADHD)	20%	75%	4.85	10%
Major Depression	27%	35%	11.82	18%
Conduct Disorder (CD) or Oppositional Defiant Disorder (ODD)	47%	57%	9.65	17%

Sample youth were 17 years-old and in care at the time of study. McMillan, CJ; et al. (2005). The prevalence of psychiatric disorders among older youths in the foster care system. Journal of the American Academy of Child and Adolescent Psychiatry. 44:88.

Who intervenes to address these issues?

- *The President's New Freedom Commission on Mental Health* (2003) identified a need for 30,000 additional child psychiatrists to address child behavioral health issues in the US – five times the number practicing at the timeⁱ
- Caseworkers – the primary service providers working with children and families in child welfare – do not typically address the social, emotional, and behavioral health needs of children, but rather provide general case managementⁱⁱ
- Overwhelming workload, minimal support, and a lack of expertise are cited as common reasons for child welfare workforce turnover^{ii, iii}
- A mismatch between job demands and available resources (autonomy, supervisory support, etc.) in child welfare leads to higher unmet expectations especially among practitioners early in their careers^{iv}

i. Achieving the promise: Transforming Mental Health in American, Final Report. (2003). DHHS Publication SMA-03-3832. New Freedom Commission on Mental Health.

ii. Williams, S, Nichols, QI, Kirk, A, & Wilson, T. (2011). "A recent look at the factors influencing workforce retention in public child welfare." *Children and Youth Services Review*. 33: 157.

iii. Chen, S, & Scannapieco, M. (2010). The influence of job satisfaction on child welfare worker's desire to stay: An examination of the interaction of self-efficacy and supportive supervision. *Child and Youth Services Review*. 32: 482.

iv. Hansung, K. (2011). Job conditions, unmet expectations, and burnout in public child welfare workers: How different from other social workers? *Children and Youth Services Review*. 33:358.

Summary

- How will we reach the next 25%?
 - Understanding the complex needs of these children-specifically in the areas of social-emotional, behavioral, and mental health-and their families
 - Targeting effective interventions that improve functioning and well-being towards children in child welfare
- What are the transformations required of the child welfare workforce to continue the progress of the last 13 years?
 - Enhanced understanding of the clinical characteristics of children in child welfare and the sequelae of trauma experiences
 - Increased competence in data- and outcomes-driven decision-making in practice
 - Development of general capacity in selecting, adopting, and implementing evidence-based practice
 - Substantive collaboration with mental health, physical health, education systems, and others