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Depression and Service Use Among Caregivers Dually Involved in the Child Welfare and Mental Health Systems

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Abstract

Introduction—The purpose of this study was to investigate the prevalence of depression, use of mental health services, and correlates of service use among caregivers who are dually involved in the child welfare and child mental health systems.

Methods—This study analyzed baseline data from 129 caregivers who reported child welfare system involvement and were participating in a Multiple Family Group service delivery model to reduce childhood disruptive behavior disorders.

Results—Seventy-eight (60.5%) of caregivers met or exceed the clinical-cut off for depression; of them 50 (64.1%) reported utilizing mental health services for their emotional health. Race, employment status, and CES-D score were significantly associated with lifetime mental health services use.

Discussion—Depression rates exceeded those found among caregiver involved in either the child welfare or child mental health systems. Rates of service use were higher than found in existing research. As expected, racial differences and depression were associated with service use; contrary to expectations, full time employment was not associated with service use. Discrepancies between this study and existing research are discussed, as are practice, policy, and research implications.

Keywords

Caregiver depression; child welfare; caregiver mental health; child mental health

1.1 Introduction

Caregivers involved with the child welfare system contend with multiple stressors that adversely impact their emotional health. In comparison to the general population, they disproportionately experience poverty, homelessness and inadequate housing (Fowler et al., 2013), interpersonal conflict and violence (Lewin & Abdrbo, 2009), and traumatic events (Chaffin & Bard, 2011; Marcenko, Lyons, & Courtney, 2011). Many lack social support and report feelings of isolation and elevated stress related to parenting (Chaffin & Bard, 2011). Compounding these issues is the stressful experience of being involved in the child welfare system, ensuing investigation, and in the most severe cases, the temporary or permanent removal of their child from the home (Wells & Marcenko, 2011).

Unsurprisingly, child welfare-involved caregivers, who are primarily mothers of color (Kohl et al., 2010) evidence extremely high rates of depression (Ayon, 2011; Bunger, Chuang, & McBeath, 2012; Estefan, Coulter, VandeWeerd, Armstrong, & Gorski, 2012; Kohl, Jonson-Reid, & Drake, 2011; Marcenko et al., 2011; Mustillo, Dorsey, Conover, & Burns, 2011). Prevalence rates range from 19% to 52% (Burns et al., 2010; Kohl et al., 2010; Marcenko et al., 2011; Mustillo et al., 2011), which are three to eight times higher than estimates of depression within the general adult population (Mustillo et al., 2011).

Depression impacts the health and wellbeing of the entire family. It increases the caregivers' risk for social, economic and work-related difficulties (e.g., reduced productivity, absenteeism), morbidity and premature mortality (Ballenger et al., 2001; Fawcett, 1993; Kessler, 2003; McTernan, Dollard, & LaMontagne, 2013; Reading & Reynolds, 2001). Their children experience academic, cognitive, behavioral, mental health, and peer-related difficulties from infancy through adolescence (Ashman, Dawson, & Panagiotides, 2008; Hair, McGroder, Zaslow, Ahluwalia, & Moore, 2002; Lewinsohn, Holm-Denoma, Small, Seeley, & Joiner, 2008; Riley et al., 2008; Rishel et al., 2006; Weissman et al., 2004). Among families who are part of the child welfare system, depression is associated with critical, harsh, and punitive parenting practices (Kohl et al., 2010, 2011; Lovejoy, Graczyk, O'Hare, & Neuman, 2000), child abuse and neglect (Bunger et al., 2012; Chaffin & Bard, 2011; Kohl et al., 2010; Thompson, Tabone, & Cook, 2012), and critically, loss of custody of their children (Park, Solomon, & Mandell, 2006).

Despite these costs, and even though caregivers may be mandated to receive treatment, most do not receive services (Bunger, Chuang, & McBeath, 2012; Lewin & Abdrbo, 2009). By example, one recent study found only 20.9% of caregivers with depression engaged in treatment for their emotional health three years post contact with the child welfare system (Burns et al., 2010). A recent qualitative study by Estefan et al. (2012) found substantial barriers to access, including transportation and financial difficulties, a lack of geographically accessible services, and difficulties with caseworkers (e.g., not being responsive to caregivers' needs or economic hardship) (Estefan et al., 2012). Related literature of service use among caregivers in general suggests service use is impeded because they fear losing custody of their children or being viewed as a bad parent if they seek care (Abrams, Dornig, & Curran, 2009; Swartz et al. 2008; Ward, Clark, & Heidrich, 2009). Women residing in low-income communities, especially those who identify as belonging to an ethnic minority

group, are particularly unlikely to seek mental health treatment because of these perceptual impediments (Anderson et al. 2006).

Collectively, this literature is informative for understanding the high rates of depression amongst these caregivers coupled with low rates of service use. The aim of the present study is to build upon this existing research by examining the continuity of depression and service access over time amongst child welfare-involved caregivers who participated in a multiple family group intervention for child behavioral problems. Specifically, we compare both the prevalence of depression and rates of service access amongst caregivers who reported current or prior child welfare involvement to caregivers with no reported child welfare involvement. The rationale for undertaking this study was to better understand patterns of depression and service use, and the connection between them, amongst a high-risk population from baseline (prior to the intervention) to six months following receipt of treatment for child behavioral problems.

In consideration of prior research, we hypothesized that rates of depression amongst child welfare-involved caregivers would be significantly higher than among caregivers who did not report involvement. We also theorized that service access would be low (e.g., comparable to rates of service use as found in Burns et al., 2010), and given the majority of persons with mental health illness do not receive services, no association between depression status and service use.

2.1. Methods

2.2 Overview

This study is a secondary data analysis of a sample of families who were enrolled in a National Institute of Mental Health (NIMH)-funded study of a Multiple Family Group model to reduce childhood disruptive behavior disorders (see Chacko et al., in press, for a description of this study). Institutional Review Board approval was obtained through the Mount Sinai School of Medicine.

2.2 Participants

Data analyzed for this study focuses on the 129 caregivers out of a total sample of 320 caregivers who participated in a child mental health intervention. The 129 caregivers were selected for inclusion in the current study because they reported child welfare involvement at intake. For the purposes of this study, child welfare involvement was defined as having a current or previous open child welfare case, ever having had a child placed in foster care, having been referred and/or mandated by a child welfare organization to bring their child to counseling or other services, or having sought services to receive full custody or avert child removal from the home. Aside from prior or current child welfare involvement, inclusion criteria were adults 18 years or older who spoke either English or Spanish and were the primary caregiver of a child between seven and 11 years of age who met symptom criteria for Opposition Defiant Disorder or Conduct Disorder measured by the IOWA Connors Rating Scale (Waschbusch & Willoughby, 2008).

Participants were excluded from the study if they manifested a significant cognitive impairment that would interfere with understanding of the informed consent process or program content, or who had emergency psychiatric needs requiring services beyond those provided within an outpatient setting. Participants were also excluded if children resided in foster care or their legal guardian could not provide formal consent.

As described in Table 1, caregivers were 35.9 years of age on average ($SD=8.38$), and primarily mothers (biological, step, adoptive; $n=114$, 90.7%). The majority of caregivers were Black/African American ($n = 48$, 37.2%) or Hispanic/Latino ($n = 60$, 46.5%) Almost half ($n=59$, 46%) were single, more than a third were unemployed ($n=48$, 37%), and most ($n=83$, 64%) reported an annual income of \$19,999 or less. Their child was 8.75 years of age on average ($SD=1.33$), primarily male ($n=84$, 65%), and either Hispanic/Latino ($n=52$, 40%) or Black/African American ($n=44$, 34%). Of the 129 who reported child welfare involvement, 52 (16%) reported current involvement (e.g., an open case or a child was placed in foster care) at the time of the study.

2.3 Procedure

Families were recruited from 13 urban child mental health clinics in the New York City metropolitan area between 2006–2010. Caregivers who expressed interest in learning more about the study were contacted by a member of the research staff, who described the study in more detail, determined eligibility, and obtained written informed consent. A total of 320 caregivers enrolled in the study. Data about depression and service use were collected at baseline (prior to the beginning of the Multiple Family Group intervention, mid-test (8 weeks into the group intervention), post-test, and six months receipt of treatment for child behavioral problems.

2.4 Measures

Demographic variables were collected via a general sociodemographic questionnaire used in prior studies that assessed familial factors (e.g., child and caregiver age, gender, race/ethnicity, and family income).

Depressive symptoms were measured by the Center for Epidemiologic Studies Depression Scale (CES- D) (Radloff, 1977). This free, publicly available screening tool consists of 20 items that addresses key symptoms of depression. Responses range from zero to three (experiencing symptoms none to most or all of the time) within the prior week. Items are summed for a score of 0–60, and a score of between 16 and 26 is used in the literature to indicate the presence of a mild depressive disorder, and 27 and greater is indicative of major depression (Zich et al.,1990). Split-half reliability and coefficient alpha are high in the general population (.85) (Radloff, 1977). A CES-D score of 16 or higher indicated clinical significant status. CES-D clinical status was measured at all four time-points (e.g., baseline, mid-test, post-test, and 6 month follow-up) indicated by a binary variable (1 = clinically significant, 0 = not clinically significant).

To measure service use, caregivers responded whether they had received mental health services for themselves (e.g., outpatient individual therapy, medication management,

substance abuse treatment, inpatient hospitalization, day treatment, residential treatment, case management, or a psychological/psychiatric evaluation) ever (at baseline) or since the last assessment point (for all other time-points). Caregivers responded “Yes” or “No” to this question. At baseline, this question referred to any mental health services caregivers might have received in their lifetime. At mid-test, post-test, and 6 month follow-up, this question referred to any mental health services caregivers may have received since their last assessment. At all four time-points, receipt of mental health services was indicated by binary variable (1 = received mental health services; 0 = did not receive mental health services).

2.5 Data Analysis

Analyses were conducted using the Stata Version 13 statistical software. Descriptive statistics were used to calculate overall CES-D means and percentages of caregivers ever receiving mental health services for the 129 caregivers who reported being involved in the child welfare system.

All variables were first examined for level of missing data. For the $n=129$ caregivers involved in child welfare services, all variables manifested less than 8% missing data. Descriptive statistics were used to calculate overall CES-D means and percentages of caregivers ever receiving mental health services for the 129 caregivers who reported being involved in the child welfare system. Next, bivariate analyses (Pearson's χ^2) were conducted to examine the relationship between CES-D clinical status and child welfare involvement at each of the four time-points. Finally, we conducted bivariate tests (Pearson's χ^2) to examine the relationship between CES-D clinical status and receipt of mental health services at each time-point, and by child welfare involvement.

3.1 Results

Close to two-thirds ($n=78$, 65.55%) of the 129 caregivers who reported prior or current involvement in the child welfare system met or exceeded the clinical cut-off on the CES-D for the presence of a depressive disorder; the mean baseline score was 27.05 ($SD=8.9$). As indicated in Table 2, child welfare involvement and CES-D clinical status were significantly associated only at baseline. A greater % of CW-involved parents (65.55%) reported clinical levels of baseline CESD scores than non-CW involved parents (53.33%).

As indicated in Table 3, CES-D clinical status was significantly associated with prior receipt of mental health services at all time-points except at mid-test and post-test among child welfare involved caregivers. At the same time, a substantial portion (ranging from 32.5% to 52.8%) of those child welfare involved caregivers with clinically significant CES-D scores reported not having received prior mental health services across all 4 time-points.

4.1 Discussion

This study aimed to examine the association between child welfare status, depression, and service use over time among caregivers involved in the child welfare system who participated in a treatment for child behavior problems. Understanding this association can assist in guiding the provision of resources and supports for child welfare-involved

caregivers at critical junctures in their emotional health in order to reduce or even prevent risks of untreated depression upon the family.

The first hypothesis, which posited rates of depression amongst child welfare-involved caregivers would be significantly higher than among caregivers who did not report involvement, was only partially supported, in that caregivers who were involved in the child welfare system evidenced significantly higher rates of depression at baseline only. That there was no significant difference in rates of depression between child welfare-involved caregivers and the rest of the sample at the other time-points may be an artifact of comparing two high-risk groups, as caregivers of youth with mental health problems also evidence high rates of depression in comparison to the general population of caregivers (Bailey et al., 2007; Ferro et al., 2000).

Nonetheless, the prevalence of depression among child welfare-involved caregivers exceeded prevalence rates found in previous studies; specifically, close to two-thirds of the sample met criteria for a depressive disorder, and the mean score as measured by the CES-D indicated severe symptoms. This result suggests caregivers who are involved in the child welfare system may represent a particularly vulnerable population. Considering between one-half to three-quarters of children who enter foster care are estimated to have mental health problems (Landsverk, Burns, Stambaugh, & Rolls Reutz, 2009), these findings could apply to a large segment of families.

We also theorized that few caregivers would be engaged in treatment for their emotional health (e.g., comparable to rates of service use as found in Burns et al., 2010). Contrary to this hypothesis, rates of service use were substantially higher than those found in existing literature (Bunger, Chuang, & McBeath, 2012; Burns et al., 2010; Lewin & Abdrbo, 2009). Specifically, over two-thirds of caregivers who met criteria for depression reported utilizing mental health services for their emotional health, exceeding service use estimates by three fold (Burns et al., 2010). Moreover, there was a significant relationship between meeting criteria for a depressive disorder and being engaged in services at baseline and six month follow-up, and at the other two time-points, this relationship approached significance. This finding is encouraging, as it suggests that caregivers in need of mental health services had engaged in treatment for their emotional health over the course of the study. This result may be due to a greater receptivity towards receipt of care amongst caregivers who are already engaged in the mental health system, albeit for their child, or perhaps their involvement in the child mental health system served as a gateway to mental health services. Alternately, caregivers may have been mandated to services and not been impinged by the barriers noted in the existing literature. In light of the disparities between this study and existing literature, future research is necessary to determine why this result was obtained.

All together, the findings of this study suggest the critical need to attend to the mental health needs of caregivers involved in the child welfare system. One way in which to enhance service provision for caregivers at risk is through interagency collaboration. As noted by Darlington, Feeney and Rixon (2005), benefits to these collaborations include enhancing continuity of care, cost savings, and decreasing out of home placements.

In order to meet this aim, both child welfare and mental health systems need to accommodate changes in policy and practice. The adult mental health system has been faulted for not considering the family unit or their clients' role as a parent with ensuing responsibilities (Darlington et al., 2005). Beyond integrating a focus on parenting, Estefan et al. (2012) states mental health services should be provided efficiently, maximizing family comfort and in accordance with their needs. In the child welfare system, Burns et al. (2010) suggests training caseworkers and child welfare providers on mental illness, reducing caseloads to give caseworkers the time to adequately address parental mental health needs, and forming liaisons in the mental health system.

Similarly, Darlington et al.'s (2005) qualitative study found child protection and mental health staff viewed the need for communication between the two entities as critical to enhance collaboration. Authors suggested organizational changes including (1) having both systems formulate guidelines for interagency interaction; (2) having a liaison in the other organization; (3) providing knowledge and training for mental health providers about abuse and neglect; (4) providing knowledge and training on mental health issues for child welfare staff; (5) reducing caseloads or adding staff to accommodate a focus on parental mental health needs; and (6) adding services to meet the demand.

A second way in which to respond to the mental health needs of caregivers is to better understand whether they would and have accessed additional supports and services beyond the traditional mental health system. As noted in the limitations section, caregivers may have interpreted service use to mean formal mental health services provided by a licensed professional. In order to best serve caregivers at high risk for depression, it is imperative to examine services that go beyond this narrow definition and utilization, particularly by different cultural groups. This area of inquiry could provide valuable information about how to serve diverse individuals with mental health problems.

4.2 Limitations

There are several limitations to this study. First, this study focused on a broad definition of child welfare involvement, and did not specify temporally whether caregivers were currently involved or had prior involvement. However, there are many variants of child welfare involvement (e.g., foster care, preventive services), and information on allegation subtypes and mandated status were not recorded in this study. Further, arguably current involvement would be more stressful than prior involvement. Type of involvement and current involvement may have implications for treatment access and are worth future examination.

Second, findings from the current study are limited to those families with children between the ages of 7–11 years old, as was specified by the intake criteria for the parent study (i.e., Family Groups for Urban Youth with Disruptive Behaviors study). And third, although we did not specify the type of provider that caregivers may have been seeing, it is possible that respondents interpreted this question about service use to mean formal mental health services delivered by a mental health professional such as a social worker, psychologist, or psychiatrist, and not considered other providers such as pastors or rabbis. Thus it is unclear whether the entire range of service use was captured by this question.

Nonetheless, this study builds upon the current literature through examination of the association between depression, service use, and child welfare involvement, and suggests the need for future investigation to better understand the pattern of depression and service access within this high-risk group over time.

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Table 1

Demographic Characteristics of Child Welfare involved Caregivers (n=129)

Characteristic	n	%
Race/Ethnicity:		
White/Caucasian	13	10.08
Black/African American	48	37.21
Hispanic/Latino	60	46.51
Other	8	6.2
Primary Caregiver:		
Mother	103	79.84
Father	4	3.1
Mother and Father	10	7.5
Grandparent	7	5.43
Other	4	3.1
Age (mean $\pm$ SD)	35.87 $\pm$ 8.38	
Caregiver Marital Status:		
Single	59	45.74
Married or Cohabitating	35	27.13
Divorced	8	6.2
Separated	21	16.28
Widowed	1	0.78
Other	3	2.33
Income		
Less than \$9,999	54	41.86
\$10,000–\$19,999	29	22.48
\$20,000 to \$29,999	21	16.28
\$30,000 to \$39,999	12	9.3
\$40,000 to \$49,999	4	3.1
Educational Status:		
8 th Grade or Less	7	5.43
Some High School	43	33.33
Completed H.S./G.E.D.	30	23.26
Some College	27	20.93
Completed College	13	10.08
Some Grad/Prof. School	2	1.55
Completed Grad/Prof. School	6	4.65
Employment Status:		
Employed Full-Time	22	17.05
Employed Part-Time	17	13.18
Student	11	8.53
Retired	4	3.1
Disabled	16	12.4

Characteristic	n	%
Unemployed	48	37.21
Other	8	6.2

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Table 2

Relationship between CESD clinical status and Child Welfare status over time

Variable		Non-CW involved (n = 191)		CW involved (n = 129)		χ^2	p
		n	% ^a	n	% ^b		
Baseline CESD Clinical Status (n = 289)	Clinically significant	91	53.53	78	65.55		
	Not Clinically significant	79	46.47	41	34.45	4.16	0.04*
Mid-test CESD Clinical Status (n = 224)	Clinically significant	67	51.54	49	52.13		
	Not Clinically significant	63	48.46	45	47.87	0.01	0.93
Post-test CESD Clinical Status (n = 245)	Clinically significant	72	49.32	61	61.62		
	Not Clinically significant	74	50.68	38	38.38	3.60	0.06 ⁺
6 month follow-up CESD Clinical status (n = 207)	Clinically significant	60	47.62	43	53.09		
	Not Clinically significant	66	52.38	38	46.91	0.60	0.44

Note. CESD = Center for Epidemiological Studies Depression Scale; CW = Child Welfare

^a% of all non-CW involved caregivers

^b% of all CW involved caregivers

⁺ p < 0.10;

* p < 0.05;

** p < 0.01

Relationship between CESD clinical status and prior receipt of mental health services over time, by child welfare status

Table 3

Variable		Has not Received Mental Health Services (previously or since last assessment)		Received Mental Health Services (previously or since last assessment)		χ^2
		n	% ^a	n	% ^a	
Total sample	Baseline CESD Clinical Status (n = 288)	84	52.83	35	27.13	19.40**
	Clinical significant	75	47.17	94	72.87	
Not CW involved	Baseline CESD Clinical Status (n = 169)	59	55.66	19	30.16	10.56**
	Clinical significant	47	44.34	44	69.84	
CW involved	Baseline CESD Clinical Status (n = 119)	25	47.17	16	24.24	6.86*
	Clinical significant	28	52.83	50	75.76	
Total sample	Mid-test CESD Clinical Status (n = 218)	89	58.55	17	25.26	19.81**
	Clinical significant	63	41.45	49	74.24	
Not CW involved	Mid-test CESD Clinical Status (n = 126)	55	61.11	7	19.44	17.86**
	Clinical significant	35	38.89	29	80.56	
CW involved	Mid-test CESD Clinical Status (n = 92)	34	54.84	10	33.33	3.75 ⁺
	Clinical significant	28	45.16	20	66.67	
Total sample	Post-test CESD Clinical Status (n = 241)	84	55.63	26	28.89	16.25**
	Clinical significant	67	44.37	64	71.11	
Not CW involved	Post-test CESD Clinical Status (n = 142)	59	60.20	13	29.55	11.42**
	Clinical significant	39	39.80	31	70.45	
CW involved	Post-test CESD Clinical Status (n = 99)	25	47.17	13	28.86	3.72 ⁺
	Clinical significant	28	52.83	33	71.74	

Note. CESD = Center for Epidemiological Studies Depression Scale; CW = Child Welfare

^a% of Receipt of Mental Health Services status

⁺ p < 0.10;

* p < 0.05;

** p < 0.01