"They Think You Are a Magician—That I Could Just Pull a Rabbit out of a Hat"

An exploration of the barriers that prevent girls in the Cook County foster care system from receiving adequate mental health care and how to eliminate them.

By

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Abstract

Girls in foster care have poorer mental health outcomes than boys in care. Gender-specific barriers to effective mental health care have been seldom identified in current literature. This thesis seeks to explore these barriers through interviews with six caseworkers in the Cook County foster care system. Through these interviews, themes of barriers relating to resources, provider quality, youth in care, and caregivers emerged. This paper proposes several reforms for the Illinois Department of Child and Family Services and outlines an integrated-services model for a third party not-for-profit organization to mitigate barriers to girls' mental health care and improve the quality of care that girls receive.

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Introduction

According to the National Conference of State Legislatures (NSCL), 80% of children in

the foster care system suffer from significant mental health issues. In contrast, only 18-22% of

the general population experiences issues with their mental health. Looking further into this

statistic, the NSCL states that 21.5% of foster care alumni have Post-Traumatic Stress Disorder

compared to 4.5% of the general population, 15.3% of foster care alumni have major depressive

episodes compared to 10.6% of the general population, and 2.9% of foster children suffer from

bulimia compared to 0.4% of the population. In fact, the NSCL reports that every mental illness

is more prevalent in foster care alumni than in the general adult population (Mental Health and

Foster Care).

Following their emancipation from foster care, children in care are often extremely

disadvantaged. A study published by the American Academy of Pediatrics reported that of those

individuals who spent time in foster care, between 19-37% are unemployed, 33% live at or

below the poverty level, 33-50% lack health insurance, 22-36% were homeless, and only 16%

completed postsecondary education (Szilagyi et al. 1146). The evidence suggests a clear link

between untreated mental health issues and the negative outcomes that many foster children face

once they leave the foster care system. This can be further broken down by gender. Current

research seldom discusses the barriers to mental health care that girls face specifically due to

their gender, but some research has shown that boys in foster care received more outpatient visits

than did girls in foster care (Villegas and Pecora 1454). Additional research has shown that certain mental illnesses have often been less likely to be identified in girls which has led to a lack of treatment for these illnesses (Zima et al. 283).

Despite a lack of current research on the role gender plays in the barriers to care that are experienced by girls in the foster care system, there is evidence that gender plays an important role in children's outcomes. Research has shown that girls are uniquely vulnerable to certain mental health outcomes and challenges. For example, one study found that girls in the foster care system were less likely than boys to have positive peer relations and struggled more with behavioral issues (Leve et al. 7). Women who spent time in foster care have been shown to experience more mental health issues than women who never experienced out of home placement. Additionally, girls who spent time in the foster care system have been shown to have worse mental outcomes than boys (Schneider et al. 443, Villegas and Pecora 1454). At the very least, it seems that gender plays a factor in the challenges that girls in foster care face. Children in care represent a vulnerable population that is under the supervision and care of the state, therefore the state should do everything in its power to ensure that these girls are receiving the most effective mental health care available. However, the state is currently not fulfilling this role.

I define mental health care as counseling, psychiatric care, and miscellaneous mental health treatment because this is what the Office of The Cook County Public Guardian states that the Department of Child and Family Services (henceforth referred to as DCFS) is required to provide for children in foster care ("Foster Youth Mental Health & Education"). As the Illinois DCFS indicates that children have access to both inpatient and outpatient care, I am considering both of these types of care to be a part of my definition ("Health Services" 15, 18).

I seek to understand what barriers there are to girls receiving mental health care in Cook County, and how these barriers are tied to girls' gender. I am limiting my scope to Cook County because of my own resources, and only interviewed caseworkers from one DCFS office on the South Side of Chicago. I am applying my data as generalizable to the rest of Cook County, as the budget and demographics of children in care are likely similar throughout the region. However, future research into Cook County could delve deeper into different DCFS offices in order to potentially find nuances in the barriers that individual offices face.

Additionally, these results could potentially be generalized to other DCFS offices across the country. First, these results from Cook County could likely be applied to other DCFS offices in urban areas that are similar to Cook County in terms of budget and resources, number of children served, number of DCFS employees, and child-to-caseworker ratios. Secondly, in terms of demographics, 71.63% of girls in the Cook County foster care system are African American, 14.34% are Hispanic, and 13.04% are white ("Reports and Statistics"). The results of my study could be applied to cities that have similar demographics of girls in foster care.

To conduct my study, I interviewed social workers in Cook County about the current process through which a girl in the foster care system receives mental health care, identifying barriers each step of the way. I chose to exclusively interview social workers because my goal is to recommend a policy that will improve the way in which DCFS delivers care. By interviewing caseworkers, I gained insight into what those who are most directly responsible for providing care have found to be the most common barriers to girls receiving mental health services. This provided the framework for me to propose several policies that would allow DCFS to improve the care that girls receive.

I am proposing a third party, not-for profit organization that would operate independent of DCFS as a supplement to the services that DCFS already provides. Such an organization, through integrated services, would be best suited to provide a way to overcome many of the barriers expressed by social workers without requiring that DCFS seek additional funding or hire more employees. The evidence suggests that this organization would connect the greatest number of girls with the most consistent mental health care possible, especially girls with mental health issues that may not be easily identifiable. This organization will help foster parents better identify their foster children's mental health issues. Additionally, I am recommending several reforms within DCFS that would improve girls' access to care. Something must be done to ensure that girls in foster care are receiving the mental health care that they so desperately need. Many former foster children are struggling financially or living in some form of poverty after emancipation, and this has a detrimental impact on society as a whole as national resources must be diverted to these individuals through welfare and other programs. Additionally, the potential that many of these children have to be successful adults is lost when they are unable to find stability after their time in care. Improving mental health care for children in foster care would have a positive impact on all of society.

Beyond societal benefits, it is imperative that the state care effectively for girls under its jurisdiction. When the state removes a child from her home, the state is taking on the role of that child's parent. If the state is going to take on this responsibility, then the state should be acting as a parent would. The state should be the child's fiercest advocate and her greatest support system. The state should be not only providing girls with mental health care, but also working to ensure that each and every girl in foster care is getting the best mental health care possible. The state has an obligation to girls in foster care, and currently this obligation is not being given the attention it

deserves. Through my research, I hope to show the extent to which the needs of girls in foster care are not being met, and argue that without a massive increase in budget, DCFS would be unable to effectively remedy their provision of mental health care. With this in mind, I recommend supplementing DCFS with a third-party organization rather than increasing the burden on DCFS to connect girls with mental health resources. Along with several potential reforms to DCFS, this third-party organization would be the best way to better serve girls in the Cook County Foster care system and potentially girls in foster care across the country.

Policy Review

Current Policy

According to the office of the Cook County Public Guardian, youth in DCFS foster care have the right to receive mental health services, specifically "a right to receive counseling, psychiatric care, or other mental health treatment. DCFS must provide these services for you" ("Foster Youth Mental Health & Education").

There is policy in place that outlines the way in which children in the foster care system receive access to mental health care. Illinois DCFS developed the HealthWorks with the intent to ensure that children have "access to quality health care; routine and special health care they need; and documentation of health needs and care readily available to foster caregivers, other health care providers and DCFS" ("Health Services" 1). HealthWorks is run by DCFS, the Department of Healthcare and Family Services, and the Department of Human Services. All children involved in the foster care system are required to be enrolled in HealthWorks ("Health Services" 1).

Through HealthWorks, a child who enters into foster care must be taken for an Initial Health Screening within 24 hours of entering the foster care system, but this screening does not include a mental health screening. Within 21 days, the child must be taken for a Comprehensive Health Evaluation with a primary care physician. This does include a screening by a mental health professional, and there is no indication that screenings occur throughout a child's time in foster care ("Health Services" 7).

In terms of specific mental health services, HealthWorks states that in order for caseworkers to determine what services children need, children are given certain behavior and mental health screenings. Foster parents can specifically request counseling for their foster children, and this service is provided by private agencies. However, it is possible that a request for counseling or a mental health assessment can be denied by a caseworker. If this occurs, families can file an appeal ("Health Services" 15,16). Youth can also request therapy themselves, and social workers can also make the decision to refer their clients to a caseworker ("Foster Youth Mental Health & Education").

SASS (Screening Assessment, and Support Services) exists for children who "appear ready to harm themselves or others" ("Health Services" 17). This screening is geared toward crisis intervention and subsequently providing children experiencing a mental health crisis with ongoing care. This screening can also lead to children being admitted to inpatient care ("Health Services" 17). This screening is only for children in crisis, and children with less severe mental health issues are not included. Current DCFS policy regarding mental health makes clear that children in care should be receiving mental health resources, and yet research shows that a high volume of girls in care are still struggling with mental illness. My research will attempt to understand what barriers to mental health care are creating this discrepancy.

The Success of Supplemental Third-Party Organizations

Operating independently of the state, third party organizations have had past success in providing services to children within the child welfare system, especially when working collaboratively with communities and public sector organizations. In 1997, Elizabeth A. Mulroy discussed the findings from an organizational analysis of Dorchester CARES, an initiative in Massachusetts through which a nonprofit children's advocacy organization joined with a federation of neighborhood housing settlement houses in order in order to achieve the coals of "coordination, advocacy, resources, education, and services" in order to prevent child abuse and neglect (Mulroy 257). Although the initiative faced growing pains, Mulroy reports that collaboration between multiple nonprofit organizations, community members, and the public sector "can be used to produce a systemic neighborhood service network that engages residents in joint action, fosters close cooperation among different service agencies (Hadley, 199), and develops new programs that meet more community needs than one agency could do alone" (Mulroy 263). The findings from this initiative indicate that third party organizations can be demonstratively successful, especially when they collaborate and work with communities, other nonprofits, and the agencies currently in place.

Urban Peak is more recent example of a nonprofit service-provision organization that collaborates with various stakeholders from the public and private sector, although this program utilizes neighborhood and community intervention less prominently than DorchesterCARES. Urban Peak is Colorado's sole licensed homeless and runaway youth shelter. Jamie Van Leeuwen describes the success of this organization which has been achieved through its three housing programs that assist youth who are aging out of the child welfare system. Through three different programs that partner with multiple public and private agencies as well as nonprofit

organizations, Urban Peak was able to expand its housing units and 60% of youth who participated in Urban Peak's housing programs were able to find stable housing off of the streets (Van Leeuwen 463). Van Leeuwen concludes that through "strategic collaborations between the nonprofit, private, and public sectors," it is possible for Urban Peak to find innovative ways to assist homeless youth and provide them with housing" (Van Leeuwen 466). This further indicates that third party organizations can successfully provide services, especially when they collaborate with other organizations from all sectors.

Tennessee Voices for Children (TVC) is an organization that, similarly to Dorchester CARES and Urban Peak, brings together government and third-party resources in order to provide services. Unlike these organizations, TVC is focused specifically on children's welfare, and perhaps most extensively involves the community and family in child welfare. In 2007, Elizabeth Pufahl described TVC's successful provision of services to children and families in order to avoid state custody for children with serious emotional or behavioral problems. Due to what its founders believed to be a need for integrated child mental health services, TVC was founded in 1986 and operates on a system of care philosophy, "recognizing that strengthening an individual, community-based system of support is ideal to serving youth with mental health diagnoses and emphasizing parents and family members as integral parts of the service at all levels" (Pufahl 79). TVC collaborated with the Tennessee Department of Children's Services to create a program that enrolls families for four to six months with a Child and Family Team which consists of the child, their family members, a Behavioral Specialist, a Family Support Provider, and other individuals from the community who may be able to provide support. This team is chosen by the child and the family and seeks to "build strong foundations at the community level and service coordination at the child and family level" (Pufahl 85). The team

then creates an Individual Service Plan that is unique to the child and the family (Pufahl 86).

This program has seen success, as it served almost 130 children by the end of 2006 and had a

90% success rate of keeping children in their current placement, as only 13 children were

transferred out of their home placements (Pufahl 87). Additionally, Pufahl found that child

welfare employees were more open to seeing parents and caregivers as part of the solution

instead of part of the problem, were more willing to pursue nontraditional options for children's

services, and began to see children more individually, considering their individual needs instead

of "lumping children together based on a diagnosis or reason for custody" (Pufahl 87). As seen

through the success of this program, it is possible for third party, nonprofit organizations to

provide services that effectively address the mental health needs of children without placing

additional responsibilities on the state.

Literature Review

The Need for Mental Health Services Amongst Foster Children

The intersection between mental health and the foster care system is a complicated one,

and has been addressed so far in a small body of literature. It has been shown that children in

foster care are very likely to need mental health resources. A study by Sullivan and van Zyl in

2007 found that 44.01% of foster children were diagnosed with an emotional need. This study

also found that the longer a child was in foster care, the more likely they were to be diagnosed

with an emotional need, with 75% of children who had been in care for more than 40 months

being diagnosed (Sullivan and van Zyl 782). Although this study does not discuss gender, it does

show that in foster care very clearly need substantial access to mental health resources.

Additionally, it has been shown that children in foster care receive more mental health care services than children not in foster care. In a 2006 study, Becker, Jordan, and Larsen found that children in foster care were twice as likely to be receiving mental health care services than were children outside of the system. Thirty-four percent of children in foster care received individual or family counseling, in contrast to 12% of non-foster care children (Becker et al. 279, 280). While this study does discuss service use by foster children, it does not analyze the ways in which service use differs between boys and girls in the foster care system.

Lack of Mental Health Care Relative to Need

While there is a clear need that children in foster care have for mental health services, there are several studies that indicate that many foster children with mental health issues are not receiving care, and those who do get mental health services often receive care that is insufficient in treating their mental illnesses effectively. In 2004, Burns et al. found that although a 2000 survey of welfare agencies indicated that 814,300 children had need for mental health services but only 192,185 children were actually getting services (Burns et al. 966). Although this study is somewhat out of date, it still seems to be significant as it portrays a gap that is so wide it seems unlikely that it has been closed in recent years. Additionally, this study is referenced by many current studies, and its findings are echoed by a 2010 study by Raghavan et al. Raghavan et al. consider how children in the foster care are not receiving care that is consistent with the standards put forward in the 1997 Adoption and Safe Families Act. They found that only half of children involved in the child welfare system receive care within at least 1 index of the national standard, and only 1 in 10 children received care that met all the standards set forth (Raghavan et

al. 746). It is clear that children in the foster care system are not receiving sufficient mental health care, or receiving any mental health care at all, despite significant need.

The Importance of the Continuity of Care

There is a need for girls in foster care to actually receive mental health care, and for mental health care to sufficiently address these girls' needs. An important component of effective mental health care is continuity, and research has shown that continuity of care is important for youth in the foster care system. Fontanella, Gupta, Hiance-Steelsmith, and Valentine studied youth with "serious emotional disturbances," focusing on bipolar disorder, psychosis, and schizophrenia (Fontanella et al. 38). They write that for these children, "high-quality care requires access to comprehensive mental health assessment and an array of both acute and long-term care, and extensive coordination across funding sources, medical and non-medical providers, and service delivery systems" (Fontanella et al. 39). They found that in their sample, more than half of children in the foster care system were not receiving monthly care. Although gender was not the purpose of their study, they found that male youth were more likely to receive care than were female youth (Fontanella et al. 42). Continuity of care is important for foster children, and yet many are not receiving continuous services.

However, it is not just children who experience severe mental illnesses that can benefit from consistency in mental health services. Ruff, Aguilar, and Clausen found in 2016 that early mental health interventions with infants and very young children in foster care were linked to a decrease in symptoms of depression, anxiety, dissociative symptoms, self-injurious behavior, sleep problems, and more (Ruff et al. 193). Evidence suggests that no matter what the disorder, children benefit from long-term and consistent mental health care. Therefore, it is important to

study how children are receiving care, and to what extent they are receiving it, as continuously provided care has important impact on their outcomes once they exit the foster care system.

Caregivers' Impact on Care

Along with continuity, caregivers' behavior and mindsets strongly impact the success of a child's mental health care. Existing studies show that the caregivers that a foster child is placed with have a major impact on the way in which children receive mental health care. One way in which this is evident is the difference between kin and non-kin caregivers. In 2000, Leslie, Landsverk, Ezzet-Lofstrom, Tschann, Slymen, and Garland found that only 11.1% of children in kinship care received outpatient mental health visits in contrast to 50.7% of children with non-kin foster parents (Leslie et al. 471). Although this study was conducted eighteen years ago, the idea that foster parents influence the extent to which children in their care receive care is echoed in more recent studies.

The extent to which that a child's mental illness impacts the caregiver can also influence how that child receives care. A study by Margarita Villagrana in 2010 considered birth parents, foster parents, and relative caregivers. Villagrana found that across all types of caregivers, these caregivers were more likely to seek mental health care for children if the children presented external behaviors indicative of a mental health problem. They were also more likely to seek care if the children in their care had impaired social functioning and exhibited aggressive behavior. Finally, caregivers' stress levels correlated with how likely they were to seek mental health care for children, as caregivers who were more stressed were more likely to seek care (Villagrana 695). With this in mind, it seems that children who experience mental illnesses that do not

present clear symptoms and whose mental illnesses do not have a strong impact on caregivers'

daily lives may not be receiving the care that they need.

Foster Care Outcomes for Girls Specifically

While the previously discussed studies provide valuable insight into mental health care

for foster children, what a significant portion of existing data seems to lack is a detailed analysis

of how gender plays a role in foster children receiving services. However, gender has been

shown by a limited number of studies to be an extremely important factor in foster children's

mental health. In one study, Leve, Fisher, and DeGarmo found that girls in the foster system

were significantly more likely to have poor peer relations than were boys, and there was a strong

relationship between foster care and behavior problems for girls but not for boys (Leve et al. 7).

Although this study did not specifically address mental health, mental health was factored into

the study, and it seems that it would be valuable to continue to address gender as an important

factor in foster care outcomes. There is also evidence that girls in the foster care system

experience mental health challenges that are gender-specific in terms of outcomes, receipt of

treatment, and even the type of mental illnesses they have.

In terms of mental health, studies have shown that the outcomes of girls exiting the foster

care system are linked to their gender. A study by Schneider et. al showed that compared to

women who never experienced an out of home placement, women who spent time in foster care

often face a large number of mental health challenges in the long term (Schneider et al. 443).

Boys in the foster care system have better mental health outcomes than girls do. A 2012 study by

Villegas and Pecora found that boys were almost twice as likely as girls to have a successful

mental health outcome (Villegas and Pecora 1453).

Gender also plays a role in how girls are receiving treatment. Leslie et. al found that boys received more outpatient mental visits than did girls (Leslie et al., 2000 472). A study by Zima et al. in 2000 showed that girls in the foster care system were less likely than boys to be perceived as suffering from ADHD, which played a role in their lack of care that they received in this area (Zima et al. 283). It is important to note, however, that both of these studies are from 2000 and therefore may be slightly outdated.

Finally, although all children may experience the same mental illnesses, the frequency with which particular mental illness presents themselves can be very different between girls and boys. For example, Jackson, O'Brien, and Pecora found in a study of foster care alumni that 30.6% of women had experienced PTSD in the year preceding study, compared to 11% of men (Jackson et al. 81). Additionally, Courtney and Dworsky found that alcohol and substance abuse were more common among boys who had graduated from the foster care system, while major depression and PTSD were more common among female alumni (Courtney and Dworsky 215). From the evidence, it is clear that the mental health issues faced by girls in foster care are not independent of their gender.

The experiences of boys and girls in foster care are not the same, and they do not lead to the same outcomes. While current studies do indicate disparities between men and woman, they do not specifically focus on what barriers are specifically in existence that lead to these different outcomes, and I hope to address gender-specific barriers in my research. It is a mistake to treat gender as a factor that can be ignored or controlled for in such studies. Girls and boys must be treated as very separate demographic groups, as I have attempted to do in the following research and analysis.

Methodology

After considering current literature, I conducted the following study in order to identify barriers to girls' effective mental health care in the foster care system.

Interviews

In order to study the barriers to mental health care in the foster care system I interviewed caseworkers, because these are the individuals who are the main point of contact that a child in foster care has to the state. In many ways, caseworkers are the gatekeepers to children receiving mental health resources as they are the ones who make the recommendations that a child receive mental health care and they are the ones responsible for ensuring that a child is getting the care that they recommend. I designed a series of questions to ask these individuals about their individual experiences and how they have personally experienced the barriers to girls receiving care. I hoped to discover if barriers were standard across different individuals' experiences, and if so, what barriers were the most common. If barriers were not standard, I hoped to discover in what ways they differed.

The only criteria for selection in my study was that the subject has worked as a social worker in the Cook County foster care system. I contacted these individuals by calling each office individually using a standard script and asking for the contact information of social workers. I then emailed individual social workers to invite them to participate in an interview for my study.

I conducted twelve individual interviews. Interviews were between thirty minutes to an hour in length. I recorded interviews using technology on my cell phone with the permission of interviewees. I also took notes during the interviews. Interviewees were asked the following questions:

1. How long have you been a social worker in the foster care system?

2. About how many cases would you say you process a year?

3. About how many of those cases are girls?

4. Do you feel that girls face any unique challenges in the foster care system?

5. Are there any mental health issues that you see more frequently amongst girls?

6. What training did you undergo that specifically dealt with the issues faced by girls in foster care?

7. Describe the process through which a girl in the foster care system receives mental health care, beginning from the identification of a need to your connecting a girl with mental health professionals.

8. How do you ensure that girls who need mental health care are getting those resources?

9. What are the challenges in getting girls the mental health care that they need?

10. What are the circumstances under which you most frequently see girls not getting the care that they need?

11. Do you find that you see continuity in mental health care (i.e., are girls going to care consistently, are they seeing the same medical professionals over time)? If not, what do you see instead? Why do you think this is?

12. What systematic changes or supports do you think would help you be more effective in connecting girls with mental health resources?

Transcription and Coding

Interviews were transcribed and any identifying personal information was removed from each transcript in order to preserve privacy. After the interviews were transcribed and labeled, interviews were then coded. I looked for certain themes in the interviews based on the literature

review I compiled. With a general idea of what I might be looking to identify in mind, I analyzed

the interviews and drew the following themes (codes) from the interview data.

Code Identifier	Description
Financial	Any time a caseworker mentioned barriers to mental health care that were based on financial limitations, their statements were coded as financial. Financial limitations include a general lack of funding, needs that go beyond what DCFS has the capacity to pay for, or needs that were deemed to minor to warrant the use of funding.
Turnover	Any time a caseworker mentioned barriers to mental health care that were caused by youth experiencing inconsistency and variability in their caseworkers, parents, or mental health professionals, their statements were coded as turnover.
Training	Any time a caseworker mentioned barriers to mental health care that were caused by their own lack of training, or the lack of training of a therapist, their statements were coded as training. Training relates to social workers' training that was specifically focused on girls' mental health needs, training on mental health needs in general, and training related to the identification of mental health issues and how to respond to them. For this code to be selected, training must be explicitly mentioned.
Capacity	Any time a social worker mentioned barriers to mental health care that were caused by too many children being assigned to one social worker, or more children needing mental health care than there are available mental health professionals, their statements were coded as capacity.

Caregiver	Any time a caseworker mentioned barriers to mental health care that were caused by the child's foster parent caregivers themselves, their statements were coded as caregivers. This includes caregivers being unable to identify their foster child's needs in order to communicate these needs with social workers, or caregivers being unable/unwilling to ensure that the child in their care is actively receiving the services to which they have been referred.
Youth	Any time a caseworker mentioned barriers to mental health care that were due to the youth themselves, their statements were coded as youth. This includes youth refusing to participate in treatment or not engaging in the treatment to which they have been referred.
Identification	Any time a caseworker mentioned barriers to mental health care that were due to their inability to identify a girl's mental health issue or the inability to identify what would be the most effective course of treatment, their statements were coded as identification.

Table 1

Once data was coded, data was sorted based on the most frequently identified codes.

These results are presented and analyzed in the following section of this paper.
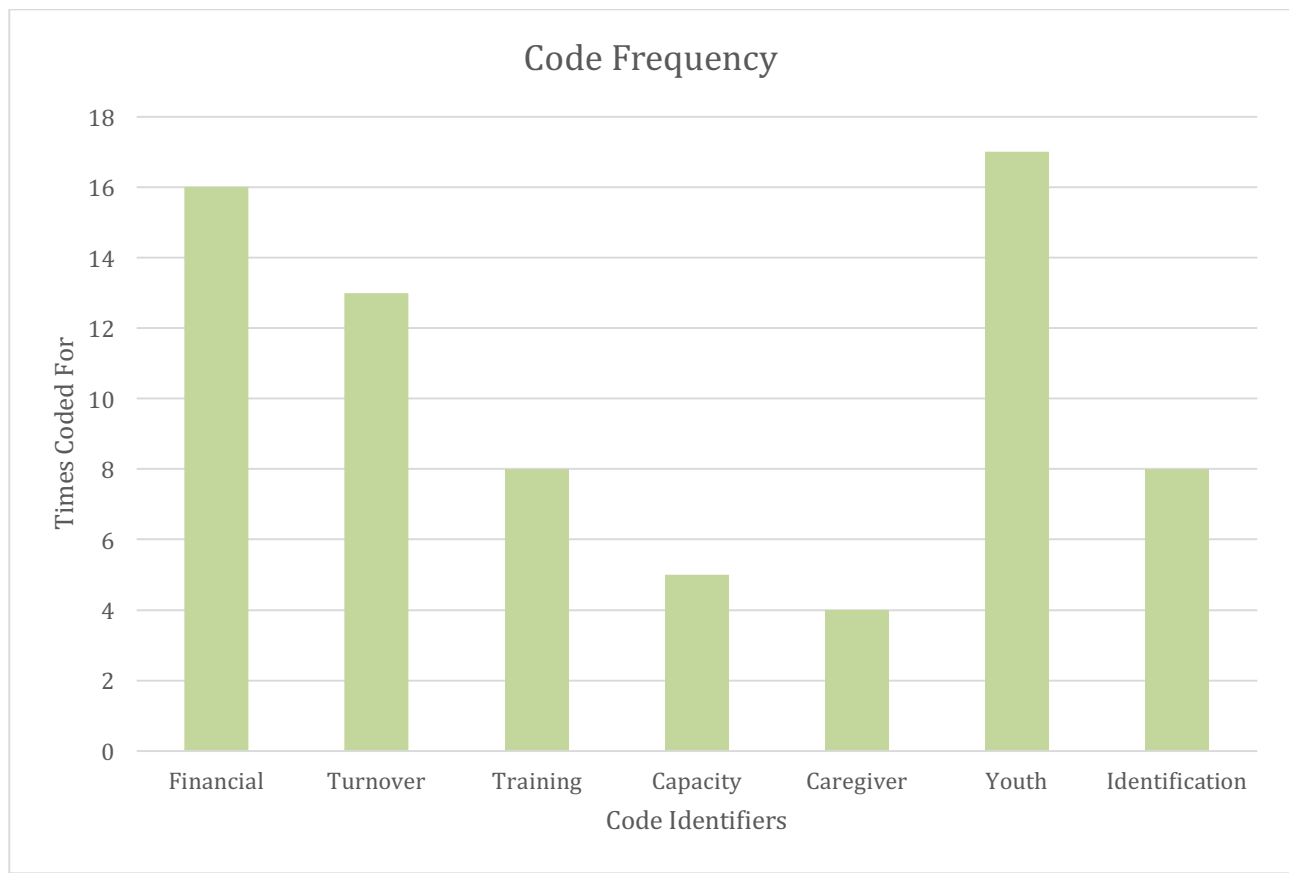
<u>**Results**</u>

Before discussing the frequency of each code, it is important to discuss the demographics

of the caseworkers that I interviewed. I interviewed six caseworkers at a single Child and Family

Services office on the South Side of Chicago. These six workers displayed much of the diversity

that there is in the casework profession. Caseworker 1 is a former caseworker who now serves in

an administrative position and has a Masters in Social Work and is a woman of color.

Caseworker 2 is a caseworker who has severed as a caseworker for less than 5 years, and is a

woman of color. Caseworker 3 has been a caseworker for around 20 years and is a white woman. Caseworker 4 been a caseworker for around 20 years, has a Masters in Social Work, serves on a committee in DCFS that investigates racial disparities in the child welfare system, holds a position managing other caseworkers, and is a man of color. Caseworker 5 has been a caseworker for around 20 years, has an MSW, and is a woman of color. Caseworker 6 is a woman of color who has been a caseworker for around 20 years and holds a Bachelor in Psychology. Initially when creating my study, I did not intend to consider caseworker demographics. However, as I conducted my interviews I began to see that demographics and experience influenced the perspective of each caseworker. There were themes expressed amongst all caseworkers, but some themes and ideas seemed to be tied to experience and demographics. With this in mind, I am considering how each caseworker's individual experience plays a role in what they discussed in their interviews

Figure 1 depicts how frequently each of the codes I identified were expressed. It is essential to note that just because a code was expressed most frequently does not mean that I am considering it to be most important, as the issues coded for are complex and cannot be distilled down in this way. This will be discussed further in the analysis section of this paper. However, Figure 1 can be referenced for general sense of what caseworkers spoke about most frequently.

Figure 1

<u>**Analysis**</u>

      Looking at the coded data broadly, it becomes clear that certain caseworkers were more inclined to identify gender-specific barriers than were others. Caseworkers 1, 2, and 4 were much more likely to discuss gender than Caseworkers 3, 5, and 6. Caseworker 3, although ceding that girls are more likely to be diagnosed with Bipolar Disorder than boys are, stated that "I think mental health issues go all the way across the board. I don't think it's necessarily more girls than boys…I don't see any challenge in [getting mental health care for] girls more than with the boys." Caseworker 5 identified that girls are more likely than boys to engage at all in talk therapy, but beyond this expressed similar ideas to Caseworker 3 and was less inclined to identify gender-specific barriers to getting girls mental health care. While this could be for

various reasons, and my scope is limited to the six interviews I conducted, I noted that

Caseworkers 3 and 5 were older than Caseworkers 1, 2, and 4. As the language and culture

surrounding mental health has changed greatly over the past ten to fifteen years, I hypothesize

that the difference in the way these caseworkers discussed mental health may be due to different

generational understandings of mental illness. It would be beneficial for future research to

consider age and generation when considering caseworker perspective on these issues.

Another possible reason for the difference in how caseworkers identified gender-specific

barriers could be the nature of their experience. Caseworkers 1 and 4, although being in social

work for a similar length of time to caseworkers 3, 5, and 6, had more experience with leadership

within DCFS. I hypothesize that individuals who hold leadership positions may be more well-

versed on the literature surrounding mental health. Future research into how leadership

experience impacts how caseworkers identify barriers to mental health care for girls would be

beneficial to expanding understanding of this topic.

The following codes have been organized into four broader categories: resources,

provider quality, youth in care, and caregivers. Certain codes appeared in every interview, which

indicates that the issues coded for are experienced by each of the caseworkers and are likely

commonly experienced throughout DCFS. Although Figure 1 does depict how frequently each

code was identified, considering frequency of codes is not meant in any way to claim that

because a code was expressed most frequently means that the issues it identifies are more

pressing or more problematic than other, less-coded-for issues. Due to a diversity of caseworker

experience, education, and training, each caseworker had a very different perspective and

identified key issues that, while perhaps not experienced by every caseworker, are no less

important to consider. Additionally, remarks and identified barriers will not be excluded from

analysis simply because they are not specific to girls. Barriers were extremely intersectional, and due to the diverse needs of girls that were identified in the literature review, it is likely that non-gender specific barriers to mental health care impact boys and girls differently. For this reason, all barriers will be included in analysis even if caseworkers did not identify that they were specific to girls.

Resources

        Caseworkers frequently identified how a lack of resources is a barrier to girls receiving effective mental health care. They largely identified this lack of resources presenting as general financial barriers as well as barriers stemming from caseworker and mental health providers' capacity to serve as many clients effectively as need mental health care.

Financial Barriers

        Each caseworker described financial barriers, and financial barriers were expressed more frequently than any other barriers. Financial barriers were often described as gender-neutral, impacting both girls and boys. However, simply because caseworkers did not identify resources as a gender-specific barrier does not mean that these barriers have nothing to do with gender. Financial limitations interact with other barriers that are gender specific. The interconnectedness of all of the barriers identified by caseworkers makes it difficult to divorce gender from any barriers once it has been identified at all.

        Caseworker 3 discussed how cuts in budget have decreased over her twenty years working in foster care. She described how due to this lack of resources:

        "DCFS is feeling that crunch where you may have to wait for some counseling for

        a child. You may be put on a waitlist for a few months…we used to have a better

choice of [mental health providers] where you can get your kids in…if the state

doesn't have the money in the budget to pay those agencies they can't pay the

staff, so they can't hire quality staff."

Limited options for providers were described by other caseworkers as well. Caseworker 5

described similar conditions, and also described how more resources would be helpful to her

clients. For example, she described how "if a young lady, we referred her and things weren't

going well with the therapy, we would have someone else to possibly refer her to…that she

might do better [with]." Finally, Caseworker 6 identified how Medicaid limits the number of

psychiatrists that girls can see, as not all mental health professionals accept patients through

Medicaid. A lack of resources limits the options for girls in foster care, and prevents them from

receiving timely care.

Caseworker 4 echoed these sentiments, but further described how a lack of resources

limits valuable mental health resources within communities, stating:

"Say I'm looking for a resource for a child in Englewood. Where we are now is a

lack of community resources in specific neighborhoods. It's inappropriate for me

to send a child that stays on 63rd and Halsted to therapy that's on 16th and Damon

or 16th and Indiana....I'm not sure that the child is actually going to get that

because of transportation issues."

When community resources exist in communities, they can be very beneficial for children in

foster care. However, as these resources cease to exist due to a lack of funding, girls are

negatively impacted. Both Caseworkers 2 and 5 discussed how a lack of community resources

has limited the number of in-home therapy appointments available to girls. Furthermore,

nontraditional services which often originate in the community can be eliminated due to a lack of

funding. Caseworker 1 identified this problem, stating, "based on some of our problems with our budget in Illinois, some of those very helpful but non-traditional service programs have kind of shut down." Caseworker 1 discussed how non-traditional mental health treatments can be very helpful to girls in the foster care system, especially girls of color due to cultural stigma surrounding traditional therapeutic methods. When these resources are eliminated, the quality and effectiveness of the care that girls receive is diminished as the only options available to them are more traditional therapeutic methods to which they may not respond.

Financial barriers strongly impact girls in foster care, and were identified by all caseworkers interviewed. Some of these barriers impact boys in addition to girls. However, a lack of resources likely influences boys and girls differently, as caseworkers frequently stated that boys and girls have different needs. Financial barriers do not have the same impact on girls as they do on boys, and as such it is important to consider them when discussing barriers to girls' mental health care.

Capacity Barriers

Capacity was coded for very infrequently, only being mentioned 5 times. Caseworkers 1, 3, and 5 identified capacity as a barrier to girls' mental health care, but none described gender as having an impact on barriers due to capacity. Caseworker 1 identified how having a high number of cases makes it difficult for them to ensure that girls receive services because their time and energy is divided between too many cases to give each case a large amount of individual attention. She explained:

> "What we really are wanting caseworkers to do is to look individually at the
>
> family system, look individually at the child. Legally for follow-up [caseworkers
>
> should have] no more than twelve to fifteen cases…. but in many cases…folks

can be carrying up to fifteen to twenty cases at a time, so trying to get to that

individual intervention can be difficult."

Caseworker 5 identified a different challenge that can arise when caseworkers have limited

capacity. Sometimes, when foster parents cannot take children to their mental health

appointments, and when no transportation is provided by the mental health provider, caseworkers

do not have time to take their clients to appointments themselves. She explained that it is

difficult to take her clients to mental health appointments herself because "you got your other

cases and everything… you might be able to [take them to appointments], you wouldn't be able

to do it on a consistent basis…one agency don't provide transportations to appointments and then

when they do, they're not consistent." Caseworkers' high volume of cases prevents them at times

from making sure children's healthcare is as effective as possible.

Caseworkers 3 and 5 both expressed how capacity becomes a problem from the side of

the mental health provider. Caseworker 3 described this:

"I don't think there is a continuity in [mental] healthcare because of the fact that,

one agency may have all interns and just one person that's supervising them.

Another agency may have MSWs working there or LCSWs, or qualified health

professionals. So the quality of service you're going to get here compared to here,

it's different… and that's why really good agencies always have a waitlist."

There are limits to how many clients agencies can take, and the number of clients who

caseworkers want to send to the best mental health providers is greater than the number of clients

that these providers can service. Although gender did not come up specifically during

discussions of capacity, this barrier intersects with barriers that are related specifically to gender.

For example, often times identification can be a barrier to girls' effective care because girls'

mental health issues can be more difficult to identify than are boys. If caseworkers and mental health providers had more capacity to take on cases and devote time to existing cases, these identification barriers could be mitigated in some way. Therefore, it is important to understand how barriers intersect with one another, and just because caseworkers did not identify capacity as having to do with gender does not mean that this barrier impacts girls the same way that it impacts boys.

Caseworkers consistently identified how insufficient resources in the form of financial limitations and limited capacity are a barrier to girls in foster care receiving adequate mental health services. In addition to these obstacles, caseworkers identified other barriers within DCFS and mental health service agencies that prevent girls from receiving effective care.

Provider Quality

Caseworker and mental health provider quality is also a key theme that emerged throughout the interviews. Training, identification, and turnover barriers were most commonly associated with this theme. A lack of training, or a lack of effective training, strongly influences the quality of caseworkers and mental health providers and their ability to effectively connect girls with effective mental health care. A lack of sufficient training can also lead to identification barriers, as caseworkers and mental health providers are unable to effectively identify the mental illnesses or needs of the girls in their care. Caseworkers also identified structural causes of identification barriers. Finally, frequent turnover of both caseworkers and mental health providers creates significant barriers to effective mental health care, as girls are often not given the opportunity to work with the same professionals continuously, decreasing the quality of care that girls receive.

Training Barriers

Training appeared less frequently than other barriers, and was identified by Caseworkers 1, 2, 4, and 5. However, some themes regarding training did emerge. Caseworker 1 discussed how a lack of joint training between mental health professionals and caseworkers leads to mental health professionals and caseworkers being unable to coordinate effectively in order to deliver services to children with mental health needs. She stated:

> "I think it is there is too much isolation… there is the mental health system, and then there is the child welfare system. There really need to be more policies, more memorandums of understanding, and shared training and resources between the different state entities in terms of how we coordinate care better… I think that more policies that kind of mandate that has to happen would be helpful, because it then raises that standard of requirement on both sides."

Caseworker 2 also identified how mental health providers and caseworkers are not trained effectively on mental health care. She stated that "we need agencies, service providers who can, they need to change the way they look at mental health. Mental health is a dual diagnosis [more than one mental illness in a child] now…what you did 30 years ago should not be how you practice now." Caseworker 2 identified that mental health providers need more up-to-date training on how to most effectively serve children. An intersection with identification can be seen here, as Caseworker 2 discussed how a lack of effective training causes providers and caseworkers to misidentify or fail to identify mental illnesses and needs in girls.

Caseworkers 4 and 5 discussed how therapists need to be trained in order to connect with the child. Caseworker 5 said that it can be difficult to find a mental health provider for a girl because "it takes a special person… to be able to talk with the young lady and for her to be

comfortable enough to talk with them about what's actually going on with her." While

Caseworker 4 described this as a "special person," it seems that training would help mental

health providers to better connect with girls and make it easier for caseworkers to find girls

effective mental health professionals. Caseworker 4 went even more in depth into this issue,

explaining how a lack of cultural competency is a major barrier. He stated:

> "cultural competence of workers… the child welfare system itself is about close
>
> to 73 percent are children of color…but the [race and ethnicities of] workers and
>
> the therapists themselves don't match the number of children of color that are in
>
> care…the agency is driven by their leaders, right? So if the leaders [are] not
>
> culturally competent, it is going to create a pattern of cultural incompetence in the
>
> agencies."

Having providers, caseworkers, and DCFS administrators effectively trained in cultural

competency is important for girls to receive effective care. Caseworker 4 further explained:

> "I can't send a young black girl that's been traumatized by gang violence and
>
> family domestic violence to a young white lady [mental health provider] that grew
>
> up in Westchester or something like that, talking about the trauma that she's [child
>
> in care] experienced growing up in the community… that provider that is not
>
> familiar with the community, cannot provide her the proper tools to overcome
>
> some of that trauma."

Without training that allows providers to effectively work with the children who make up the

body of foster care, caseworkers are limited in how effective they can be in directing girls toward

mental health resources.

Despite being identified less frequently than other barriers, the barriers that exist due to training practices are not to be overlooked. Without proper training, providers and caseworkers are less effective than they otherwise could be, and may misidentify or fail to identify girls' mental illnesses and needs. Additionally, a lack of proper training could lead to youth resistance to care. Finally, every caseworker interviewed stated that they did not receive any training specifically about girls and their mental health, and this lack of training is a key finding despite not being coded for as an identified barrier because it could explain why certain caseworkers denied any gender differences in the foster care system or regarding children's mental health.

Identification Barriers

Identification as a barrier was expressed less frequently than financial, youth, and turnover as barriers. However, this barrier was identified by Caseworkers 1, 2, 3, and 4.

Certain structural components of how DCFS identifies and delivers mental health care also impede identification of mental health problems in girls. Caseworker 4 described how the integrated assessment, in which DCFS interviews a child newly entering foster care in order to identify mental health issues, is conducted by someone who is not a child's caseworker. Furthermore, this individual is not involved in the child's life past the assessment. Caseworker 4 described how children are resistant to this stranger, and often do not open up fully. The assessment this individual conducted "may say, well she was recluse and didn't want to [answer] some of my questions… she may need some socialization skills. No, she just doesn't know you." When girls do not know the person conducting their initial integrated assessment, they may not open up and therefore their mental health issues can be misidentified or not identified at all.

Caseworker 3 described a different way in which the structure of DCFS service delivery creates an identification barrier. She explained that when a child is in crisis, Screening,

Assessment, and Support Services (SASS) intervenes with the child in order to stabilize them. She explained that sometimes, when a child has a major crisis, SASS does not intervene quickly enough, making it difficult for them to correctly identify that child's needs. She explained:

> "I had a young lady that had a meltdown at school. The called the police…the police, called the ambulance, the ambulance took her to [the hospital] …they sat there [at the hospital] for two hours and that's the difficulty, is it takes two hours for SASs to get there. If you have a child in crisis… or even a teenager in crisis for two hours, for the most part, they're going to have calmed down. Somebody's going to be able to calm them down. Well then SASS will say 'well, they don't need to be hospitalized, they're calm.'"

SASS delays can lead to misdiagnosis as they wrongly identify a child just because that child has calmed down over the time of the delay, as described by Caseworker 3.

Caseworkers also identified gender-specific identification barriers. Caseworker 1 stated that there is often difficulty in identifying girl's mental health issues because of the particular way in which that mental health issues present themselves in girls. She described how the "squeaky wheel gets the oil," and since girls often experience mental health issues that do not have as clearly identifiable symptoms, they "fly under the radar." She further described this issue:

> "So things like depression… often times I think girls from a societal standpoint (in terms of how they're raised) are in many cases taught to fly under the radar…unless they're having active psychosis or something that is uncontrolled, I think the depression— people might know it's there, but it doesn't seem to be having a major impact on their functioning in other life domains… and often

times, unless it is really kind of off the charts behaviorally, it might be diagnosed,

we might give them kind of traditional type of services, but…oftentimes it just

goes unaddressed effectively."

The issue of identification is a serious barrier to girls' mental health care, as girls do not show their symptoms as obviously due to the socialization and the nature of the mental illnesses from which they most frequently suffer. Additionally, Caseworker 1 explained that caseworkers may not know how to identify the best course of treatment if they "don't really have a strong background from experience," which can further prevent girls from getting effective treatment for their mental health issues.

Further themes about identification as a barrier emerged as Caseworker 2 described what she considered to be the "biggest challenge" in getting girls effective mental health care, stating:

"These mental health facilities [are not] looking at girls and boys

differently…they look at them all the same. 'Oh, she has bipolar, la da da da

da'…, but she might [also] need sexual abuse…mental health services…That's

what I have a problem with. You need to… curtail that particular therapy for this

child based on that integrated assessment, not because your company has just

been doing therapy for the last 30 years. It just needs to be adjusted to the needs

of these girls."

Not treating girls differently from boys, as Caseworker 2 identified often happens, leads to situations in which mental health providers do not correctly identify all of a girl's needs. Failing to consider girls as a unique case causes certain needs and illnesses to be overlooked or misidentified. When girls are placed in residential mental health facilities, this lack of

differentiation between girls and boys further prevents them from getting care. Caseworker 2 described that:

> "we ship these kids off to these residential [placement]…which is so used to just
> housing kids and treating everybody's mental health and issues the same. And
> that circle might not fit this girl. So she'll stay there a year, and then she's not
> getting the treatment she needs at this place—who's getting paid to 10,000 a
> month to care for her to make sure she getting her mental health [care]— and she
> gets out, and it's [her mental health] the same. They… need to reprogram these
> agencies and residential [facilities]."

Caseworkers and mental health providers delivering services without considering gender as a factor in a child's needs can misidentify issues or prescribe incorrect or incomplete treatment. When this happens, girls do not receive effective mental health care.

Turnover Barriers

Turnover was expressed consistently by each interviewed social worker as a barrier. Consistent care has been shown to be one of the most important parts of adequate mental healthcare, but social workers have identified that it may be interrupted through several different types of turnover. First, Caseworkers 1, 2, and 6 identified that children who experience the most symptomatic mental illnesses are often moving in and out of the foster care system and between different families. These children then lose the continuity of their relationship with their therapists or mental health professionals. Caseworker 1 described this: "if you're being kind of moved from placement to placement to placement out in…new areas, especially after maybe brief stays of mental health stabilization through hospitalization or residential treatment, then it's going to be hard to maintain that continuity with a therapist." Caseworker 2 agreed, stating that

"If they are in a stable foster care [placement], then they tend to come out better at the end then someone who's moved around a lot." Turnover in placement disrupts continuity, which then negatively impacts girls in foster care.

Caseworkers also identified how turnover in mental health professionals negatively impacts girls in foster care. Caseworker 1 discussed how therapists are not contracted in a way that requires them to work with DCFS for a certain number of years. She explained that therapists will often move on from DCFS in order to start their own private practices or start work at agencies where they can make better pay and "prestige."

In addition to this movement due to career changes, caseworkers also identified turnover barriers that exist due to the system through which mental health care professionals are educated. Caseworker 3 described the negative impact of the fact that one of her client's therapists is a Ph.D. student. She stated that "after a year she's gone and another Ph.D. student comes in her place…any agency that uses interns is only going to have them for a certain period of time." When mental health professionals turn over, she explained, "then you have to start all over, to a certain extent." Caseworker 5 also described how girls react negatively to therapist turnover, describing how the experience of getting a new therapist is "disheartening." When girls get new therapists they often tell her "I don't get along with that [therapist,] that person doesn't understand me." Turnover in mental health providers is difficult for girls in foster care, and is clearly identified by caseworkers as a barrier to girls receiving care.

Caseworker turnover, while not necessarily interrupting continuity in mental health care in the same way as mental health professional turnover, also has a negative impact on girls in foster care. Caseworker 5 echoed Caseworker 1's explanation of the negative impacts of professionals leaving the foster care system in order to enter into more prestigious jobs. He

explained how he tells new DCFS caseworkers that "as a worker, you may be the only trusting, loving adult in a child's life. So if you're using social work as a springboard, I suggest you don't do it as a caseworker…what that does is it creates a lack of trust in the child welfare system." Caseworker 4 also spoke extensively about the negative effects of caseworker turnover:

"So say I take a client, that's 13 years old, introduce her to a new worker that she starts a relationship with. And now she's willing to do services, after this worker has talked her into it, [and] established a rapport with her after six months. Now she trusts this worker. Now she's willing to engage in services. Right? Now this worker takes a new position, or can't handle social work, and she leaves. That child has experienced abandonment all over again."

Caseworker 4 continued to describe the effect that this turnover has on a child, stating:

"So that child's like, 'See I told you, nobody loves me. I ain't doing this. I was willing to do so, but now [caseworker] is gone again. So I don't trust the system. Nobody's ever going to be there and [be] stable enough for me, so I'm just not going to do it. So it creates a resistance for that child to engage in services."

Caseworker turnover erodes the trust that girls have with the foster care system, making them more likely to resist services. This is an example of how different barriers interact with one another, as it can be seen how issues with turnover barriers can interact with youth barriers.

Caseworkers further identified how girls are uniquely impacted by caseworker and mental health provider turnover. According to Caseworker 1:

"I think that [turnover] makes it a greater challenge and a barrier for young people to open up, especially girls who are struggling to have their own voice heard just based on gender differences. They [girls] many times may just kind of

shut down. Whereas you may see that explode in terms of boys, it implodes and it kind of starts that vicious cycle with girls."

Girls have particular responses to turnover, making turnover a barrier that does impact girls differently than boys. Caseworker turnover, turnover in home placement, and turnover in mental health providers are major barriers to girls' receiving of mental health care, and can this turnover can actually make their mental health worse.

Training, identification, and turnover barriers all contribute to caseworker and mental health provider quality and their ability to effectively serve girls in their care who are suffering from mental illness. These barriers, alongside financial and capacity barriers, are largely centered structurally within DCFS and mental health service agencies. However, there are barriers to girls' mental health care that exist externally to these two systems.

Youth in Care

The theme that most commonly emerged throughout interviews was barriers created by or perpetuated by youth in care. Caseworkers frequently identified how youth themselves are often the source of barriers to their own care. Oftentimes, the barriers that come from youth can be symptomatic of other barriers, such as a lack of resources preventing youth from taking advantage of non-traditional or community-based mental health services, or long waitlists due to issues of capacity. Youth barriers intersect heavily with other barriers.

Youth barriers were discussed by five out of six caseworkers. Within this theme, caseworkers expressed a wide variety of barriers to mental health care that come from girls in foster care themselves. Youth sometimes refuse to engage in the mental health care social workers have recommended, and their lack of response to mental health treatment was identified

by caseworkers. Caseworker 1 described how youth often do not respond well to traditional therapeutic methods like medication and talk therapy. She described how "for people of color, traditional mental health services are still really demonized within the community…we do see in many cases that they [foster youth of color] just don't really respond well to that kind of treatment." She described how youth resist these traditional methods of treatment and how this can become a barrier when caseworkers and mental health professionals continue to push these methods anyway.

> "When dealing with older teens…they do have rights, and they have the right to refusal… [teens feel like] yeah you can physically make me go, but you can't make me engage. So I think not really listening to youth (in terms of looking for looking at some of the alternative types of therapeutic interventions) is also a barrier."

Caseworker 4 identified a similar cultural resistance, stating:

> "And now those that do need medication may not be compliant with medication because of this stigma that black people don't need medication or black people don't need therapists, right? We handle our own business. But that just comes from a lack of knowledge of what the medication is actually supposed to be used for."

Foster youth's resistance to traditional forms mental health care, for reasons of race and culture as well as simply not wanting to engage in treatment, prevents them from effectively dealing with their mental illnesses. This barrier intersects with financial barriers, as a lack of funding for community-based or non-traditional resources likely exacerbates youth's aversion to care, and in some cases may be the root of this barrier.

Caseworkers also identified gender-specific barriers in this area. Specifically describing girls' resistance, Caseworker 4 also described how girls in foster care have "been so traumatized, they've been neglected, that they resist services." Caseworkers 2 and 5 also described how as girls get older, they are less inclined to attend therapy or take their prescribed medication. Caseworker 5 described how girls refuse engage in services:

> "What I've found with females is that after a certain time they don't want to take
>
> the medication. Some of them say that it's not doing any good. And then some
>
> just say… they're tired and they're tired of taking medication. And then they get
>
> around their peers and all of that and they don't want their peers to know that
>
> they're on medication."

Caseworker 5 further discussed how girls begin to resist treatment because they feel it is not effective. She described how girls tell her that "It's [the medication] not doing any good anyway, so why even take it…[and] the therapist asks the same thing over and over so they get tired of talking with them." Caseworker 2 described how girls resisting treatment gets worse as they get older, and that as girls age it becomes more difficult for caseworkers to ensure that they are getting the treatment they need, because "teenagers…they won't go [to mental health appointments] without an adult being behind them." She stated that "when they get older, when they start feeling better, the stop taking their medication." In addition to not taking medication because of feeling better, she explained to me that "it's a peer thing. Peer pressure…they don't want to…be different or feel different than the other kids. So they put on this mask that 'there's nothing wrong with me' until they have a full-blown episode." She explained to me that these episodes often end up in these girls being committed to the hospital due to self-harm. Additionally, Caseworker 2 stated that girls stop taking their medication once they go to college.

Caseworker 5 additionally described how girls who use marijuana often decide to stop taking their medication. She said "they know that the marijuana doesn't mix with the medications, so they choose to smoke weed… rather than take the medication." While Caseworker 5 was the only caseworker to identify this particular issue, it may be an important point. If girls are using marijuana to self-medicate, and therefore stop taking their medications, they at risk not only of losing out on the important effects of their prescribed medication, but also of arrest and criminalization. Future research may benefit from further exploring marijuana use among girls who have been prescribed mental health services.

Finally, Caseworker 6 identified that men are the most common perpetrators of abuse of girls in foster care. Due to this traumatization by men, girls often struggle to connect with male mental health providers. She explained how "sometimes, when they're older they just don't feel that they [mental health providers] can understand them, so therefore they are very guarded." When girls are not connecting with male providers, limited resources often prevent caseworkers from finding a new, female provider. She described the following case:

> "they just could not get a female [mental health professional] for this particular
>
> young lady. And what happened was the worker had to always be in the room,
>
> because…she was just not comfortable being in the room alone with a male."

This demonstrates the intersection between barriers, as both financial and youth barriers contributed to this scenario. When youth are averse to participating in care, and when the resources to accommodate them are limited, girls may not be receiving effective mental health resources.

Caregivers

The final broad theme that emerged after coding was barriers stemming from caregivers. Under the umbrella term of caregivers are kin caregivers, foster parents, and caregivers in group placements. Caseworkers 1, 2, 5, and 6 identified challenges with caregivers, which includes kin caregivers, foster parents, and caregivers in group placements. This barrier appeared the least frequently, only appearing 4 times. However, the caregiver barriers that caseworkers identified were significant. Caseworker 1 explained how for their own personal reasons, foster parents sometimes contribute to girls not receiving effective mental health care. This happens due to foster parents' own personal biases against mental health care and their desire to medicate the children in their care. Caseworker 1 described this:

> "I believe that there is…some of it is cultural… that stigma against mental health
> [issues] and the desire to not necessarily have to deal with behavior…sometimes I
> think foster parents just push for medication as the remedy, as opposed to really
> formulating those connections [with girls] in a way that may be inconvenient for
> the foster parent."

Stigma and the desire to use medication a quick and easy solution to mental health problems lead to foster parents advocating for medication despite this not always being the best course of treatment for girls.

The barrier created when caregivers cannot take their foster children to appointments was discussed more frequently, and was brought up by Caseworkers 2, 5, and 6. Caseworker 6 described how some caregivers "don't keep the appointments," which impacts younger children who cannot get to appointments themselves. Caseworker 5 explained how transportation is a major barrier. She explained how "sometimes…the foster parent can't bring them [to the

appointment], and the foster parent really don't trust them to take public transportation." When caregivers are unable to take their foster children to mental health appointments, the children are negatively impacted. A clear example of the intersectionality of caregiver barriers with other barriers, transportation to mental health appointments emerges frequently as a problem in mental health care, and is identified in the context of financial, capacity, and caregiver barriers.

The barrier of caregivers being unable to take children to appointments intersects significantly with both capacity and financial barriers. No caseworkers discussed gender specifically when talking about caregiver barriers, however it is possible that caseworkers are unaware of caregiver barriers because they are not in the home and do not see caregivers and foster children interact every day. Even if this is not the case, the caregiver barriers that were identified are significant on their own and in conjunction with other barriers such as financial or capacity.

A multitude of barriers emerged after coding and sorting coded data into the categories of resources, provider quality, youth in care, and caregivers. With these barriers to girls' receiving mental health care in mind, it is possible to consider changes in policy that can address these barriers and ideally mitigate them in some way.
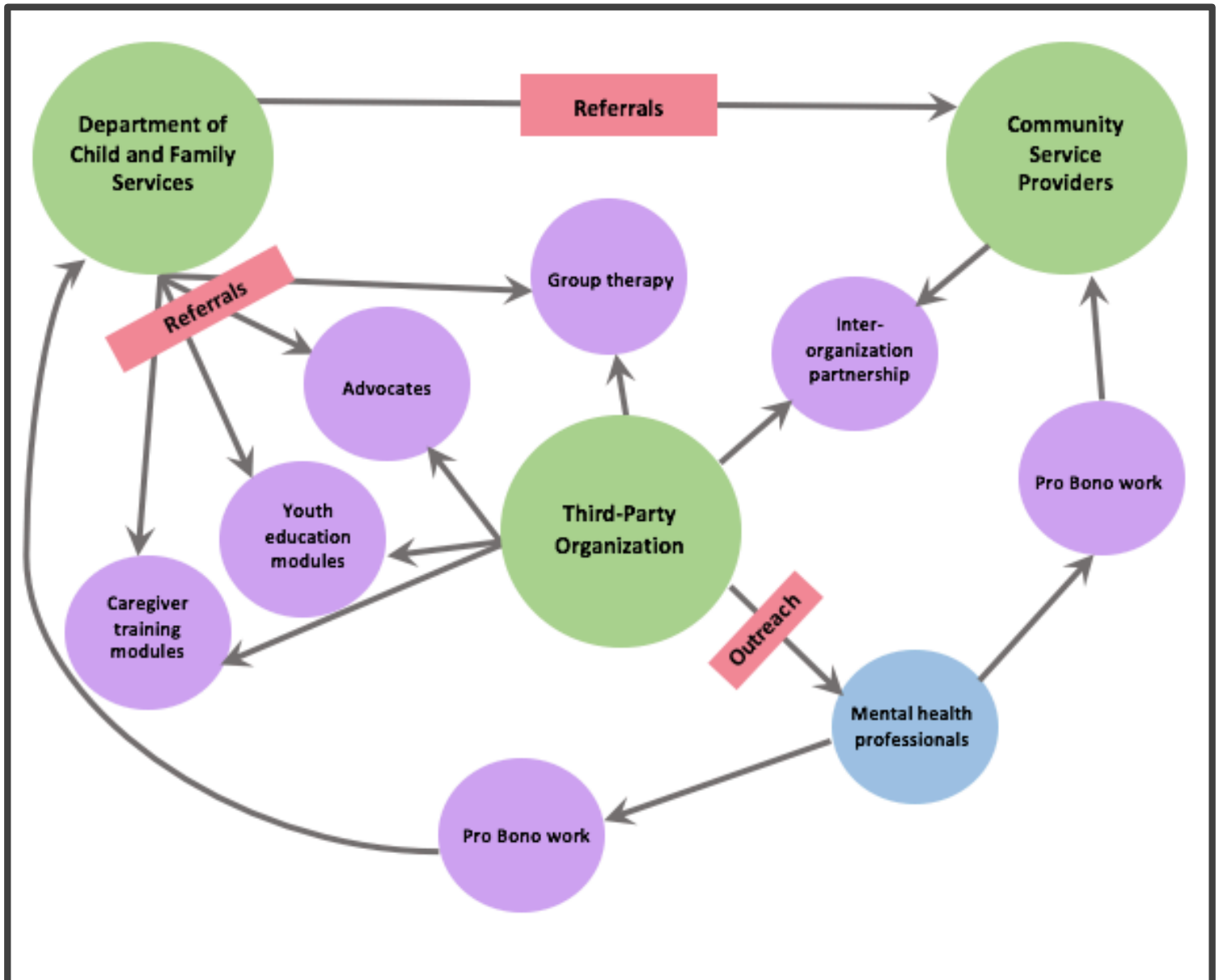
Policy Recommendations

It seems that almost all barriers that emerged in interviews are connected in some way, and the majority of barriers were tied to a low budget and a lack of resources. Due to this extensive interconnectivity, it is unlikely that policymakers could eliminate one of these barriers without eliminating all of them. Therefore, it is important to find a holistic approach that would tackle as many barriers as possible, as simply attempting to eliminate one or two would be

insufficient. In fact, tackling the issue of barriers to mental health care primarily through changes within DCFS may actually be an insufficient course of action. Realistically, the only way to eliminate all of these barriers would be a massive increase in funding to DCFS and the Department of Health and Human Services, but this increase in funding seems unlikely unless the federal and state government readjust their priorities to focus on foster children. For this reason, it is beneficial to look outside of DCFS in order to identify a solution that would supplement social workers without requiring any increase in funding or any increase in the work of the social workers themselves.

Third-Party Organization

Research has shown that third party organizations can be very effective in delivering services. A third-party organization providing integrated services could address a multitude of issues in a way that would not require state funding, and would additionally not place a large burden on caseworkers themselves. Additionally, several caseworkers described a desire to strengthen already existing and already successful community service providers. This organization would be able to work with already existing community service providers in order to bring resources into various communities rather than having girls travel in order to receive services.

This organization would be funded through grants and private donors. It will work with both DCFS and community service providers that already exist and already provide certain mental health resources. This organization will have six major facets, listed from most to least intensive. For a general understanding of the organization's structure, Figure 2 can be referenced.

Figure 2: Integrated Service Model

Advocates

Advocates are the most significant part of this organization. These individuals will be either staff of the nonprofit or outside volunteers who are willing to make a significant and long-term commitment to the organization. They will undergo extensive, mandatory training on mental health issues and how these issues present themselves in and are experienced uniquely by girls. These individuals will be assigned a girl (more than one, if they have the capacity) who has

been referred to the nonprofit by DCFS. They will meet with this girl a minimum of once a month, taking note of any major developments in the girl's life and noting the state of her mental health. They will report what they have observed to caseworkers as well as any mental health professionals in the girl's life. Finally, advocates will provide transportation for girls to their mental health appointments if their foster parent is unable to, and if these individuals are unable to do this then the third-party organization will find other volunteers to fill this role (additionally, volunteers can be organized for transportation for girls who are not in the advocate program).

Ideally, these individuals will be with a girl as long as she is in the foster care system. In order to mitigate barriers due to turnover, if the child were to change social workers or mental health professionals this individual would remain with the child, providing continuity to ensure that this child's needs to do not slip through the cracks. This individual would remain a part of the child's life even if they go in and out of the foster care system, making sure that she is attending therapy sessions and that she is getting the help that she needs. Additionally, this individual would be able to serve as a mentor to the girl. Caseworker 1 identified mentorship as a valuable form of nontraditional mental health care, and the individual assigned to a girl through the nonprofit organization would have the ability to step into this role. If for some reason this individual has to leave their role as an advocate, there will be an extensive transition process in order to lessen the impact of the turnover. These individuals will operate out of community service providers' offices as to be located in the community and easily accessible to their mentee. The purpose of these advocates is to provide a source of continuity in the life of a girl in foster care, as there is often turnover in her life from caseworkers or mental health professionals. This individual will be a constant, and will ideally be a valuable and trusted part of a girl's life.

Group therapy

This organization will also offer group therapy sessions, framed as a support group and in some ways a social outlet. Bringing girls together to discuss their experiences without the pressure of one-on-one therapy ideally will lessen some of the stigma surrounding mental health treatment, and will also allow girls to connect and form bonds with other girls who understand what they are experiencing in foster care. These therapy sessions will be run by a volunteer psychologist or psychiatrist, and caseworkers will refer girls to the program. These sessions will take place in community service providers' offices, and if the community service provider wishes to run the support group they are entitled to do so.

Youth education modules

These sessions will consist of presentations and discussions led by mental health professionals and the nonprofit's staff. They will focus on educating girls on different mental health conditions, the importance of medication when properly prescribed, and self-care practices. Caseworkers will refer their clients to these sessions, which will be held at community service providers' offices if possible and would ideally include community service providers as leaders and participants. These sessions will be very tailored toward girls, focusing on issues faced by girls specifically.

Foster parent education modules

These sessions will consist of presentations and discussions led by mental health professionals and the nonprofit's staff. One focus of these sessions will be educating foster parents on different mental health conditions and how to best support foster children who have been diagnosed with various conditions. As this research has shown, many of the issues that girls experience, such as depression, do not always present as externally and obviously as they do in

boys. Therefore these sessions will help foster parents know what they are looking for and when to seek assistance for the girls in their care. Additionally, these sessions will educate foster parents on the benefits and dangers of medication so that these parents can make more informed decisions on whether or not to advocate that their foster children receive medication.

These trainings would also focus on removing stigma surrounding mental health care. Trainings would allow for open discussion so that foster parents could explore their own thoughts surrounding health care and could learn from different perspectives. These trainings would also work to eliminate stereotypes around mental health care, and would aim to improve foster parent attitudes toward therapeutic practices. The trainings would also focus on how foster parents can work to combat stigma in their communities. Ideally, after participating in these trainings, that foster parents would be more open to ensuring the girls in their care receive needed services. Finally, the training sessions will also be a place for foster parents to connect with one another and share their experiences. While caseworkers are welcome to refer parents to these modules, parents can also attend of their own volition. These modules will take place at community service providers' offices, and would ideally include community service providers as leaders and participants.

Community service provider partnership

As already discussed, this third-party organization will work closely with community service providers already in existence. Beyond operating additional services at these providers' offices, the organization will provide other supports. First, this third-party organization would assist with finding volunteers for any support that a community service provider might need, whether it be administrative, operational, etc. Additionally, this third-party organization would

work to support community service providers by fundraising and connecting donors with these organizations.

Outreach to mental health professionals

This third-party organization will also work on outreach, connecting mental health professionals interested in taking a pro bono client with community service providers. These professionals, who would ideally (but not necessarily) have background knowledge or experience with working with girls from low-income communities who have experienced trauma. If they wish to take a client, they will be required to commit to a lengthy period of time so as to reduce turnover, and will provide their services from the offices of community service providers. Many caseworkers described the need for more providers, and this pro bono work could potentially give caseworkers more options and keep girls from waiting a long time for services.

If they do not want to commit to taking on a client, these psychiatrists and psychologists would be able to be a part of the initial assessment for girls entering the foster care system. Because a primary care physician does the screening currently in place, it would be very beneficial to girls to speak with a mental health professional who is specifically trained to identify any mental health issues that they may be facing. This lower-level commitment would be a way to relieve pressure off of DCFS without the outside professional needing to commit to a long-term relationship with a child.

Drawbacks and Challenges

Although this third-party organization would have substantial benefits for mitigating barriers to girls' mental health care, this solution is not all-encompassing. It is not realistic or possible for third-party organizations to serve every girl in foster care who needs mental health

care. It is also not realistic to expect that third-party organizations could be implemented

successfully in every area where there are children in foster care, as there are far too many cities

and children in care for this to ever be possible. A third-party organization, while a very valuable

resource, is not a permanent solution to the issues in girls' mental health care.

Additionally, it may be difficult to find volunteers who can commit long-term to a child

through the third-party organization's advocate program. The organization may struggle to find

these individuals, and it may be difficult for the organization to get off the ground initially as it

may be hard to find people to buy-in to this model because the organization is so new. This

challenge can be taken into consideration and be lessened in some capacity by the third-party

organization connecting with other not-for-profits and organizations that serve children in foster

care and advocate for mental health awareness. The third-party organization should pursue these

connections so that more established and credible organizations can promote the advocate

program to circles of people who would be interested in volunteering or donating. Another way

to find volunteers is to reach out through DCFS, as DCFS will lend credibility to the third-party

organization and can also promote the organization among individuals who already have an

interest in volunteering within the foster care system.

Recommendations for DCFS

Despite the fact that the most comprehensive recommendation is a third-party

organization, I would also like to recommend several policies that DCFS could implement in

order to attempt to better connect girls with mental health services. None of these policies are a

silver bullet, and without a serious budget reform it is unlikely that any one reform to DCFS will

eliminate all the barriers to girls receiving mental health care. However, there are some reforms that could mitigate certain barriers.

Gender-specific training

All caseworkers identified that they did not undergo any training exclusively about girls, and did not receive any training about how girls' mental health issues and needs are unique from boys' issues and needs. However, both existing literature and caseworkers in this study identified differences between boys' and girls' mental health needs and the ways in which mental health issues present themselves differently in boys and girls. Identification is a barrier to girls' effective mental health care, and training specifically regarding girls' and their mental health needs would potentially help to mitigate this barrier. By giving caseworkers gender-specific training, they may better be able to identify what girls' needs are and may better be able to communicate these needs to mental health providers. Additionally, gender-specific training would potentially mitigate certain youth barriers. Girls refusing participate in their treatment is a barrier identified by several caseworkers, and gender-specific training may allow caseworkers to better reach girls in order to convince reluctant girls to partake in mental health treatment. While gender-specific training would be beneficial to caseworkers and lessen the impact of certain barriers, it also would require funding in order to design and implement the training. As many caseworkers identified, funding is already stretched thin for DCFS. Policymakers may need to consider how to reorganize the budget for DCFS in order to find the funding, and it is possible that they may have to prioritize gender-specific training over other parts of the budget. This gender-specific training would be beneficial, but policymakers may see difficulty with finding ways to fund it.

I did not interview mental health providers, and therefore cannot make substantial claims about their training. However, some caseworkers did discuss how girls are treated the same as boys in their mental health care, and identified this as a barrier to girls receiving effective care. Further research into how mental health providers are trained and if they undergo any gender-specific training would be valuable. If this research indicated that training was not adequately preparing mental health providers to provide effective mental health care for girls in foster care, then policy recommendations could then be made to provide more gender-specific training to mental health providers if they need it.

Cultural Competency Training

Cultural differences regarding the perception of mental illness emerged in discussion of both Youth Barriers and Caregiver Barriers, and a lack of cultural competency within DCFS and among mental health providers was specifically noted by Caseworker 4. Cultural differences and perceptions of mental health play a significant role in how effective mental health care is for girls in foster care. Cultural competency training for both caseworkers and mental health professionals would help to mitigate some of the barriers that arise when girls in foster care and their caregivers perceive mental health and the issues surrounding it differently from providers. Through cultural competency training, caseworkers and mental health providers could better understand the diversity of values and perspectives of their clients. With this better understanding, caseworkers would be much more effective in communicating with girls and caregivers about mental health issues and would be better at connecting girls with effective services. Mental health providers would be able to work with girls much more effectively if they better understood girls' perspectives and could take this into consideration with their treatment. Similar to gender-specific training, cultural competency training would require funding.

However, if caseworkers and providers are not able to provide services in a culturally competent way, then these services may not be effective even if girls are participating in prescribed treatment. Furthermore, a lack of cultural competency can alienate girls from wanting to partake in treatment if they feel as though providers do not understand them. Cultural competency training would make mental health services more effective for girls in foster care, and I recommend it be prioritized despite budgetary concerns or restrictions.

Transportation

Caseworkers also identified how transportation is a barrier to mental health care, as girls are not always able to go to their mental health appointments due to foster parents being unable to take them and the girls not being able to go on their own. By trying allocating part of the DCFS budget to transportation, DCFS could mitigate this barrier. While this reform may be difficult to find funding for, there is little point in caseworkers and mental health providers using resources to identify girls' mental health issues and try and connect them with the correct services if girls are not even attending their appointments. Providing transportation to these appointments would be an effective way to ensure that resources are being utilized effectively. DCFS could also attempt to partner with mental health service agencies that can provide transportation, or have these agencies provide part of the funding for transportation. It is in the best interests of these agencies for girls to come to appointments so that their resources are not being put toward services that will never actually be provided. Transportation is a barrier that could not only be mitigated without having to significantly restructure any part of DCFS. Although it would require funding, it would be a structurally simple change, and would likely allow mental health resources to be more effectively utilized by girls in care.

<u>Conclusion</u>

Girls in foster care have poorer mental health outcomes than do boys, but there is little understanding in past literature as to why this is. Through interviews of caseworkers in an office on the South Side of Chicago, this paper sought to illuminate some of the reasons why caseworkers perceive girls to not be receiving effective mental health care. Through six interviews, a multitude of themes and barriers emerged.

Resources, provider quality, youth in care, and caregivers are all aspects of the foster care system that Cook County caseworkers identified as creating barriers to girls' mental health care. A lack of financial resources and the limited capacity of providers were common themes that emerged in interviews, intertwining with many other identified barriers. Provider quality also surfaced as a major theme, as caseworkers identified how insufficient training and failure to identify girls' mental illnesses and needs prevents girls from receiving effective care. Furthermore, turnover in foster care among caseworkers and mental health providers disrupts continuity of care, which has been shown in literature to be an extremely important aspect of effective mental health services. Youth themselves were the most commonly identified source of barriers to effective care, as girls often refuse to participate in treatment and reject care in a variety of ways. Finally, caregivers created barriers to mental health care through their own perception of mental health as well as their limited personal resources.

These barriers to girls in the foster care system receiving mental health care are complex on their own, but are made even more complex by the way that they intertwine with one another. It is difficult to consider the challenge that turnover causes without understanding in the ways it is related to the identification of less obvious mental illnesses, and it is difficult to understand the importance of financial barriers without understanding issues of youth engagement and caregiver

cooperation. These barriers cannot be extricated from one another. For this reason, it is difficult to eliminate one barrier without eliminating all of them, and therefore the best way to improve girls' access to mental health care is to find a solution that can address the issue's many facets at one time. Previous literature has shown that third-party organizations can very effectively deliver services to youth and other disadvantaged groups. The nonprofit organization that I have proposed would ideally be an effective way to address many different barriers without needing to increase DCFS funding or place additional responsibilities on caseworkers. By creating more continuity, limiting turnover, providing nontraditional therapeutic methods, and taking some of the burden off of caseworkers, this organization would be an asset to DCFS. This organization could supplement DCFS, working alongside it in order to ensure that more girls receive access to the mental health care that they need. Some reforms to DCFS could also be valuable, especially relating to training of caseworkers and issues of transportation.

It is imperative that future studies are conducted in order to identify weaknesses in the current system of delivering mental health care to girls in foster care in order to strengthen the quality of care that is provided. As the state has taken on the responsibility of the parent for all children in foster care, it is essential that policymakers and researchers are constantly working to ensure that these children are receiving the most effective care possible. There are several limitations to my study. If I were to conduct this study again, I would interview a higher volume of caseworkers and would interview caseworkers from more than one DCFS office. I recommend that future researchers attempt to broaden the scope of interviews in this way. Additionally, this study is limited to the perspective of caseworkers, and further research would benefit from incorporating the perspectives of girls in the foster care system themselves, as well as the perspectives of caregivers and mental health professionals. A broader research agenda would

allow researchers to see the barriers to girls receiving mental health care from different perspectives, showing the barriers identified in this study in a different light and elucidating new barriers that this study did not identify. By hearing the perspectives of all of the individuals who are involved in the process of a girl in the foster care system receiving mental health care, future studies could provide more effective and more comprehensive recommendations for how to improve this area of policy.

This study is also limited to the Chicago-Cook County area, and as such can only be applied to this area and areas that are similar in terms of demographics, DCFS size and budget, number of children in foster care, and other similar factors. Further research that identifies barriers faced by regions with smaller DCFS offices, fewer resources, fewer girls in care, or a different demographic of girls in care could allow researchers to propose recommendations that would be fitting for these different regions. While there may be some overlap with the barriers identified in this study, it is likely that different regions have their own particular barriers, therefore further research into other regions would be valuable in ensuring girls across the country are receiving quality mental health care.

Caseworker 2 described her frustrations with the system like this: "Because doing this work, they think you are a magician. That I could just pull a rabbit out of the hat and here this is your services…but the services that we have out here to treat these kids with mental health is just insufficient." The state has committed to preparing these girls for an auspicious and independent life after they leave care, and through reform and future research, the state will better be able to fulfil this obligation. When girls are getting necessary and sufficient mental health care, not only does their current mental health improve, but they are also more likely to be successful after being emancipated from foster care and entering the world. Several reforms and partnership with

a third-party organization will allow Cook County to better serve the girls in its care, and this partnership may be able to serve as a model for organizations across the country to improve the delivery of vital mental health services to girls in the foster care system.

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Education

The University of Chicago:	Chicago, IL

- Bachelor of Arts in Public Policy Studies, minor in English and Creative Writing — *Expected June 2018*
- GPA: 3.85/4.0, Dean's List: 2015, 2016

Professional Experience

COMMUNITY ACTIVISM LAW ALLIANCE	Chicago, IL
Executive Assistant to the Executive Director	*August 2018-Present*

- Communicated with clients regarding their cases and ensured client documents were sent to the proper third parties
- Managed Executive Director's schedule and monitored email for important messages
- Drafted fundraising letters and compiled lists of potential donors and foundation grants
- Assisted with CALA's accounting and various other organizational and operational tasks

COMMUNITY ACTIVISM LAW ALLIANCE	Chicago, IL
Operations Intern	*June 2017-August 2018*

- Created outreach materials and drafted messaging for fundraising and awareness campaigns
- Standardized organization metrics and drafted a presentation to share these metrics with funders
- Researched and compiled general practices for internship programs and created materials such as intern evaluations or CALA's internship program

50 STATE LLC	Washington, D.C.
Junior Associate	*June 2016-September 2016*

- Created and updated informational materials focusing on policy and political issues from the national and state level relevant to operations for a diverse client base
- Wrote reports and completed projects to keep team members up to date on gubernatorial races, state policy, and other news relevant to the firm's clients

THE OFFICE OF UNITED STATES SENATOR JOE DONNELLY	Washington, D.C
Intern	*June 2015-August 2015*

- Researched policy and drafted letters on current issues to send to constituents and directly with concerned constituents
- Attended and summarized committee hearings to report to the Senator's staff
- Drafted updates for the Senator's social media profiles

Leadership and Activities

UNIVERSITY OF CHICAGO WOMEN IN LAW	Chicago, IL
Founder and President	*April 2016-Present*

- Founded organization with the intention of creating a space for women with an interest in law to connect and collaborate
- Manage a board of eight women, organize weekly modules for general members as well as planning events outside of weekly meetings for member participation

PROJECT ROUSSEAU	Chicago, IL
Mentor and Broadening Horizons Chair	*October 2015- June 2017*

- Met with a high school student from Hyde Park Academy once a week to help the student succeed personally and academically, especially concerning the student's transition to college
- Served on the Executive Board and organize events as Broadening Horizons Chair on the University of Chicago campus and in Chicago for all students involved in Project Rousseau

UNIVERSITY OF CHICAGO DEPARTMENT OF COMPARATIVE HUMAN DEVELOPMENT	Chicago, IL
Research Assistant	*June 2016-Present*

- Analyzed interviews with students at various universities in Chicago in order to extract data relevant to the relationship between civic engagement, campus integration, micro-aggressions, and mental health for first year college students
- Worked with graduate students to write an academic paper on our findings from the interviews

ARTSHOULD	Chicago, IL
Mentor	*January 2015-Present*
School Coordinator	*September 2016-December 2016*

- Mentor a group of elementary students once a week by creating art projects with them
- Organized the group of University of Chicago student mentors as a school coordinator, handling individual mentor concerns and facilitating mentor participation

Skills

Technical: Microsoft Office, Basic AutoCAD, Basic STATA

Language: Spanish proficiency