



# Best Practice

## Next Practice

### Family-Centered Child Welfare

A publication of the National Child Welfare Resource Center for Family-Centered Practice, a service of the Children's Bureau

Winter 2004  
Mental Health in Child Welfare  
A focus on caregivers

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## Frontline Worker from Mars

Stranded on this planet for a few months, a caseworker from Mars stopped me in the hall one day. The Martian asked, "How do you keep your children safe?"

It didn't take me long to reply. I said, "Well, we hire a group of 24-year-olds, we give them a month of training, we send them to look at incredibly complex and deeply disturbing, distressed families for a few hours a month, we tell them to make life or death decisions, and if they are wrong, remind them that something terrible will happen in the family and that they will be publicly crucified. That's how we do it."

"What?" the Martian asked. "You do what?"

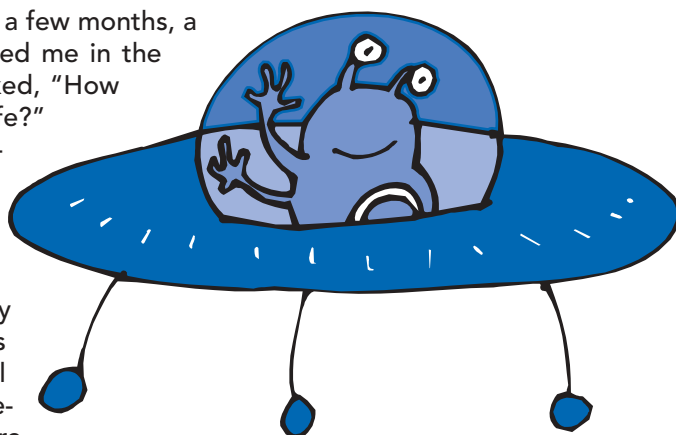
"That is what we do to keep children safe. We isolate frontline workers," I explained. "We send them out there fearful and confused, to make huge decisions about which they know they do not have the knowledge base, the evidence, or the expertise," I said.

"They must constantly say to themselves, 'Oh, dear God, I know what I am doing, I know what I am doing, I know what I am doing.' There is nothing more dangerous in this world than the person who thinks they know what they don't know and has power over others."

The Martian was astonished. "Are all important decisions made this way, in isolation?" he asked. "It's a terrifying notion."

"Oh, no," I said. "In our judicial system we have juries of 6 to 12."

—Harry Spence, Commissioner, Massachusetts Department of Social Services



## Mental Health Issues in the Child Welfare System

This issue of *Best Practice/Next Practice* is the second of a two-part series on mental health issues for families in the child welfare system. The first issue, Summer 2003, focused on the significant number of children identified by the child welfare system for safety concerns who also demonstrate signs of developmental de-

lays and/or emotional or behavioral conditions. In addition, the Summer issue described the experience of those who are placed in care, for which the separation experience and the multiple placements further compromise their social and emotional development. This Winter 2004 issue focuses on another key player for

families in the child welfare system: caregivers, especially frontline workers and supervisors who often are expected to function directly or indirectly to ensure the healthy development of children in the child welfare system. The child welfare system and the state, especially when assuming custody, becomes responsible for the care, education, nurturing, and healthy development of the child.

The demands upon the child welfare system are great. Frontline workers and supervisors carry a great responsibility. As explained to the Frontline Worker from Mars, they are expected to perform difficult interventions and make skilled judgments that have the power to shift the trajectory of a child's or family's life. Workers become the only connection between troubled families and the system that is designed to help them. The public expects that workers will mitigate often deep-rooted consequences of poverty, isolation, mental illness, inadequate education, and other complex issues.

These expectations, however, are not matched with adequate salaries and supports such as appropriate training and supervision. In addition, many state child welfare systems are burdened with staff shortages, high caseloads and turnover rates, and a range of administrative challenges. Workers operate under a punitive system of accountability in meeting minimal safety

and permanency needs of the children under their watch—cases of maltreatment in the system often are front-page news. The workers' feelings about the families with whom they work can have a profound—usually unexamined—impact on their work. Their mental health and emotional wellness frame workers' actions and interventions, but they often have difficulty separating their own needs, problems, feelings, and thoughts from those of the families they serve. Seldom can they allow themselves to *feel*, to ask for support, or obtain mental health interventions for themselves. These professionals are in double jeopardy: staff at risk, helping families and children at risk.

In the words of a former associate commissioner of the Children's Bureau, Carol Spigner, "The child welfare system suffers from the same lack of support that many of its vulnerable families suffer." Nevertheless, and despite these ongoing challenges, child welfare staff work hard to improve children's and families' lives. They are the key to improving mental health outcomes for children and families in the system.

The healthy emotional development of children and families within the child welfare system is truly a responsibility of many systems—health, behavioral health, early childhood care and education, early intervention, education

and special education. All these systems need to work with the child welfare system to fulfill its part in getting children and families the supports and interventions they need.

Spurred in part by the federal Child and Family Services Reviews, momentum is growing to improve the outcomes of safety, permanency, and well-being of children in the child welfare system. This current interest in improving child welfare systems can highlight the importance in providing supports to staff to meet the program improvement plan goals.

In addition, the work of *Systems of Care*, a collaboration of community-based, culturally sensitive, and family-based interventions, show there is currently strong interest in programs and strategies to enhance the quality, coordination, and accessibility of supports and interventions for families with children who demonstrate severe emotional disturbances. As states develop and fund system of care communities, there are opportunities to incorporate strategies related to child welfare's role in enhancing the well-being of children. Child welfare staff and advocates should be part of the deliberations on what strategies to undertake to ensure the mental wellness of the children they serve.

Drawing on the work of the National Child Welfare Resource Center for Family-Centered Prac-

tice and several other agencies, this issue highlights family, staff, program, and multidisciplinary perspectives on effective practices that can help address mental health concerns in children and families in the child welfare system. Our emphasis is on issues

not typically defined as part of the mental health agenda, but integral to improving the outcomes for children and families: providing training and supervision as well as emotional and other supports to staff and caregivers such as biological, foster, kin, and

adoptive families of vulnerable children. Perhaps more workers could then feel empowered, as Trevor John in New York City (see box), and become an agent for positive change for families.

Why ... does a frontline social worker like Trevor John love what he calls “grunt work”—a job that repeatedly brings him face-to-face with heartbreak, anger, and cruelty?

“I’m an agent for change—that’s the gratification I get,” said John, 31, a New York City social worker since 1997.

“I’m the one who puts the first foot into that family’s home — we’re the first responders when something goes wrong with children. Within three or four weeks, you’re engaged with that family and you begin to see a change.”

John, who grew up in New York, works for the Administration for Children’s Services in a program that tries to help troubled families stay together, rather than remove children and place them in foster care.

“They used to call us baby snatchers,” John said. “But now we have more preventative services. I’ve gotten thank-you letters; one family sent me a photo of their child graduating from first grade.”

John joined the New York City agency as it was still struggling with aftershocks of one of its worst horror stories—the 1995 beating death of 6-year-old Elisa Izquierdo. The city conceded that child welfare officials knew Elisa was at risk for abuse but did not adequately monitor her case.

New York City’s record has improved since then. Initiatives like John’s Family Preservation Program have boosted the morale of social workers and enabled the city to cut by almost half the number of children moved from their own families into foster care.

Since the Elisa Izquierdo tragedy, New York City’s Administration for Children’s Services has

sought to improve its performance and its social workers’ morale by emphasizing teamwork and encouraging creative, community-based approaches to problems.

“People used to be afraid to make the wrong decision,” the agency’s commissioner, William C. Bell, said. “If they did, the caseworker and the supervisor were fired, but the system would stay the same. Now,” Bell said, “if you’re doing your best, you’re going to be supported.”

Trevor John, who is working toward a master’s degree with financial help from his agency, said the new approach had given him and his colleagues more confidence.

“You don’t have that sense of being thrown out to the wolves,” he said. “Now, you have six or seven collective ideas, and you feel more secure in making a decision.”

Aspects of the job remain difficult—especially when John encounters an infant or toddler who has been beaten or sexually abused.

“You learn to cope, you learn to deal with it, but you don’t get used to it,” he said. “To make an impact on our country, to help shape the future, you have to work with these children and their families,” he said. “Regardless of how people feel, we’re there to help.”

*Adapted from “Social Workers Embattled but Not Embittered,” by David Crary, Associated Press Writer, and published in the Los Angeles Times, January 4, 2004.*

## The Experience from Within: Helping the Child Protective Service Caseworker

by Gerard Costa, Ph.D.

*Diego, a 31-year-old Child Protective Service (CPS) caseworker, is called into his supervisor's office and told that a five-month-old infant in his caseload was killed by the infant's mother while her three- and seven-year-old children were at home. Diego had visited the family just yesterday and, as mandated by the courts, the mother had completed a parenting skills course the prior week. One hour before the tragedy occurred, the home health aide left for the day noting nothing of concern.*

*Felicia, a veteran of 17 years in the CPS agency, worked closely with a mother who took an overdose of drugs during pregnancy with a child she did not want. The infant survived with serious medical injuries and remained hospitalized for four months in the neonatal and special care nurseries. The mother grieved her actions and actively participated in therapy. Plans were made to reunite the mother and child, and the infant was released to a special care facility for medically fragile infants. One week after her arrival at the facility and the night before her planned return to her mother, the infant suddenly stopped breathing and died. Felicia is asked to go to the mother's home to inform her of the infant's death. When she arrives, she sees the mother at the curbside where a parcel service has just delivered an infant's high chair and crib. The elevator is not working and Felicia is asked to help carry the items up three flights of stairs where she enters the apartment to tell this mother of her infant's death.*

*Martin began working in the CPS agency four months ago, just after graduat-*

*ing from college with a bachelor's degree in social work. He made it the hard way. He was placed in foster care at age seven because of his father's abuse and his mother's drug habit. He ran away at age 17, stole a car with some friends, and spent six months in juvenile detention where he completed his high school diploma. Now at age 23, he wants a career that will, in his words, "...save other children from what I went through." Among his first cases is a seven-year-old boy whose father physically abused him while his mother was high from drugs. These are familiar stories to those who work in the child protective service systems in our nation and to the other allied professionals who work with them. The child protective caseworker is among the "frontline" helpers, the "first responders," who are confronted with some of the most painful and damaging experiences that occur in the lives of children and families. In all cases, some failure or inadequacy in parenting is evident, and the CPS system is obligated to protect the child and provide support and intervention to a family that has not met their caregiving responsibilities. Achieving a balance between these two tasks, child welfare and family support, is indeed necessary and quite difficult.*

In 2001, more than 900,000 children were maltreated, most at the hands of their parents. Children between birth and three years of age are at greatest risk for abuse: Over 85,000 victims (9.4 percent) were un-

der age one, and over 249,000 (27.8 percent) were under age three. The data consistently reveal that the greatest risk for abuse is for children who are between birth and three years of age. Childhood deaths that result from maltreatment also occur at the greatest rate under age three: 1,300 in 2001. (*Child Maltreatment 2001, DHHS.*)

### The Caseworker's Experience from Within

While the period from birth to three has been given increased attention in the past decade, information about these developmental periods and risks, and the field of infant mental health, has not been integrated in the training and supervision of the very frontline staff who need it most—for caseworkers and the families they must help. Knowledge about infant development, human attachment, mental health, and family dynamics is essential to casework, but equally critical is the availability of regular case supervision for the caseworker. This is essential for several reasons:

- Caseworkers are not robots! They have personal lives, histories, knowledge, attitudes, and beliefs that form who they are and what they do. While we often consider the impact a client's prior experiences have on the way they regard the caseworker (what is called *transference* in mental health work), we fail to examine the reverse process where caseworkers, *on the basis of their personal lives and experiences in the field*, will also carry notions and feelings about the children and families they encounter. The impact of these subjective experiences has a profound but often unexamined effect on the nature of the work with families.

- Caseworkers encounter families in crisis when the families' resources and coping strategies are severely compromised. Like all "first responders," child protective caseworkers can experience *vicarious trauma* and *caregiver fatigue*. By *vicarious trauma*, we mean that the worker can feel within themselves something akin to what the family is feeling, whether it is fear, anger, chaos, sadness, hopelessness, helplessness, and countless other emotions. These experiences deplete us physically, emotionally, and spiritually. By virtue of their responsibility to intervene in crises where the stakes literally can involve life and death decisions, caseworkers can experience fatigue, exhaustion, and "burnout."
- Decisions must be examined to ensure that the needed balance between child protection and family support is reached. When caseworkers, like Martin (page 4),



encounter events that evoke shadows and experiences from their own pasts, the risks in their work are even greater and may include enormous empathy to “save the child” along with rage at a hurtful parent. How can we be sure that those decisions are really in the best interests of the child and family and are not rooted in a wish to undo an old injury? This is not unusual, and appropriate supervision is necessary so that no case is ever handled alone.

## Reflective Supervision

Casework involves skill, experience, and emotion, and requires attention to better understand and guide effective helping relationships. Given the importance of attending to the nature of this



relationship, particularly in child protective casework and the caseworker’s often unexamined emotional response, what can we do to enhance our awareness and use our feelings to help families in their parenting journey? *Reflective supervision* has long been viewed as an essential component of training mental health professionals and an integral part of clinical work for experienced clinicians. Reflective supervision is becoming equally important for staff within child protective services.

What is reflective supervision? It is a *helping relationship for the helper* where both the client’s and the worker’s needs are considered. This optimizes the effectiveness of the intervention. Supervision creates a partnership so that the caseworker never feels alone, is not overwhelmed by fear or uncertainty, feels safe to express thoughts, feelings, and reactions, and learns more about him/herself, the client, and the work.

Emily Fenichel (1992) and the Zero to Three workgroup on supervision and mentorship describe the supervisory relationship as one in which the worker’s *vulnerabilities are partnered and strengths are enhanced*. They describe three essential components of “reflective” supervision:

**Reflection.** This is a “stepping back;” an encouragement to slow down and wonder about the family and the nature of the work.

**Collaboration.** Supervision requires a partner in the process of reflection. Typically the partner is more experienced and from the same discipline, but collaboration only requires an openness to create a safe and secure environment in which the helper can explore information, activities, and feelings in the work without fear of criticism, shame, or retribution.

**Regularity.** Supervision is not a “once in a while” event, happening only when time permits, or when other meetings are cancelled. Reflective supervision must occur regularly and consistently and is “protected” time. (Bertacchi, 1996, examines organizations from the vantage point of “reflective practices.” Shahmoon-Shanok, 1992, offers a clear description of reflective supervision.)

## What is Needed

Child protective caseworkers must be supported in their work by rigorous preparation and training, limited caseloads that allow the needed level of monitoring and support, and regular reflective supervision. These needs are met in many ways. Costa, Caragol, and Calello (1998) describe a model of training and case consultation for integrating infant and family mental health principles into early intervention services, for children from birth to three years with developmental disabilities and their families. This

model involved an initial training module, monthly case consultations with peers and mental health consultants, regular individual or small group reflective supervision, and periodic trainings and seminars on topics related to the problems families were facing.

The critical features are regular, protected, collaborative, reflective opportunities to meet with supervisory staff and peers to examine the complex nature of the cases and the experiences that occur within the caseworker. This is not a practice that occurs only when some “free time” occurs, but must be viewed as an essential ingredient of child protection.

Dr. David Peters, a cherished supervisor, had a wonderful, humorous way of reminding his staff of the need for supervision: “We need supervision to save patients from *ourselves!*” Supervision is needed not only for the difficult cases, but especially in those cases in which caseworkers “fall in love” with the family and are not aware of any difficulties or challenges in the work. Such cases can present a number of “blind spots”—caseworkers remain unaware of certain aspects of themselves and of the family. Dr. Peters had another admonition: “If you overidentify with your patient, there are *two* patients and *no* doctor!”

Child protective caseworkers serve a critical role in our obliga-

tion to protect children from harm. In 2001, the number of maltreated children approached one million. These children become disproportionately represented in the special education system, in the juvenile justice system and when they age, as abusive parents. The intervention provided to them and their families will determine whether such predictions can be reversed.

It is not just the children and their families who suffer. The cost in real and human capital is enormous. Caseworkers like Diego, Felicia, and Martin are changed by their experiences. It is our obligation to be sure that change is productive.

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## Childhood Abuse History, Secondary Traumatic Stress, and Child Welfare Workers

Social work educators and other helping professionals teach students how to use empathy as a tool for effective practice. Educators have not, however, been as effective in teaching students about the potential hazards in using empathy with clients who have experienced trauma. The work done by social workers vicariously exposes them to trauma through their clients' trauma. This phenomena, called secondary traumatic stress (STS), vicarious traumatization, or compassion fatigue, presents a risk of negative personal psychological consequences. Social work professionals have just begun to recognize the relevance of the phenomena to their work.

Child welfare work is stressful for many reasons. Child welfare organizations operate on a tight wire strung between family privacy and child protection. The public perceives workers as powerful—they can take children from parents—whereas workers perceive themselves as powerless, their hands tied by the red tape of their own bureaucracies and the lack of resources to adequately address the complex problems of child abuse and neglect. These factors contribute to burnout. Burnout is a “state of physical, emotional, and mental exhaustion caused by long-term

involvement in emotionally demanding situations.” Workers who suffer from burnout experience physical, emotional, behavioral, work-related and interpersonal symptoms including fatigue, irritability, indifference, and poor work performance. Burnout is often characterized as an organizational problem, not an individual problem. Steps can be taken within an organization to reduce its occurrence. Organizations may rotate work assignments, decrease workloads, and encourage staff to take time off in an effort to reduce burnout.

STS, in comparison, is an outcome or risk that is related to engaging empathically with another's traumatic material. This phenomenon has been characterized as a

natural consequence of caring between two people, one of whom is affected by the other's traumatic experience. The effects of STS are not necessarily a problem in the therapeutic process, but more a natural by-product of caring for traumatized people.

Burnout and STS share similar symptoms and the effects of these symptoms are cumulative. Those suffering from STS also experience physical, emotional, and behavioral work-related and interpersonal symptoms. Workers with STS may experience increased fatigue or illness, emotional numbing, social withdrawal, reduced productivity, and feelings of hopelessness and despair. The key factor that differentiates STS and burnout lies in the cause of the



symptoms. Symptoms of STS occur as a direct result of hearing emotionally shocking material from clients, whereas burnout can occur as a result of work with any client groups, but in response to stressors resulting from the organizational environment.

Several studies have examined the effects of personal trauma history and trauma work on emergency service personnel and mental health and law enforcement professionals. The deleterious effect that trauma work has on emergency service personnel has been recognized for decades. Researchers have moved beyond acknowledging and identifying the effect of trauma work to include research examining the effect that empathic engagement with clients' trauma has on helping professionals who provide psychological support to trauma victims.

Researchers have not, until now, investigated STS with child welfare professionals. This is unfortunate because child welfare work makes those professionals likely candidates for STS. Child welfare professionals must establish empathic engagement with children who have experienced trauma. The more successful in engagement, the more at-risk workers may become due to indirect exposure to their client's traumatic material. Empathic engagement helps workers meet the needs of traumatized children.

Empathic engagement, however, has also been associated with inducing traumatic materials from the primary victim, the client, to the secondary victim, the worker. Empathizing with a traumatized client helps the worker to understand the client's experience of being traumatized, but in the process the worker may be traumatized as well.

Child welfare workers and therapists share similarities and differences in their work with traumatized clients. Both are expected to listen to clients' traumatic stories and help them work through painful or disruptive reactions to the trauma. The methods each uses to help clients achieve resolution may differ, but the goal remains the same.

Unlike therapists, however, child welfare workers carry the burden of assessing whether abuse or neglect has occurred. Their role requires them to establish contact with children when the children are in acute distress. The child welfare worker has the additional responsibility of confronting the alleged perpetrator regarding the abuse allegation. If the allegation is founded, child welfare workers deal with the perpetrator and decide what happens to the child. Workers understand that their assessments greatly affect what happens to children. An assessment can mean the difference between life and death.

According to a recent study, personal experience of childhood trauma in the form of child abuse and neglect increases a child welfare worker's risk of STS. The findings indicate that a combination of more than one type of childhood maltreatment (emotional abuse, physical abuse, sexual abuse, emotional neglect, physical neglect) presents the greatest risk for that vulnerability. Emotional abuse or neglect seem to be issues in a person's history that place them at most risk. The findings support the results of studies of other types of professionals, who report that a history of childhood trauma heightens risk of STS.

In acknowledging and providing intervention for the emotional effects of child welfare work, we could paradoxically end up blaming the victim (the worker). A worker's own history of abuse and neglect could be acting to increase vulnerability to STS. A preventative approach is necessary—we must change the environment in which people work rather than rescue them from it. The recognition of the risks and effects of STS is imperative within child welfare agencies. Prevention and management of STS must be shared by the agency and the workers; neither can do it alone.

Addressing the occupational hazard of STS is in the best interest of all involved, including vulnerable children, the organizations

responsible for their care and protection, the workers doing the work, and society. Many have postulated that burnout is related to high turnover in child welfare agencies. Perhaps STS, a more treatable phenomenon than burnout, might be another significant predictor of worker turnover. The organizational costs of hiring and training new employees are significant. More important, however, are the long-term effects on the mental and physical health of people. The most important resources in the effort to care for vulnerable children are the people who do the work. Those who do their work well, who use empathy most effectively, are most vulnerable. It may be that personal backgrounds of maltreatment enhance professionals' empathy level, thus placing them at greater risk of psychological harm.

Administrators and staff developers must include STS in their thinking about

developing and retaining staff. They need to be aware of the research so that they can minimize harm to their workers. In-service training about the phenomenon and an ongoing program to manage the effects of STS may be imperative for all workers, not only those with histories of childhood trauma. Ensuring that employee health plans provide coverage for mental health intervention is also pressing.

Those who educate child welfare workers should enable students to make an informed decision about using empathy in practice and inform them how their personal characteristics may increase that risk.

*Nelson-Gardell, D., & Harris, D. (2003). Childhood abuse history, secondary traumatic stress, and child welfare workers. Child Welfare, 82, 5-26. To subscribe to Child Welfare, please visit [www.cwla.org/pubs](http://www.cwla.org/pubs).*

## Announcement

### Training Institute

June 23 - 27, 2004  
San Francisco, CA

Developing Local Systems of Care for Children and Adolescents with Emotional Disturbances and their Families: Early Intervention. In-depth, practical information on how to develop, organize, and operate coordinated, community-based, family-focused, culturally competent systems of care for children and their families and how to provide high quality, effective clinical interventions and supports within them. Special emphasis on early intervention and providing mental health services to young children and their families. For more information, contact:

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## Adult Disorders

The following DSM-IV Axis I and Axis II diagnostic categories represent an overview of conditions that child welfare workers encounter.

### Substance-Related Disorders

Between 80 and 90 percent of child welfare cases are estimated to involve substance abuse. Many symptoms and behaviors of individuals who are abusing substances are similar to other mental disorders, so it is important to determine whether the presenting symptomology is substance induced. Substance-related disorders are associated with maladaptive use, abuse, or dependence on one or more substances, including alcohol, legal or illegal drugs, and effects of toxins. Individuals who use one or more substances may experience adverse social, behavioral, psychological, and physiological effects. Symptoms may include delusions, hallucinations, depression, irritability, anxiety, euphoria, mania, sexual dysfunction, restlessness, and sleep problems. It is also possible for an individual to have both a substance disorder and a mental disorder, as is the case for 15 percent of all adults.

### Anxiety Disorders

Anxiety disorders are characterized by a heightened state of arousal or fear in relation to stressful events or feelings. The frequent experience of worry and apprehension is more intense and longer lasting than the anxiety experienced by the average person in everyday life. Symptoms are expressed in three ways: cognitively—symptoms include fears, intrusive thoughts, obsessions, dissociation, and numbing; somatically—symptoms include motor tension, the startle response, autonomic hyperarousal, rapid shallow breathing, increased heart rate, and/or other physical sensations; behaviorally—symptoms can include hypervigilance, avoidance of evocative stimuli, apprehensive self-absorption, compulsions, rituals, and compensatory behavior.

A common anxiety disorder is Acute and Post-Traumatic Stress Disorder. Those who have faced an extreme trauma may develop the disorder within the first month after experiencing trauma. Common symptoms include nightmares, flashbacks, numbing of emotions, irritability, and being easily distracted.

### Mood Disorders (also known as Affective Disorders)

Individuals show a noticeable disruption of mood that is outside the bounds of normal fluctuations of sadness or elation. Mood disorders are characterized by depression, mania, or both symptoms in alternating fashion. The abnormal mood may impair the client's social or occupational functioning. Various mood disorders are characterized by the intensity of the abnormal mood, its duration, the impairment it produces, and the accompanying behavioral, cognitive, or physical symptoms. Common mood disorders child welfare workers encounter include:

*Depression.* Characterized by an unusually sad and dejected mood, diminished interests, weight loss or gain, insomnia or hypersomnia, agitation or psychomotor retardation, lack of energy, feelings of worthlessness or guilt, difficulty in concentration and decision making, and at times, suicidal attempts or preoccupation with death.

*Mania.* Characterized by an unusually and persistently elevated, expansive, or irritable mood, inflated self-esteem or grandiosity, decreased need for sleep, excessive talking, distractibility, psychomotor agitation or increased goal-directed activity, and risk-taking behavior. Hypomania is a less severe variant of mania.

*Major Depressive Disorder.* Characterized by one or more significant depressive episodes.

*Dysthymic Disorder.* Chronic, low-grade depression, lasting two or more years for adults, and one year for children and adolescents.

*Bipolar Disorder.* Characterized by dramatic mood swings, severe changes in energy and behavior, from mania to depression, with periods of normal mood in between.

### Schizophrenia and Other Psychotic Disorders

Individuals are characterized as having a profound disruption in cognition and emotions, which affect their language, thought, and sense of self. Their perceptions of reality are strikingly different from the reality seen and shared by others around them. Symptoms include psychotic manifestations, such as hallucinations, delusions, disorganized speech, and loss of ego boundaries. In addition, individuals may demonstrate marked disorganization in their personal care, social relations, and job performance.

## Factitious Disorders

Individuals attempt to assume the role of a sick person who is in need of help by intentionally producing physical or psychological symptoms. The motivation is the psychological need to assume the sick role, which differs from acts of malingering. In malingering, the goal is to avoid environmental circumstances (i.e., going to work, taking responsibility) by intentionally producing physical or psychological symptoms.

## Dissociative Disorders

The distinguishing feature of this class of disorders is a disturbance of one's sense of personal stability due to a disruption of the normally integrative functions of memory, consciousness, sense of personal identity and/or perception of reality. This can lead to amnesia, feelings of depersonalization, or multiple distinct personalities in the same individual. This disorder is associated with individuals who are overwhelmed by intense pain or trauma and are trying to protect themselves from their distressing thoughts and feelings. Five essential dissociative symptoms are amnesia, depersonalization, derealization, identity confusion, and identity alteration.

## Eating Disorders

Eating disorders are characterized by severe disturbances in eating behavior and body image. Individuals may excessively restrict food intake or engage in binge eating. This is usually followed by compensatory behavior that includes excessive exercise, purging through self-induced vomiting, or the misuse of laxatives or diuretics. These disorders can be life threatening. The majority of eating disorders occur in adolescent and young adult women. Core symptoms include a distorted body image, inability to control food intake to maintain a healthy body weight, and fluctuation of self-evaluation that is dependent on perceived body shape or weight.

## Impulse Control Disorders Not Elsewhere Classified

Difficulties in impulse control can occur in many disorders, such as substance abuse, conduct disorder, and attention deficit disorder. In this class of diagnoses, the focus is on disorders of impulse control (intermittent explosive disorder, kleptomania, pyromania, pathological

gambling and tricotillomania) that are not addressed in other mental disorders. The essential features can include giving in to an urge or impulse to perform a harmful act, an inner sense of tension or arousal prior to performing the harmful act, and a sense of relief, gratification, or pleasure while committing the harmful act.

## Personality Disorders

Personality Disorders are characterized by long-lasting patterns of maladaptive behaviors and modes of thought that begin in adolescence or childhood. It often interferes with normal interpersonal relationships, and produces functional impairment or subjective distress. These patterns of behavior are markedly different from the expectations of the individual's culture, are pervasive, and stable over time.

Common personality disorders encountered by child welfare workers include:

*Borderline Personality Disorder.* Characterized by instability in mood, self-image, and personal relationships. Some symptoms include marked mood swings with periods of intense depression, irritability, or anxiety; inappropriate or uncontrolled anger; recurring suicidal threats or self-injurious behavior; unstable personal relationships with extreme black-and-white views of people; and frantic efforts to avoid abandonment. Occurs mostly in young women.

*Narcissistic Personality Disorder* involves a pervasive pattern of grandiosity (in fantasy or behavior), self-centeredness, and lack of empathy.

*Dependent Personality Disorder.* Characterized by a pattern of submission with a persistent need to be taken care of by others.

*Antisocial Personality Disorder.* Characterized by a pattern of disregard for the basic rights of others. Central features can include deceitfulness, aggressiveness, and lack of remorse. This disorder begins in childhood or early adolescence and continues into adulthood.

*Adjustment Disorders.* Characterized by significant distress due to a recent identifiable, psychosocial stress (financial difficulties, becoming a parent). The level of distress in response to the stressor is excessive. Symptoms develop within three months and clear up within six months of the removal of the stressor. Adjustment disorders are subdivided into subtypes according to the symptoms displayed.

## Keeping Families Together

*Adelia Moore, Ph.D.*

In three years Ginny and her preschool daughter Shelley lived in five shelters, after fleeing a man who had been violent with her and sexually abusive to Shelley. Highly anxious, depressed, and suffering from Post-Traumatic Stress Disorder, Ginny lacked judgment about people and had difficulty processing information or following through on tasks. Endearing and friendly in an almost childlike way, she attracted both exploitative friends and willing social service professionals. Ginny kept Shelley dressed and reasonably clean; she got her to school daily and to therapy weekly; she went to therapy herself, and came faithfully to a parents support group. But her judgment was poor, her neediness ran high, and her patience often wore thin. She kept taking in cats and choosing “bad” men, and Ginny fretted that Shelley might be taken from her. She had reason to be concerned.

Because of Esther’s passivity and unkempt physical appearance, many who met her assumed her to be mentally retarded. In fact Esther was a high school graduate who read the newspapers, had nursed both her boys, shopped and cooked for them, and brought them to the shelter’s preschool program daily. Yet her house was a mess, and strange adults were of-

ten in and out. The boys’ father was an addict who left dirty needles lying around the house and had no income except what he earned from salvaging bottles and cans. To be sure that there was money for food and rent, Esther had to hide her Social Security Insurance money from him.

Ginny was in danger of losing her daughter, and Esther’s boys were removed from her home because of alleged neglect.

### The Limits of the System

The Department of Children and Families’ (DCF) assessment of risk was legitimate in both cases, but foster care seemed a draconian solution. I had worked with Ginny and Esther for years as the facilitator of a parents support group. I felt compelled to act on behalf of “my” mothers. I contacted child welfare workers and court-appointed lawyers, attended case review conferences, and testified in court. I met with Ginny’s community-based team—a family preservation worker, a married couple from the Salvation Army, the shelter plus care worker, the child welfare worker, Ginny’s therapist, the outreach worker from a shelter, the Social Security Insurance payee—representatives from public, private, and religious

sectors who were all frustrated at the inability to really make things work for this small family. My passion to keep both Ginny’s and Esther’s families intact grew along with my frustration with the limits of existing services. Who was going to teach Esther the basics of housekeeping or the importance of looking presentable? Who would take the time to show Ginny how to brush Shelley’s hair or to better discern who was a safe friend?

A typical DCF treatment plan includes counseling and parenting classes. Esther and Ginny had attended both. The dirty needles in Esther’s house disappeared, but the dishes remained unwashed, the clothes stayed in garbage bags all over the apartment, and the supervised visits with the boys included no training in behavior management, child safety, or other parenting skills. Ginny made great strides in assessing the safety of visitors but continued to overreact to Shelley’s behavior. What if, instead of Esther’s children being removed from their home, or Ginny worrying that Shelley would be, both families could live in a place where case management, life skills classes, job training, and even therapy were there on site? What if Esther and Ginny’s strengths could be reinforced, their particular deficits identified and

specifically addressed, rather than try to fit them into the usual one-size-fits-all treatment plan?

## Networking

What if there was a way to prevent foster care placement and homelessness by providing housing for families with services attached? The director of my agency was intrigued when I talked to her about this idea. The agency had signed on to “Reaching Home,” Connecticut’s ten-year plan to end homelessness and planned to transform all of its shelters into permanent housing. “Develop the idea,” she told me and “and don’t worry about money.”

I needed answers to two questions: First, was there a need? Were the families I knew the exception, or were there many others like them? Second, would this idea work?

I began my research with people I knew, who in turn suggested people *they* knew. I discovered that a retired Sister of Mercy wanted to create a community of support within an apartment building; a professor of developmental psychology who was writing a book on risk and resilience in families was interested in this concept too. I kept a record of all the contacts I made and added names to the list with every new contact. I got really lucky; a friend knew the leading developer of supportive housing for homeless single adults. We met in New York City and talked about the possibility of ex-

tending the concept that had been successful with single adults to families. She recommended contacting the Corporation for Supportive Housing (CSH), an organization that works to create permanent affordable housing with supportive services for the chronically homeless or disabled. Their mission is to advocate and organize, to conduct research and create materials, to convene conferences and otherwise support the efforts of groups like ours. CSH had provided technical assistance to programs in Connecticut similar to what I imagined. Through CSH, I learned about a DCF program of “scattered-site” supportive housing that provided case management for recovering addicts recently reunited with their children and living in apartments throughout the community. Others I met confirmed that families such as Ginny’s and Esther’s were clearly an underserved population. Many others in the state were concerned about this same group of parents—chronically homeless families who could not meet Connecticut’s stringent requirements for welfare reform, who had loving and “good enough” relationships with their children, but simply could not manage family life without ongoing support. Indeed, there is a national movement in both the public and private sectors away from shelters and transitional housing toward permanent housing with supportive services built in.

## Keeping Families Together

The risk of emotional and behavioral disturbance rises precipitously for children who experience homelessness or spend time in foster care. Children who lose both home and family are that much more vulnerable, and far more likely to be homeless as adults. However chaotic, insecure, or even dangerous a family may appear to the outsider, it is still a family bound by love, familiarity, routine, and above all, attachment. Attachment is the mutual drive of a child to stay in proximity to the caretaker and of the caretaker to care for and protect the child. However small, disorganized, or ill-equipped it may be, a home provides a familiar refuge and a foundation from which to make forays into the world.

Parents also suffer when their children are placed in foster care. If parents are chronically homeless, they are likely to have a history not only of poverty but also of some combination of domestic violence, foster care, substance abuse, trauma, and cognitive or emotional deficits. Parents in these situations have few resources to muster for the long fight for reunification. The support such parents need to acquire and maintain affordable, appropriate, and stable housing for their children is greater than anything offered by the child welfare system. Yet only with stability in their housing will these parents have a chance to provide

some portion of the emotional stability and nurturing family life that their children—and they themselves—need for optimal development and mental health.

### Funding for Services

Were Ginny or Esther mentally ill? Were they HIV positive? Were they substance abusers? And that, of course, was exactly the problem: They were not. These were families who were served, but not targeted, by any current programs. They were families who fell through the proverbial cracks because their needs crossed the boundaries of funding and services. A crucial contact was a DCF official, head of their behavioral health unit, who recognized the potential in supportive housing for the prevention of family separations. This was someone in the system who was open to ideas for alternative programming for her agency and had the power to make it happen—if she could get the funding. Not only that, she believed that collaboration among state agencies made sense both philosophically and politically.

### Working Together

A year of networking produced the Fostering Families Working Group, a diverse group of concerned individuals and agencies who were committed to preventing family separations and chronic homelessness for families like Ginny and Esther. The group included the director of Special Services for the De-

partment of Mental Health and Addiction Services (DMHAS), the director of Kidcare, behavioral health at DCF, the director of Family Services at the Department of Social Services (DSS), who was responsible for Temporary Aid to Needy Families (TANF) and Section 8 housing vouchers, and particularly concerned about those families who exceeded Connecticut's strict limits under welfare reform. A lobbyist from the Partnership for Strong Communities who worked on housing legislation in the state, the director of the transitional shelter where Ginny had spent a year, directors of two agencies serving homeless families, and a lawyer whose cases included many homeless families were also part of the group. Since the first meeting in October 2002, the group has expanded to include a social worker who worked in an intensive case management program for homeless families through the Yale Child Study Center in New Haven, and who now works in partnership with the New Haven Housing Authority to prevent evictions, the director of prevention for DCF, and a Hartford city councilman. Meeting monthly, we worked together to identify the population and define the services they need. In addition, the group visited supportive housing projects in New York and Boston and invited researchers, providers, and consumers of such housing to share what they have learned. Between meetings, CSH

has met privately with the officials from DCF, DSS, and DMHAS to review funding possibilities and political strategies.

### Next Steps

Where are we now? Like the other 49 states, Connecticut's budget is tight. The group needs to identify funds that are already serving this population and redirect it rather than depending on new money. Triggered by the DSS group member's decision to earmark a portion of his agency's high-performance bonus for family supportive housing, state officials are now seriously considering using those funds to create one or more demonstration projects. If these funds are made available, the group's next step is to produce a Request for Applications based on the work we have done during the past year. We need to make decisions about whether the project should be a single or scattered site, whether sobriety should be required, what staff are needed, and how to measure outcomes for families. It is only the beginning of a lot more work—more collaboration, more advocacy, more politics—to reach the group's goal of a statewide network of family supportive housing.

### Conclusion

Ginny and Esther's needs are complex and the path the working group has taken to help them is not a linear one. Yet a simple truth emerged over and over again: Ex-

isting systems do not do enough for chronically homeless families. What they need is not particularly difficult or “rocket science,” nor even necessarily more expensive, but they have been served in a partial, fragmented way: as adults in need of housing or job training, for example, or as children in need of therapy or child protection. To make a difference in the lives of adults and children from chronically homeless families, we must serve them as families, recognize the link between housing and family preservation, and provide the services that would enable them to stay together, *and* to stay housed.

The Fostering Families Working Group came into existence because of networking and collaboration. One phone call after another confirmed that there was indeed a significant group of underserved homeless families, and a growing belief that permanent housing with supportive services could make the difference. The Corporation for Supportive Housing directed us to other experienced advocates whose focus was ending homelessness, and to people in state government already involved or likely to be interested in supportive housing. Connecticut is a small state and Hartford is a small city; it was not difficult to gain access to the officials of state agencies. They already knew each other well, but to serve this population—families they wanted to

serve but who didn't fit easily into state or Federal funding criteria—they needed to come together with providers and advocates for the homeless for a new conversation.

Despite my passion about the harm done by family separations, I had never before considered taking my concerns to policymakers. It took first nerve and then persistence to keep making calls—fueled always by remembering Esther and Ginny and their children. My colleague at CSH has kept me going by reminding me of the credibility I bring as a clinician with long experience with homeless families. It is easy to forget the power of what we know. My state colleagues have also been persistent: they keep on coming to meetings; they keep on working to overcome the challenges posed by funding restrictions. And, perhaps most importantly, they have had the courage to say that what we have been doing in the past has not worked for these families. Let's try something different. Let's have a more inclusive focus. Let's work together. Let's keep at this until we figure out how to keep families together *and* keep them housed.

Finally, the timing has been in our favor. We were ready to move to the next stage just when DSS needed to allocate its high-performance bonus; the appointment of our DCF member as deputy commissioner has given our group more clout. In a bigger sense, the timing was right as well: Connecti-

cut, and indeed the nation, *will* develop supportive housing for families. This is the direction housing for the homeless has taken.

Each of us has the ability to effect change. Who could *you* call to get something started? Don't worry about money. Be passionate. Be persistent. Be brave. My clinical experience, my passion for keeping families together, and above all, my frustration with the limits of the system, pushed me to begin with people I knew and end up with a group of new colleagues who may actually make my dream for families like Ginny's and Esther's come true.

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## What Does the CFSR Tell Us? Mental Health in Child Welfare

The federal Child and Family Services Review (CFSR) rates two basic elements for mental health well-being: the first one concerns whether mental health needs were adequately assessed, and the second concerns whether mental health services were adequately provided. Reviewers assess that mental health needs are met or services provided as “significantly,” “partially,” or “not at all.” In at least 90 percent of the cases reviewed during an on-site review, these elements must be demonstrated “significantly” for a state to be in substantial conformity with the federal guidelines. Items are often rated as “Area Needing Improvement” when reviewers determine that assessments or services were provided partially or not at all.

Common concerns among the 2001 and 2002 reviews of 32 states indicate the scarcity of mental health services for children, the questionable quality of mental health services, and the lack of routine mental health assessments even when there was an adequate reason to conduct such an assessment.

### Trends—Who Receives Mental Health Services

Nearly all states assess and provide some amount of mental health services for children in foster care with the belief that children entering care need services due to the

trauma of removal and adjustment to a new environment. There is, however, a general lack of mental health services for children who are not in foster care. Mental health services for in-home child protective services cases are spotty.

Linda Mitchell, Senior Child Welfare Specialist for the Children’s Bureau, in her presentation at the 2003 Annual Meeting of State and Tribal Child Welfare Officials pointed out, “Children receiving in-home services were much less likely to have their mental health needs met and addressed than their physical health needs and were much less likely to have their mental health needs met than children in foster care.”

Few services exist for adolescents and youth in transition from residential care to community-based placements, and for children with mental retardation or developmental disabilities.

### Quality and Accessibility

The quality of and access to mental health services varies from state to state and from county to county. Inconsistencies include lack of progress reports and documentation of treatment or therapy, shortage of providers, extensive waiting lists, and geographical distances, especially in rural areas, that make access to services very difficult. Many areas lack treatment for sexually abused children.

Some of the findings of the CFSRs with regard to mental health services include:

- All 32 states reviewed to date will need to enter into program improvement plans to strengthen the quality of needs assessment and service delivery to children and families. This is a critical issue since caseworkers often fail to identify important needs of children, including mental health needs, when they develop case plans and provide services.
- Thirty one of the 32 states reviewed failed to achieve positive ratings on the indicator in the CFSR that addresses the provision of physical and mental health services.
- Access to services is one of the weakest areas of performance identified among the 32 states reviewed. Most often, the more specialized services, such as children’s mental health services and substance abuse treatment, are among the services that are lacking or inaccessible due to wait lists, location, and so forth.

Joan Ohl, Commissioner of the Administration on Children, Youth and Families, remarked at the Annual Meeting, “A common theme in the final reports is a lack of sufficient access to children’s mental health services and to substance abuse treatment services. This is especially true in the rural areas where access of services present barriers both to the successful and timely outcomes for children and families.”

Family-focused services are often unavailable. Often only a child will receive mental health services, and other issues and concerns within the family are not adequately addressed. Often there is not adequate treatment for adults and youth who are perpetrators of sexual abuse, substance abuse treatment services for families, counseling and treatment for domestic violence, or respite care.

Frequently, the reviews show, mental health issues were either not identified or identified but with little or no follow-through. This shortfall occurred most often in in-home service cases.

### **Who Pays for Care?**

Funding of mental health services is a critical area. Managed care and Health Maintenance Organization policies can restrict treatment for mental health. In Florida, however, Title XXI funds enable children of parents without health coverage to receive medical and mental health care at a minimum costs and the TANF program provides alcohol, drug abuse, and mental health services.

An over-burdened mental health system and difficulties in securing payment

for non-Medicaid-eligible children often make assessment and services to children in-home and out-of-home placements.

Yet most of those in child welfare are keenly aware of the shortcomings when it comes to mental health in child welfare. What the CFSR process allows us to do is assess these shortcomings and begin a process of systemic change to address these problems.

The Reviews also identify exceptional programs that do exist and that show promise and encouragement. The CFSR points to strengths within each state and helps states develop plans for improvement. Modeling and adapting these programs and ideas would help close some of the gaps between. For example, to address providing care to both children in out-of-home placements and those in-home, New York’s case records reflected that the mental health needs of children in foster care, as well as in-home care, were identified and services were provided based on available resources. Mental health screenings were provided to the children regardless of whether they were in foster family care, in a residential facility, or in their homes.

North Carolina has worked to change its delivery of services. Soon it will offer a System of Care approach that is based on the needs of the child, not the existing services as well as informal supports and community resources.

To see all the reviews completed to date, visit <http://www.acf.hhs.gov/programs/cb/cwrp/staterpt/index.htm>.

## A System of Care: Meeting the Mental Health Needs of Children in Foster Care

by Anita W. Marshall,  
MSW, LCSW

Each year, about three million children and their families nationwide come to the attention of the child welfare system through child abuse and neglect reporting systems. Two-thirds of these allegations are not substantiated, which often terminates the child or family's contact with the child welfare system. Yet, about 3 percent of these children are placed in out-of-home care.

More than 500,000 children reside in some form of foster care. Children may be removed from their homes for a variety of reasons that include severe abuse and neglect, the child's chronic serious problems, and an unmet need for mental health care. Parental problems, such as abandonment, physical or emotional illness, alcohol or substance abuse, domestic violence, AIDS, incarceration, or death, may also precipitate removal.

The Adoption Assistance and Child Welfare Act of 1980 mandated increased efforts to maintain children in their own homes. Consequently, children often enter the foster care system only after in-home services have been unsuccessful. As a result, the children in out-of-home place-

ments frequently have more physical, developmental, and psychological problems than their peers who do not have a history of abuse or neglect.

### Vulnerability of Children in Care

Research shows that children in foster care have higher rates of chronic medical, mental health, and developmental challenges than children from similar socioeconomic backgrounds who have not been in foster care, even though most children do not enter foster care because of a mental health diagnosis. *The Surgeon General's 1999 Report on Mental Health* indicates that one in five children and adolescents experiences the signs and symptoms of a DSM-IV disorder during the course of a year, and that 5 percent of all children experience "extreme functional impairment." In contrast, the Child Welfare League of America estimates that between 30 to 70 percent of children in foster care have a serious emotional disturbance. In addition, children in foster care are coping with the events that brought them

Because serious emotional disturbance is usually not a presenting problem at the time of placement, it may not be recognized until the child experiences a crisis after placement. Children in care frequently struggle with:

- Having undiagnosed serious emotional disturbances
- Blaming themselves and feeling guilty about removal from their parents
- Desiring greatly to return to their parents despite previous maltreatment
- Feeling unwanted if there are other children in the foster home
- Feeling insecure and uncertain about their future
- Being ambivalent about attaching to foster parents
- Anticipating rejection after multiple placements or while awaiting adoption

into care, such as extreme abuse and neglect and exposure to inappropriate adult behavior including drugs, crime, and domestic violence. At the same time, they are enduring the personal grief and trauma that accompany the loss of family and friends. These circumstances make them extremely vulnerable to serious emotional disturbances.

Children in care have a high incidence of behavior problems, academic delays, and problems in peer relationships that negatively affect their placements, options for permanency, and long-term social adjustment. These vulnerable children need interventions to build or restore their self-esteem and prevent poor social outcomes as children mature. To achieve these goals, effective interventions and treatments must be provided.

### Systems Challenges

These children and youth often find themselves involved with several social systems: foster care, mental health, and their own families. All three systems share the same ultimate goals: to enable children to live safely with their families, attend and make progress in local schools, participate in the social and cultural life of their communities, and develop the skills to live independently as young adults and contribute to society.

*Foster care* sees these goals through the mandates of child safety, permanence, and well-being. *Mental health's* vision is characterized by the fulfillment of age-appropriate developmental-intellectual, emotional, and social milestones in the child's family, schools, and community. *Families* want their children to be successful and to be-

long. Families want to be asked what they know, what they think will or will not work, and what support or resources they may need for their child and family to reach those goals. Yet in spite of the connections between these goals, foster care, mental health, and families face numerous systemic challenges that require an uncommon level of collaboration to resolve. A system of care approach can effectively meet the mental health needs of children and families involved in the foster care system.

### Why Use a System of Care Approach?

System of care is emerging as a promising practice. Congress passed legislation in 1992 creating the Comprehensive Mental Health Services for Children and Their Families Program. The program has funded 85 state and local communities to build systems of care. The core values and principles that drive systems of care are already visible in many localities and human services systems. This is an enormous feat in just 10 years given the many adaptive and practice changes needed to partner multiple complex systems into single focused entities focused on children with serious emotional disorders and their families. During the next decade or two, these collaborative efforts will evolve into institutionalized partnerships as individual communities share their learning and successes.

The Child Welfare League of America (CWLA) and the Academy of Child and Adolescent Psychiatrists (AACAP) have incorporated the values and principles of system of care into their strategic plans. The Children's Bureau has also found strong

### Challenges in the Foster Care System

- Staff turnover hinders the ability to meet the special needs of children and youth who have serious emotional disturbances. New staff often receive inappropriate training or insufficient supervision to support the child, the foster parent, and the biological parent. When a child is oppositional or aggressive both the foster parent and child need adequate support. Otherwise, a disrupted placement and another rejection for the child results.
- The growing needs of seriously emotionally disturbed children and youth and the inconsistent availability of the foster parent training and supports results in high foster parent turnover. Placement disruption, inconsistent treatment, and increased trauma in the child results.
- Foster parents need to be considered partners in the planning and treatment of children in their care.
- The legislatively mandated focus and media attention on the safety needs of children increase the child welfare professionals' anxiety and takes time away from attending to the emotional and/or trauma needs of the children for whom they are responsible.
- Increased mental health challenges of children require training to ensure earlier recognition and intervention. Younger children who display aggressive and/or sexually inappropriate behaviors are an increased challenge to staff and foster parents who have limited training and supports.
- Access to mental health services for referred children and youth is limited.

### Challenges in Mental Health System

- Fewer child and adolescent mental health professionals, especially psychiatrists, are available to work with children in foster care. This shortage is complicated by systemic budget cuts and low insurance rates of reimbursement.
- Mental health professionals working with foster care staff may not understand the child welfare system's mandates; the roles of individual workers; judicial time frames; the variance of roles across differing services components, such as guardianship, family reunification, and permanency planning; and the rights retained by parents with children in foster care.

- Opportunities to identify children who are showing early signs of serious emotional disturbances are limited. Children entering foster care are not routinely screened for mental health needs but are referred only after they display problematic behavior.
- Coordinating and integrating care with multiple systems is difficult due in part to different mandates and values.
- Mental health providers often receive referrals with insufficient information to appropriately assess for treatment.
- Multiple and disrupted placements, missed appointments, lack of communication with mental health providers, and discontinuation of treatment after the child is reunified with family contributes to the lack of continuity of mental health care.
- Many mental health providers need more training to work with an increasing population of preschool sexually abused and/or sexually aggressive youngsters.
- Many mental health professionals need more training in effective and/or evidence-based interventions.

### Challenges in Families

- Although 70 percent of children in foster care return to their families, these families are seldom seen as team members in their children's treatment while in care.
- Families are not routinely included in information gathering, such as their child's previous behaviors and demonstrated needs; previous treatments, both effective and ineffective; family history; and treatment preferences, including issues about drug use.
- Within both the foster care and mental health cultures, families are not usually seen as partners and therapeutic allies.
- Youth in care are seldom involved in decisions about their care, such as treatment options, medications, education about psychotropic drugs and alternatives, and transitions prior to discharge from foster care.
- Often family members have unmet mental health needs.

collaboration and good results in communities where systems of care exist. This observation, based on the first two rounds of the Child and Family Services Reviews, is specifically relevant to meeting the mental health needs of children in foster care.

### Using Evidence-Based Practices

Systems of care have always been concerned about the quality and effectiveness of community-based treatment interventions. Using practices that have been proven effective preserves limited funding and other resources and respects the right of parents and children to receive the most effective services. Using proven practices also ensures the most positive outcomes with a focus on flexible, individualized, and integrated care.

ORC MACRO, the national evaluator of the Comprehensive Mental Health Services for Children and Their Families Program, identified the five most prevalent DSM-IV diagnoses of children referred by foster care:

- Mood Disorders and Depression
- Oppositional Defiance Disorder
- Post-Traumatic Stress Disorder
- Adjustment Disorder
- Conduct Disorder

*The Surgeon General's Report on Mental Health* (1999) and the California Institute on Mental Health in Evidence-Based Practice in Mental Health Services for Foster Youth (March 2002) document the overall effectiveness of cognitive behavioral therapies to address these diagnostic issues. However, they highlighted three evidence-based interventions that are effective with foster youth:

- **Multisystemic Therapy (MST).** A home- and community-based intervention developed for adolescents that addresses their conduct-related mental health needs by intervening in all of the systems that impact youth, including family, school, peers, and neighborhood. This intervention also focuses on building skills within their family.
- **Treatment Foster Care.** Foster parents provide the primary mental health intervention in their homes. Mental health training, consultation, and clinical support are provided.
- **Intensive case management and wrap-around services.**

These three interventions share these common system of care values: providing treatment in community settings, regarding parents as partners, and showing sensitivity to culture. In random studies of these interventions, the outcomes addressed many of the barriers facing systems as they serve children in care who also have serious emotional disturbances. MST trials reflect fewer placement changes, decreased aggressive behavior, and fewer arrests for children in the juvenile justice system. Treatment foster care trials reflected more rapid improvement, decreased aggression, and better post-discharge outcomes for children who received treatment foster care than for those who did not receive the service. The combination of intensive case/care management and wraparound resulted in less restrictive placements and increased functioning for youth receiving the intervention than for those that did not.

A review of long-established system of care communities that focus on children referred by child welfare—both child pro-

tective services and foster care—reflect broad and expansive outcomes for children and their families. These communities all use the interventions described as well as combinations of them. These interventions are provided in nontraditional settings; are provided by parents, professionals, and paraprofessionals (except MST); are less expensive than institutional interventions; and are transferable to mental health, child welfare, education, and juvenile justice settings.

System of care communities in Wisconsin, Florida, Indiana, and West Virginia that reflect a population of 33 percent to 52 percent of children from child welfare indicate even broader outcomes for children and families owing to the flexibility and individualized application of these interventions. Their experience includes:

- Significant reductions in inpatient hospitalizations
- Long-term and ongoing mentoring and supportive relationships between treatment foster parents and natural parents
- The development of free respite opportunities between parents needing relief and natural helpers invested in the families' and children's success
- Increased referrals of juvenile and family court judges into system of care communities
- Measurably reduced strain on caregivers
- Decreased placement disruptions
- Increased options for services, both in range and in accessibility, by using non-traditional community facilities at non-traditional business hours, which also reduces stigma and increases compliance
- Increased mental health screening of children and youth as they enter the foster care system

- Increased cross-systems understanding and support of child welfare mandates
- Community-based interventions specifically developed to support the child welfare mandate of child safety

Communities decided to develop systems of care for many different reasons including court class action suits, local media pressure, funding reductions, legal or programmatic mandates, and the continual insistence of families and well-meaning citizens for change. As noted earlier, our goals for these children include the opportunity to live safely with their families, attend and make progress in local schools, participate in the social and cultural life of their communities, and develop the capacity to live independently as young adults and contribute productively to society. Although a system of care is not a panacea, it is a model to help children, families, child welfare, and mental health achieve these goals. The vulnerable population discussed here requires a coordinated, integrated, collaborative, culturally competent, strengths and community-based, family-driven approach as part of an overall strategy for success.

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## Impossible Choices: Custody Relinquishment

Families of children with mental and physical disabilities are often unable to obtain the specialized and intensive service their children need through their private insurance policy. Most policies limit coverage of the rehabilitative and other care needed by individuals with disabilities and chronic illness, and few families can afford to pay out of pocket. The problem is especially acute for children with mental and emotional disorders. The results scream from headlines such as “Cruellest Choice Faces Parents of Mentally Ill” from the *New York Times*, “Thousands Give Up Children to

Get Care” from the *Washington Post* or “Custody or Care” in *Newsweek*.

“Custody relinquishment has been a well-kept secret to the public, but what’s clear is that when you have a child with asthma or a heart problem or diabetes, you go to a doctor. When you have a child with a serious mental health problem, you often go to child welfare,” says Mary Giliberti, a senior attorney at the Bazelon Center for Mental Health Law, based in Washington. “Aside from being inhumane, it’s fiscally irresponsible and ends up causing more damage to families.”

The idea of being forced to decide between the custody of a child and accessing critically needed services for a child with severe mental illness is an unspeakable but very real choice for too many families. According to the recent Surgeon General’s report, approximately 5 percent of children have severe and persistent mental illnesses. Frequently, these children do not have access to the treatment and services they need. And, according to a recent report published by the Government Accounting Office (GAO), child welfare directors in 19 states and juvenile justice officials in 30 counties estimated that in fiscal year 2001 parents placed more than 12,700 children into child welfare or juvenile justice systems so that their children could receive mental health services. Nationwide, this number is likely higher because many state child welfare directors did not provide data.

Once in a state’s custody children become eligible for Medicaid, which offers a



wide range of services. This practice, however, does not always work—foster care systems also can face difficulties accessing limited treatment slots for seriously ill children and it can be emotionally devastating for families.

Indeed, many state foster care systems make no distinction between children who have been given up to qualify for mental health care and those who have been removed from their homes because of abuse or neglect. Some systems may even require parents of emotionally ill children to declare that they are neglecting or abandoning their child—an admission that may get them listed in a state registry, available for background checks to potential employers. Instead of relieving the emotional stress these families suffer, the process often exacerbates it.

Parents can lose track of their children for months while the state moves them to different facilities. “These are children who already have mental health problems,” says Giliberti, “and then on top of that you tear them away from the only family they know.”

In addition, child welfare and juvenile justice systems are expected to handle the increase in workload and provide services for children who they are not meant to serve.

The Bazelon Center for Mental Health Law recently released a report on states’ options for increasing access to mental health care without forcing parents to relinquish custody. The report, *Avoiding Cruel Choices: A Guide for Policymakers and Family Organizations on Medicaid’s Role in Preventing Custody Relinquishment*, discusses two options:

1. Under the Tax Equity and Financial Responsibility Act of 1983 (TEFRA), some States can cover children in the community if the child would be eligible for Medicaid institutional services but can be cared for at home.
2. States can pursue a home- and community-based services (H&CB) waiver under Section 1915(c). This waiver allows home-based services for children with mental and emotional disorders instead of institutional placement.

Currently, only 12 states use either option to cover mental or emotional disorders. The report includes information about how TEFRA or the H&CB waiver can benefit states, and four companion fact sheets provide information for states and families interested in learning more about these options. The report and fact sheets can be obtained on the Bazelon Web site at [www.bazelon.org/issues/children/publications/TEFRA/index.htm](http://www.bazelon.org/issues/children/publications/TEFRA/index.htm).

The GAO report, *Child Welfare and Juvenile Justice: Federal Agencies Could Play a Stronger Role in Helping States Reduce the Number of Children Placed Solely to Obtain Mental Health Services*, can be accessed on the GAO Web site at [www.gao.gov/cgi-bin/getrpt?GAO-03-397](http://www.gao.gov/cgi-bin/getrpt?GAO-03-397).

The following articles describe the painful experiences of one family as they struggled to find appropriate services for young Nathaniel as well as information about a state’s legislative efforts to reverse this issue.

## “The Child Is Worth All of It”

**Mrs. W:** My daughter, Cheryl, married when she was in college. At the time Cheryl discovered she was pregnant, she found out she was also bi-polar. When she was five months pregnant her husband returned to his home in the Philippines. After Nathaniel was born, she stayed and finished college. Nathaniel was about eighteen months old when Cheryl and he moved in with my husband and me. He is now 14 years old.

Nathaniel always has been a very difficult child. My daughter was financially and emotionally unable to get the help he needed. So, my husband and I gained legal guardianship of him when he was four years old.

He has had multiple diagnoses. When Nathaniel was four, he was diagnosed with pervasive developmental disorder and then later with attention deficit hyperactivity disorder. When he was eight he was diagnosed with bi-polar disorder. He has both auditory and visual learning disabilities. He is also dyslexic. And has a borderline IQ. Recently, he was diagnosed with Asperger's Syndrome. The psychiatrist said that his case was a “hard nut to crack.”

**BP:** What behavior presents so much trouble to Nathaniel?

**Mrs. W:** He is very violent: hitting people, destroying property, vandalism, fire settings. He steals. He was even running off for

a while. But as he gets bigger and stronger, when he gets in a rage, he can really do a lot of damage to us and the house. He has knocked me down the basement steps, broke my ankle, and knocked me off the porch.

**BP:** What type of services has he received to address these diagnoses?

**Mrs. W:** When Nathaniel was four, the Regional Center, which is under the umbrella of the Department of Mental Health, assigned us a caseworker. Our interaction was always sporadic, the caseworkers changed frequently, and it was difficult to get caseworkers to return our phone calls. We struggled to find the services available for his multiple problems. As Nathaniel got older we were begging for help with behavior. We pleaded, “Help us make this child more socially acceptable.”

He was placed in a school for children with special needs as well as “normal” children. But his behavior was so severe that they could not handle him and he was placed in another school for behavior and emotionally disturbed children.

He was in the school's day program for three years, which was as long as a child can remain in that program. He was then sent to public school. That was a very positive move. The public school really worked hard with all of us. While

most of his classes were in special ed, the teachers in his other classes made a point of getting the other kids to be positive about Nathaniel, to encourage him, and to acknowledge his accomplishments. But as he got older, he realized that he was different from the other kids. He could not read and he didn't know how to interact with other kids.

**BP:** Was he involved in any athletic activities or music activities or any other social things?

**Mrs. W:** He liked to go to church, take tae kwon do, and go places with the family like the movies. He is very intense about his environment. With Asperger Syndrome, children usually have a specific interest and his has always been bugs, insects, and electricity. He has an intense curiosity in how things work. He was always taking apart the computer, answering machines, telephones, TVs, VCRs. My husband and I were picking up the pieces of one TV and I looked at my husband and I asked, “Where is he?” There he was in the front yard taking apart the VCR. He was also really curious about fire.

**BP:** What kinds of services were you looking for?

**Mrs. W:** We needed services that my insurance does not cover, like behavior therapy, respite care, and a summer camp program. We got into this Family Directive Sup-

port program, signed a contract with them, and thought that they would provide these services. It sounded wonderful. But then after a year of waiting just to get a copy of the contract, we were told that these services were unavailable because there was no money and no program. We did receive some services from a privately funded grant program. Nathaniel received some intensive in-home behavior therapy for five weeks. It was helpful but we needed more. It tapered off; another caseworker came in every three weeks. I had weekend respite care from them a few times, and they would take Nathaniel to social things. We kept asking for help because Nathaniel was getting so violent and destructive. He needed intense therapy. Seeing a therapist only once a month wasn't enough for him. A caseworker went with me to the Regional Center to discuss what we could do about behavior therapy and options if I can no longer handle him. We asked if there was a possibility of a residential home or group home. They told us no. There is no money available, no beds available, and a long waiting list. We were told, "Tough it out. There is nothing we can do. Go home and keep this kid."

**BP:** Was he getting medication?

**Mrs. W:** He has been on medication since he was four. We paid for it through my private health insurance, which also paid for a

psychiatrist, the psychiatric medication prescribed, and individual and family therapy.

**BP:** So, Nathaniel was moving toward sixth grade by now. In most school systems sixth grade means you leave elementary school and go to another level, perhaps middle school. Is that what happened for him, too?

**Mrs. W:** Well, actually he started school in the seventh grade here in the public school. But September was a difficult month. I had to have emergency open heart surgery. Some people from the Regional Center were going to take him to a respite facility so that I could have the surgery and recuperate. My husband, who had helped in the past, had died. When they came to take Nathaniel to respite he got really violent. He got a knife and threatened to kill me. He started fires on the porch. So they called the police and an ambulance and took him to the hospital.

I was in the intensive care unit recovering from heart surgery when it was time for him to be discharged. So Cheryl and I told them that we weren't able to take care of him. The surgeon knew of Nathaniel's violence. For example, my husband was a diabetic and he got gangrene in his toe which had to be amputated, but when Nathaniel would get mad at us he would come and stomp on my husband's foot. And after I had abdominal surgery he'd hit me in the

stomach. The doctor said it would be very dangerous if Nathaniel hit me in the chest following heart surgery because of the wires holding my chest together. If he hit me it could kill me.

**BP:** You were in the hospital with a major illness and Nathaniel had been in the hospital because of his explosiveness. And then what happened?

**Mrs. W:** The hospital called DSS and said that we abandoned him.

**BP:** What was the first contact between the hospital staff and you?

**Mrs. W:** Well, they called our house. My daughter told the hospital that we weren't able to take care of him. And this is what started it all. And they said, "So, you are not going to come get him?" And she said, "No, we cannot take care of him." So that was the end of the discussion. We just kept being told that there were no programs available to help us with this child's behavior.

**BP:** Did you or your daughter let the hospital know, before discharge, while he was at the hospital, that you as a family felt that he could not return home?

**Mrs. W:** Yes. They were aware of that. We made an appointment at the hospital; some of the caregivers on our team went with us, including the social worker at the hospital who I spoke with before I had surgery. We needed to find out the options for Nathaniel,

explain what a difficult situation this was, and that we weren't going to be able to take care of him afterwards. When we arrived, the person we had the appointment with wasn't there. The one that we talked to instead didn't even know the child or anything about him. So she said, "Oh, I'll get back with you."

**BP:** Did they contact you to set up another appointment or discuss this?

**Mrs. W:** No. Except when it came to the day for discharge. He was taken into custody; we were charged with abandonment, neglect, and abuse.

It was a very difficult decision. They found a long-term residential program for him. It is the second most expensive facility in the state, which is only about ten miles from where we live. He was there for ten months and from there he went to a foster home.

**BP:** Were DSS staff helpful in terms of advocating with you about the need of a different type of service for this child? Are you able to maintain contact and a relationship with him since he's been in the custody of the state?

**Mrs. W:** Yes. When he was in the hospital we could only see him by appointment. And they told us that we had to meet with the therapist periodically and we would make appointments and ask, "When do you want to see us and so forth." But finally we were told

it is a waste of their time and ours to provide family therapy and work with us because the child wasn't coming home to us. He was going to a foster home. We had three meetings with them in the nine months he was there.

**BP:** Had you indicated that you no longer wanted contact with Nathaniel?

**Mrs. W:** No way! We were there every week, every visiting time. We were there.

**BP:** Was that your expectation that he would not come home? He would go to a foster home?

**Mrs. W:** That was the plan. By then Missouri Alliance was involved. They provided the foster home and he was there from July until November last year.

**BP:** What type of organization is the Missouri Alliance?

**Mrs. W:** They have a lot of funding available and they can provide a lot of services that were unavailable anywhere else for us. Their goal is to keep the child in the home and in the community. And that was the whole basis; getting the child back home with us.

**BP:** So their goal was to get him back home with you in the long run but in the short term they provided an interim place for him, but still under the state's custody. Where is Nathaniel now?

**Mrs. W:** Home with Cheryl and me. The foster parent Nathaniel was placed with was los-

ing his license due to some irregularities. They asked us if we wanted them to try to find another foster home or facility or did we want to bring him home. More than 20 places refused to take him because of his firesetting behavior. Even Boys Town would not take him. They said he's too naïve and those street kids would just eat him up. So he is still in legal custody of DSS, but he is in my physical custody.

**BP:** How is that working out?

**Mrs. W:** When we had to go to court the first time on the abuse, neglect, and abandonment charges I was told that these charges were confidential. Before we went into the courtroom, the lawyer took my daughter and I into a room and gave us three options. We could either admit to abuse and neglect or choose other options that would make Nathaniel a juvenile offender. We said we would take the abuse and neglect charge rather than make Nathaniel a juvenile offender. We have to go court every three months concerning the status of Nathaniel's child care. The Commissioner talks to the juvenile officer, Missouri Alliance, and the three attorneys involved. My daughter has a court guardian ad litem. The last time we went after reviewing the reports from everyone, the Commissioner was under the opinion that Nathaniel probably will not be able to be

maintained in our home because of his violent behavior.

**BP:** How has he been doing these last few months?

**Mrs. W:** There is a definite change in him. Nathaniel was so happy to come home at first. Now he doesn't want to go anywhere. He has refused to go to Boy Scouts. He won't go to church. He won't go to youth group. When the mentors come he does not want to go with them. Sometimes it is just a big fight to get him to go. We think he thinks that they will take him out and not bring him back to us. And when he gets in a temper tantrum his first words out of his mouth are, "You don't want me here. You are just trying to get rid of me, again."

**BP:** So that's become an issue between you?

**Mrs. W:** One of the diagnoses that residential placement gave him was Post-Traumatic Stress Disorder. I thought, "How could that have been avoided?"

**BP:** Do you have an answer for that?

**Mrs. W:** No. I guess I'm looking for answers that may not be there.

**BP:** Is there a plan for him to go to another place?

**Mrs. W:** The attorneys suggested that before we go to court this time that Missouri Alliance have all the options available for Nathaniel, like remaining at home or group home, foster home, resi-

dential care. Missouri Alliance has to pull out of this case in June. They could only stay involved for a certain length of time. We're back to square one after June. But DSS still has the custody.

**BP:** What is DSS saying? Is there a worker who communicates with you on a regular basis?

**Mrs. W:** Oh yes. They come to the team meetings once a month. I think everybody is of the opinion that they want to keep him at home if at all possible.

**BP:** Is that what you want?

**Mrs. W:** If possible, yes.

**BP:** Do you object to relinquishing custody?

**Mrs. W:** You better believe it! I wish there was a way that we could have gotten the help without doing this. Also, I am a registered nurse. I am a professional person. If the state board finds out that I was charged with abuse, neglect, and abandonment of a child, I will lose my nurse's license and my job.

**BP:** Are there changes in public policy that you think should be made?

**Mrs. W:** It all boils down to the state managing the budget for mental health. The Department of Mental Health, Regional Center, and all these people would come to these monthly meetings and say, "Sorry, no money, no funding." The DMH should be accountable for their lack of services. One of the

major problems has been the lack of coordination of services. We need a system of care where people should know what is available. Our caseworkers changed so frequently. Education is such an important part of it, too, because this child was diagnosed with PDD at age four. We didn't know that meant autism and Asperger's. Could he have received treatment for it at age four? Would the outcome for Nathaniel been different? Would he have had to go through all of this?

It's been disjointed; different organizations. Different services not talking to each other. No one knowing what is available. The families don't know how to access these services. There has to be a key player some place in all this to help pull it all together. I want to stress one thing: The child is worth all of it.

## Empowering Families: A Legislative Approach in Missouri

Recently the issue of families relinquishing custody of their children to the state to qualify for mental health services has come to the nation's attention. In Missouri, Citizens for Missouri's Children (CMC) worked to pass legislation in 2002 to change the situation for Missourians.

Reporting on mental health services delivery to children in Missouri, CMC reviewed issues of access to mental health services for children on Medicaid. An alarming pattern emerged: Many families, with or without Medicaid, were advised to relinquish custody of their children to the state to make them eligible for needed mental health services.

### A strategy develops

CMC's research showed that many parents in Missouri were relinquishing their children to the state through the courts with a finding of abuse or neglect. The parent's name was then entered into the state registry for cases of abuse and neglect. These were cases of economic need, where parents had no insurance, were underinsured, or Medicaid was failing to provide needed services. Many private insurance plans currently carry inadequate coverage for mental health services, particularly when there is a severe situation. Yet statistics show that many children required extensive mental health services. An estimated 90,000 children with Serious Emotional Disturbance (SED) live in Missouri. These chil-

dren and youth are most in need of the extended services not provided by private insurance.

### Development of the Legislation

CMC drafted language that was incorporated into existing legislation, Senate Bill 923 (SB923). The language invoked three major changes. First, family court judges' jurisdiction was expanded to recognize when there is an *economic* issue and not a case of neglect: Families are unable to afford or access appropriate mental health treatment for the child. Second, when the court has determined this is an instance of need of services and not of abuse or neglect, the parent's name(s) will not be entered into the central registry. Third, the family participates in the planning of service delivery for the child, and the child welfare agency must coordinate the treatment plan with other state departments, such as the public mental health authority.

The purpose of this legislation is to empower families to advocate for services. A determination of neglect immediately eliminates them from the process, stigmatizes them, and creates a gulf between themselves and their child which may never be repaired.

The legislation allows a family to present evidence in court that they are not neglectful or abandoning their child. It allows a judge some discretion and the

ability to make a distinction between true neglect of a child and the struggle to meet mental health needs.

### Next Steps

SB923 is a first step toward changing the situation for Missouri's children and families. The legislation (see box) addresses the issue of relinquishing custody after a family is already in the family court system, and has raised the need to address this issue of adequate funding for mental health services. CMC is working with state departments in Missouri as well as exploring options for Medicaid waivers to make funds available for these services.

CMC's analysis of the issue indicates that federal and state appropriations are directed heavily toward tertiary care and treatment services. The incentive to relinquish custody is funding for care: federal Title IV-E child welfare entitlement funds become available to pay for needed services for children. The Missouri state mental health budget used for prevention and early intervention services is extremely underfunded by the legislature. State departments and their service providers/contractors view each other as competing for limited resources, not as collaborators within a safety net for children in need. The fact that Missouri is a low tax, low services

state contributes to this competitive environment.

CMC continues to advocate for and work toward systemic change to improve delivery of mental health services to children. While mental health parity for children would directly address the issue of children who are uninsured, CMC is now also investigating Medicaid reform.

### New language adopted into SB923

CMC's language contained below in SB923 is in **blue**:

15. In any judicial proceeding involving the custody of a child where the court determines that the child is in need of services pursuant to subdivision (d) of subsection 1 of section 211.031, RSMo, and has taken jurisdiction, the child's parent, guardian or custodian shall not be entered into the registry.

211.031.1. Except as otherwise provided in this chapter, the juvenile court or the family court in circuits that have a family court as provided in sections 487.010 to 487.190, RSMo, shall have exclusive original jurisdiction in proceedings:

(1) Involving any child or person seventeen years of age who may be a resident of or found within the county and who is alleged to be in need of care and treatment because:

(d) The child or person seventeen years of age is a child in need of mental health services and the parent, guardian or custodian is unable to afford or access appropriate mental health treatment or care for the child;

(5) The court may order, pursuant to subsection 2 of section 211.081, that the child receive the necessary services in the least restrictive appropriate environment including home and community-based services, treatment and support, based on a coordinated, individualized treatment plan. The individualized treatment plan shall be approved by the court and developed by the applicable state agencies responsible for providing or paying for any and all appropriate and necessary services, subject to appropriation, and shall include which agencies are going to pay for and provide such services. Such plan must be submitted to the court within thirty days and the child's family shall actively participate in designing the service plan for the child or person seventeen years of age.

*Citizens for Missouri's Children a non-partisan, not-for-profit public interest organization whose mission is to advocate for the rights of Missouri's children, especially those with the greatest need. To contact them, write to Citizens for Missouri's Children, 2717 Sutton Avenue, St. Louis, MO 63143; 314.647.2003. [www.mokids.org](http://www.mokids.org).*



# National Child Welfare Resource Center for Family-Centered Practice

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