Transforming Mental Health through an Integrated Health-Centered Approach to Child Welfare
Acknowledgement

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Executive Summary

“We often miss opportunity because it's dressed in overalls and looks like work.”

~ Thomas A. Edison
American Inventor and Businessman, 1847-1931

While Edison’s words were spoken at a different time in history, these words caution us not to overlook a compelling opportunity to begin solving America’s major behavioral health and substance misuse challenges – starting with Florida’s child welfare system. That system was created to offer a safety net to our most vulnerable. As a representative microcosm of society, the child welfare system offers a real world opportunity to serve as a practical laboratory to pilot transformative integrated, health-centered and evidence-tested approaches to mental health that can be scaled to impact broader system change.

Why child welfare? Mental health difficulties and substance misuse are especially pronounced among socially vulnerable populations. Individuals in the child welfare system are particularly impacted since they are more likely to experience trauma and be exposed to substance misuse.

Mental health and substance misuse touch virtually every family in America. Many can point to family members, friends, coworkers or neighbors who are struggling to address these challenges, which can be emotionally devastating and potentially life-threatening. The current opioid epidemic sweeping the nation has only exacerbated the crisis. It is now estimated that more people are dying of opioid-related overdoses than car crashes.¹

The direct and indirect consequences of these severe behavioral health problems are poor physical health, lost productivity, reduced quality of life, increased criminalization/incarceration, increased motor vehicle accidents, higher health care costs, child abuse/neglect and more.² This translates into economic burdens on society that are estimated to cost $400 billion annually (for substance misuse alone) in legal and health services, as well as lost productivity.³,⁴

Today, research advances are transforming our understanding of mental health problems and substance misuse as conditions and behaviors that result from the combined effect of biology and environment, which may impair an individual’s ability to control personal behavior. In fact, on November 16th, 2016, former Surgeon General Dr. Vivek H. Murthy released the first-ever Surgeon General’s Report on Alcohol, Drugs and Health, calling for a public health approach to address substance misuse through integrated strategies addressing genetic, social and economic factors.² While these research advances are expanding our knowledge of mental health and substance misuse, Florida’s child welfare system has yet to have the opportunity to take full advantage of current and

As a representative microcosm of society, the child welfare system offers a real world opportunity to serve as a practical laboratory to pilot transformative integrated, health-centered and evidence-tested approaches to mental health that can be scaled to impact broader system change.

Key stakeholders from a cross-section of essential societal institutions—law enforcement, health care, social work, the judiciary, criminal justice, education and others—already interact with the child welfare system.

The need to overhaul the systems of care for these difficult social problems perhaps has never been greater.
emerging research on how to most scientifically address these very troubling social problems. Routine screening, assessment and treatment of children and families are incident-driven and overwhelmingly guided by scorecards and operational compliance supported by outdated processes. This present-day “check the box” approach too often results in children and families being treated similarly, regardless of their needs and varying severity of their environment and behavior. As a result, clients are more likely to re-enter the system, as their care was neither individualized nor their circumstances and behavior properly assessed. This unnecessarily creates a revolving door of clients that increases service demands and costs, often leading to worsening of conditions that ultimately produce poorer outcomes for the child, family and community.

Evaluations of children, individuals and families served by the child welfare system must include the specific background and circumstances (prior trauma, multi-generational abuse and other preexisting conditions) that contributed to their contact with the child welfare system. To transform Florida’s child welfare system, and potentially impact broader system change across Florida’s communities, emerging best practices and research must guide the establishment of innovative and integrated health-centered approaches for screening, assessment and treatment.

To set the stage for system transformation in child welfare, five essential elements are needed: 1) comprehensive screening and motivational interviewing, 2) assessments conducted by behavioral health professionals, 3) trauma-focused treatment through a triage delivery system, 4) cross-sector engagement, collaboration and process improvement and 5) community-wide culture of health environment.

A Criminalization and Punishment Crisis

The United States is suffering from a crisis of criminalizing rather than treating both behavioral health and substance misuse issues. The costs associated with these problems are substantial and impact not only the individual, but also the person’s family, community and society. The direct and indirect consequences of these problems as reflected in Figure 1, include poor physical health, lost productivity, reduced quality of life, increased criminalization/incarceration, motor vehicle crashes, health care costs, child abuse/neglect and more.

There are few, if any of us, who have not been impacted by these tragic social problems. Almost one in five adult Americans report having met the diagnostic criteria for a major mental disorder, and almost one in ten met the criteria for a substance use disorder. Among children, almost one in five report having a ‘seriously debilitating’ mental disorder in the past or present. The rates of the various behaviors that are covered by these diagnoses are staggering and reflect a troubling trend.
Historically, a punitive approach has been taken by the United States in addressing substance misuse, yet this has been unsuccessful in reducing its prevalence.\textsuperscript{2} The same can be said for the health care industry, which struggles to ensure ease of access to mental health services for clients. Despite national mandates for substance misuse and mental health problems to be treated at parity – the way general physical health conditions are treated – many individuals suffering with these problems cannot find affordable or available care within their networks, due to shortages of services, providers and the lack of public awareness and support.\textsuperscript{8} Moreover, the lack of meaningful prevention programs targeting mental health and substance misuse among the young often result in these individuals entering the child welfare and criminal justice systems.\textsuperscript{2,7}

A noteworthy announcement for the need to change these outcomes occurred on November 16th, 2016, when former Surgeon General Dr. Vivek H. Murthy released the first-ever Surgeon General’s Report on Alcohol, Drugs and Health.\textsuperscript{2} This landmark report calls for a public health approach that focuses on strategies addressing genetic, social and economic determinants of substance misuse and mental disorders, as well as their consequences. Utilizing evidence-based prevention and treatment measures to address these problems, like those available for other chronic conditions, should guide policies that will achieve improved outcomes at a lower cost and with less burden. Adjusting our approach is imperative, and as stated in the Surgeon General’s report, “how we respond to the addiction crisis is a moral test for America, one which will impact the social and economic outcomes of children and society in both the short and long run.”\textsuperscript{2}

\textbf{Figure 1}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{brain-disease-by-the-numbers.png}
\caption{Brain Disease by the Numbers}
\end{figure}

It is no surprise that these powerfully impacting problems are particularly pronounced among socially vulnerable populations. Thus, as a result of social and economic circumstances, the severity of substance misuse, as well as severely troubled behavior are especially intense for those within the child welfare system. These individuals are more likely to be exposed to familial substance misuse and more likely to experience trauma brought about by their social and physical environments, all of which enhance the occurrence of these problems.

While it is acknowledged that the current child welfare system was created without today’s scientific understanding of human behavior, the large-scale problems facing the system must embrace evidence-based/tested research regarding treatment and policy to solve the growing mental health and substance misuse crisis impacting the system today. Current screening, assessment and treatment protocols of children and their families in today’s child welfare system are overwhelmingly guided by an outdated approach centered on operational compliance, which causes children and families in general to be treated equally – regardless of their needs or varying severity. This over-reliance and attention on incidents and operational compliance is also referred to as a “check the box” approach in that it focuses on arbitrary criteria rather than outcome-centered behavioral change. This methodology not only limits the development of care plans that are based on trauma-focused, evidence-based/tested research and practice, but also limits the use of treatment protocols to address root causes and help the child and family heal while embracing long-term changes over the course of one’s life.

The child welfare system offers a unique opportunity to pilot transformative health-centered and evidence-based approaches to treatment, services and policies because key stakeholders from a cross-sector of essential societal institutions—law enforcement, health care, social work, the judiciary, criminal justice, education and others—are already involved with the system. Recognizing the child welfare environment as a microcosm of our society uniquely provides the potential for using how we respond to the addiction crisis is a moral test for America, one which will impact the social and economic outcomes of children and society in both the short and long run.”

- Dr. Vivek H. Murphy
evidence-based measures to address the genetic, social, individual and economic determinants of substance misuse and mental disturbance, revealing a pathway for treatment versus punishment.

The first step in transforming the child welfare system is embracing the need for a new biopsychosocial health-centered approach, one that is grounded in the ability to screen, assess and identify adequate treatment for these deeply troubling problems. This new approach provides the transformational framework to address mental disturbances and substance misuse as a public health crisis, requiring treatment and compassion for those affected rather than punishment and shame.

Also needed is the ability for child welfare professionals to acknowledge and evaluate the specific background and circumstances faced by each individual and family served by the child welfare system, including prior trauma and multigenerational abuse. Establishing new processes, services, programs and policies impacting the child welfare system must be informed by models identified through empirical research. These models, once found to be evidence based/tested, should be the theoretical underpinnings to support the programs, treatments and policies guiding child welfare professionals toward increased understanding at individual, family and community levels.

**Child Welfare: Poised for Change**

With these developments, the child welfare system is poised to embrace a health-centered approach for the children and families they serve. Shifting the child welfare system to a health-centered and integrated system of care will provide children and families with evidence-based/tested and comprehensive services. These services will be made available through a coordinated network of cross-sector stakeholders who work from a “common agenda” committed to meeting the complex and changing needs of children and families within the child welfare system. Through this health-centered and integrated approach, children and families entering the child welfare system would receive individualized, family-centered care that addresses not only the identified problems, but also the risk and protective factors often facing vulnerable children and families.

Clients with mild difficulties who do not necessarily require extensive care planning can more quickly begin and successfully undergo their care plans, permitting other clients with more severe and complex issues to receive the higher level of care required for a more successful outcome. Unless it begins addressing clients in a “triage type” fashion, the child welfare system will likely continue to experience unnecessary high rates of children and families re-entering the system.

This re-entering phenomenon unnecessarily creates a revolving door of clients that increases service demands and costs, while often creating more serious problems for the client that lead to worse outcomes overall.
Discoveries and knowledge gained by this approach within the child welfare system can then be used to expand innovative and needed treatments to the general public.

**Evidence-based Assessment Models**

Behavioral health issues often develop in childhood/adolescence and begin with mild symptomatic behavior, but over time may become disabling, potentially reaching a life-threatening stage if improperly addressed. While there are biological models that can be used to understand some of the general underlying biological developmental processes, it is important to note that each individual does not develop in the same physiological way as a result of genetic, environmental and developmental factors that are acutely individualized and interconnected. In addition to paying attention to the biological developmental issues, it is essential to pay close attention to the psychosocial environment as well.

An example of a biological model supported by the National Institute of Drug Abuse to understand the underlying biological development process is the brain disease model of addiction (see Figure 2). This model was established to better understand why and how
some individuals experience addiction, while others do not. In essence, there are three stages of the brain disease model of addiction, which provide an underlying explanation of the mechanisms of substance abuse. The first stage, binge and intoxication, occurs when the drug releases chemicals that result in sharp increases in the dopamine receptors of the brain. These receptors are responsible for regulating sensations of pleasure. When an individual is binge drinking, or becomes intoxicated, these receptors send a ‘reward’ signal of pleasure that triggers a ‘conditioned learning’ in the individual. After repeated exposure, the dopamine receptors cause the individual to physiologically need the alcohol/drug to achieve this pleasure, thus producing strong cravings for the alcohol/drug.

The second stage of the brain disease model of addiction is when the individual starts to experience withdrawal and negative effects as a result of not having the drug. During this stage, the alcohol/drugs being used by an individual begin to rewire the brain’s motivational/reward system by lowering the dopamine levels. When this occurs, the addicted person become less motivated by normal conditions that were once considered pleasant and enjoyable. Also in this stage, the use of alcohol/drugs causes adaptations in the brain’s amygdala, which has a primary role in the processing of memory, decision-making and emotional reactions. Also impacted is the basal forebrain, which produces important chemicals required for the proper functioning of the central nervous system. When these two sections of the brain malfunction, an individual’s stress levels and reactionary response increase, often resulting in significant negative behavioral feelings such as worry, anxiety and self-criticism. This condition forces the brain to be in what is called a push-pull cycle: as the brain craves the alcohol/drug’s short-lived ‘rewards’ while also intensifying the individual’s discomfort during withdrawal.

**Brain Disease Model of Addiction**

![Brain Disease Model of Addiction](Image)

**Figure 2**

<table>
<thead>
<tr>
<th>Stage of Addiction</th>
<th>Shifting Drivers Resulting from Neuroadaptation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Binge and intoxication</td>
<td>Feeling euphoric → Feeling good → Escaping dysphoria</td>
</tr>
<tr>
<td>Withdrawal and negative effect</td>
<td>Feeling reduced energy → Feeling reduced excitement → Feeling depressed, anxious, restless</td>
</tr>
<tr>
<td>Preoccupation and anticipation</td>
<td>Looking forward → Desiring drug → Obsessing and planning to get drug</td>
</tr>
</tbody>
</table>
The third and final stage is preoccupation and anticipation. This stage comprises changes in executive function in the prefrontal cortex area of the brain, which plays a vital role in the regulation of complex cognitive, emotional and behavioral functioning. In this final stage, the individual suffers from functional impairments that result in a decreased ability to voluntarily counteract strong urges and little ability to eliminate use of the alcohol/drug without experiencing significant discomfort.

Mental illness develops in a similar way to substance abuse, in that the severity of the condition worsens through successive stages.9

In addition to improving our understanding of the biological development process, we also need to systematically consider the interaction of biological, psychological and social factors in human development through an additional model. The ‘life course’ model is one we believe holds specific relevance for transforming the child welfare system through a health-centered approach. The life course model, as depicted in Figure 3, reveals that an individual’s overall health is a function of his/her developmental trajectory over the course of one’s life.11 It also suggests that there are particular periods of development (e.g., pregnancy) that are most vulnerable to the influence of ‘risk factors’ (e.g., substance abuse) and ‘protective factors’ (e.g., prenatal care, substance abuse treatment).

Risk factors represent circumstances that may worsen one’s health trajectory, while protective factors are those that may improve one’s trajectory. A downward shift in trajectory represents the accumulation of chronic and repeated stress, which is often a result of economic/social disadvantages that can cause wear and tear on the body (known as allostatic load) and possibly lead to lower reproductive potential, among other poor health outcomes. Particularly, it is suggested that state-level policies (e.g., priority access to substance abuse treatment among low-income families, criminalization of women with substance use disorders) are critical interventions that could improve or worsen the health trajectories of these vulnerable individuals. The time at which substances or trauma are introduced to an individual, combined with their social context,
can strongly impact the presence and severity of mental health and substance use disorders. Many of the risk factors reflected in the life course model are prevalent in child welfare’s vulnerable population.

**Components of an Integrated Health-Centered Approach**

Five crucial changes are needed to begin transforming Florida’s child welfare system to an integrated, health-centered approach focused on improved outcomes and more effective use of public resources:

1. **Comprehensive Screening and Motivational Interviewing:** The first step towards enabling appropriate intervention is to develop/validate and adopt a comprehensive tool based on the most common severe problematic behaviors and mood states to screen individuals correctly. To begin this process, it is necessary to note that screening differs from assessment. When conducting screenings, case managers or other child welfare professionals are only evaluating the possibility of severe problems, versus an assessment, which involves evaluating the scope of the problem and developing an assessment and treatment plan. A new comprehensive screening tool will enable case managers and other child welfare professionals to screen both the child and the parent, primary caregiver or other persons who play a critical role in the day-to-day well-being of the child.

A successful screening tool must address conditions/problems that are most prevalent in Florida’s child welfare system and incorporate components of validated screening tools that can examine specific behaviors and emotional responses of the individual. Examples of some of these behavioral problems and mood states and their currently utilized tools are:

- **Depression**, which is screened by the Patient Health Questionnaire-9 (PHQ-9) to address the likelihood and potential severity of depression by examining habits like energy and enjoyment in activities.

- **Anxiety**, which is addressed by the Generalized Anxiety Disorder-7 (GAD-7) screener consisting of questions regarding worrying, nervousness and restlessness.

- **Post-traumatic stress disorder (PTSD)**, which can impact more than military personnel and veterans, screened with the Primary Care-Post-Traumatic Stress Disorder (PC-PTSD). This instrument focuses on trauma through four questions and is especially important for problems that can progress as a result of traumatic life experiences.

- **Bipolar disorder**, which uses the Mood Disorder Questionnaire (MDQ), to examine mania (e.g., hyperactivity, restlessness) and irritability.

Components of the above listed screening tools can shape the development of a comprehensive tool capable of determining the presence of severe behavioral issues and mood states and whether a referral to a behavioral health provider is appropriate, based on symptomatic behavior and level of severity. It is important to note that the screening tool would not categorize the disturbance (e.g., diagnose), rather it would be used solely as the case manager’s guide for referral to an appropriate clinician for further assessment and treatment.

Beyond simply screening, child welfare professionals must also be educated and trained on how to utilize motivational interviewing. This practice allows the child welfare professional to obtain a basic understanding of an individual’s capacity and willingness for treatment and is essential for the process of behavior change and healing to begin. This technique is a client-focused counseling style that uses a conversational
approach to allow the client to ideally self-discover reasons to change behavior. The ‘counselor,’ specifically a case manager or behavioral health provider, questions the client about his or her desire to change and reasons why the client may be hesitant. This is followed by outlining an individualized plan of action to most successfully change the behavior and commit to the process of change. Motivational interviewing is an evidence-based technique that has been shown to produce greater treatment adherence and better outcomes among individuals with behavioral health conditions.²,¹⁷

2. Assessments Conducted by Behavioral Health Professionals: Following proper screening and referral by case managers, the behavioral health provider will use appropriate diagnostic tools to ensure a client’s problem is accurately identified. The tools utilized are at the discretion of the provider, but validated tools are recommended that accurately identify a client’s problem as well as its severity— that is, with appropriate sensitivity and specificity. Again, providers should discern the willingness and capacity of a client to engage in treatment, and individualize treatment options through motivational interviewing. For example, a provider may recommend evidence-based/tested clinical services such as behavioral therapy, or feedback informed treatment or where indicated medication for individuals who express a willingness to be treated.

3. Trauma-Focused Treatment through a Triage Delivery System: Once a diagnosis is made, the creation of a targeted treatment plan is critical. Treatment should incorporate the individual’s capacity and willingness to participate, and should build on techniques that support the client’s current mental, emotional and behavioral state. The goal of treatment is to create an individualized plan that will reduce or eliminate adverse impacts
on the client’s health and social functioning through an understanding of the severity of the problem and the client’s ability and willingness to receive treatment. Treatment plans should exist across a continuum of care and be individualized to the client’s specific problem and its severity.\textsuperscript{2}

For those assessed with a mild problem, the provider should look to early intervention strategies to prevent the problem from increasing in severity. Early intervention services may include information about the condition and normal/safe levels of substance use, and/or strategies to quit or reduce substance use or manage the mental health condition. The provider may also choose to encourage the patient to engage in further treatment.\textsuperscript{2}

For those diagnosed with a moderate problem for which motivational interviewing was deemed unsuccessful in encouraging behavior change, treatment engagement and harm reduction strategies should be implemented. Clients moderately impacted may be unwilling to change their behavior. Keeping this in mind, harm reduction strategies encourage individuals to reduce their risk of poor health outcomes. This can include, for example, outreach and educational programs about the condition/problem and overdose prevention education.\textsuperscript{2}

Regardless of the continuum, the provider may recommend medication (perhaps after behavioral interventions are exhausted), group/individual behavioral interventions or both. Behavioral interventions, specifically behavioral therapy or cognitive-behavioral therapy, teach and motivate clients about their behavioral problem, as well as how to modify associated poor behavior. One evidence-based approach mentioned, cognitive-behavioral therapy (CBT), teaches the clients techniques to modify poor behavior and improve coping skills. This individualized approach, occurring over 12 to 24 weekly sessions, reduces the likelihood for continued poor behavior by identifying and adjusting unhelpful thinking.\textsuperscript{2}

Adults and children who received CBT were significantly more likely to report improved outcomes than those who did not receive CBT.\textsuperscript{18-20}

While any number of strategies may be implemented by the provider, the treatment plan that is developed should be supportive, individualized and utilize validated tools, as this leads to optimal health and social outcomes. This includes incorporating the individual context through which one’s problem is manifested, such as prior trauma experienced by the individual. Understanding each client’s unique situation will allow for care that is compassionate and encourages behavior change. Specific details surrounding the trauma of a client, including risk factors such as prior history of abuse or victimization, can hinder one’s willingness to participate in treatment; however, recognition of this by a clinician can minimize this reluctance.\textsuperscript{21}

Additionally, trauma providers should be willing to 1) ask clients about their trauma (as they are unlikely to volunteer details on their own), 2) collaborate with critical people, 3) recognize a client’s strength and potential for growth, and 4) be knowledgeable about up-to-date/clinical research methodology.\textsuperscript{21} In particular, incorporating a client’s willingness to engage in treatment, recognizing the severity of their problem, and utilizing validated tools will lead to treatment plans with strong outcomes for both the client and society.

\textbf{To achieve improved outcomes within the child welfare system, and ultimately society, an innovative practice model is needed that also extends beyond treating individuals and addresses a system which currently does not recognize the wide variance of factors needed for individual change.}
The current child welfare system has historically focused resources on the child’s immediate safety and permanency. However, there still remains a need to promote overall family well-being. There is also a critical need for updated diagnosis and treatment practices, specifically relating to individualization and trauma. To achieve improved outcomes within the child welfare system, and ultimately society, an innovative practice model is needed that also extends beyond treating individuals and addresses a system which currently does not recognize the wide variance of factors needed for individual change, including key people in the child’s life. Addressing this can occur through an updated process that incorporates new screening, assessment and treatment, while simultaneously integrating the best available business practices.

4. Cross-Sector Engagement, Collaboration and Process Improvement: As described by distinguished American psychologist Abraham Maslow, there is a hierarchical order of needs through which individuals are motivated. On Maslow’s ‘pyramid of needs’ (Figure 4), it is made clear that certain needs must be met before others can be achieved.22

Through cross-sector engagement and a collective impact model, stakeholders can effectively address the risk factors – such as poor housing, education and unemployment – that are recurring root causes for many children and families who enter the child welfare system.

The most basic needs described in the pyramid are physical and safety needs, both of which are emphasized through current child welfare practices and programs. As Maslow’s pyramid suggests, it is important for the child welfare system to first focus on meeting the basic needs of the child related to his/her safety and permanency.

However, Maslow’s pyramid also suggests that in order to achieve long-term success for children and families, the child welfare system must move beyond meeting basic needs and establish a process to meet the higher needs of children and families. Addressing these higher needs related to well-being – such as belongingness, love and self-esteem – are critical because they equip individuals with the skills necessary to address the root causes (risk and protective factors) of their circumstances and, in turn, prevent or reduce future occurrences or poor outcomes. Only by focusing on meeting these higher psychological needs and well-being can opportunities be created for children and caregivers served by the child welfare system to realize a fulfilling, successful and productive life.

For the child welfare system to successfully meet these higher and most critical needs, cross-sector engagement and collective impact with multiple societal institutions, businesses and other local, state and federal agencies are essential.

Through cross-sector engagement and a collective community impact model, stakeholders can effectively address the risk factors – such as
poor housing, education and unemployment – that are recurring root causes for many children and families who enter the child welfare system.

Embracing cross-sector engagement and a collective impact model is a significant and crucial component for the child welfare system’s stakeholders to successfully move beyond meeting basic needs of the children and families they serve. In addition, a culture of performance improvement that recognizes and values the contributions of all stakeholders must be established in order to transform the current system in which the burden of meeting all key needs of the child and family disproportionately rests upon the child welfare professional or team.

To create a culture of health, every individual, organization or entity must be held accountable for this crisis and understand their role in the solution.

5. Adopting a Community-Wide Culture of Health Environment: Critical to the implementation of an innovative, integrated and coordinated system of care is establishing a framework that engages the protective capacities of a community, (e.g., healthcare services, transportation, employment development, child care and education, etc.) to embrace a community-wide culture of health. This culture would recognize that mental health and substance misuse must be treated as a disease of the brain. To do this, every individual, organization or entity must be held accountable for this crisis and understand their role in the solution. The entire community must embrace certain principles in working with the child welfare system to adopt a health-centered approach, such as:

1) providing incentives for businesses, governments, individuals and organizations to work together,

2) empowering individuals and families with the means and opportunity to make their own choices, and

3) ensuring that healthcare is affordable, efficient, accessible and high quality.23

There are multiple pathways for building a successful, innovative and integrated health-centered approach that will transform the child welfare system. Inspired by the work of the Robert Wood Johnson Foundation, Figure 5 summarizes the action framework required for driving measurable sustainable progress and improving the health and well-being of children and families served by the child welfare system.23

![Figure 5](image-url)
Conclusion

A healthy community is one with not just a strong healthcare system, but also a strong public health educational system, safe streets, effective public transportation and affordable, high quality food and housing – where all individuals have opportunities to thrive. Thus, community leaders should work together to mobilize the capacities of healthcare organizations, social service organizations, educational systems, community-based organizations, government health agencies, religious institutions, law enforcement, local businesses, researchers, and other public, private and voluntary entities. Everyone has a role to play in addressing substance misuse and its consequences, and thereby improving the public health.

Research is critical to guiding practice because it serves as the foundation for understanding the underlying mechanisms that drive multi-sectoral change (i.e., individual, interpersonal, institutional, systemic). By recognizing the child welfare system as a microcosm of society, the need for large-scale change and a paradigm shift that treats – rather than punishes – human difficulties such as substance misuse and behavioral difficulties can be addressed. The child welfare system offers a unique opportunity to use evidence-based/tested research to create a practice model that timely screens, assesses and appropriately treats behavioral health conditions/problems of children and child welfare-involved caregivers.

Developing such a practice model will require a multi-phase, multi-year approach. New tools appropriate for the child/parent or caregivers will need to be developed and stakeholders from across the various sectors of care will need to be engaged. A broad-scale community outreach initiative is also needed to build public awareness and support for this new approach.

Regardless of the time and effort that are needed, for the sake of our children, families and communities, this is an innovative opportunity that should not be overlooked.
References


To transform Florida’s child welfare system, and potentially impact broader system change across Florida’s communities, emerging best practices and research must guide the establishment of innovative and integrated health-centered approaches for screening, assessment and treatment.