Best Practice
Next Practice

Family-Centered Child Welfare

Summer 2003
Mental Health in Child Welfare
A focus on children and families

Mental Health Issues in the Child Welfare System

This issue of *Best Practice/Next Practice*, and the issue that follows, discusses the complexity of the challenges of mental well-being in child welfare. We focus on issues relating to mental health in child welfare, examining both barriers to and promising practices for accessible, appropriate care for all children in the child welfare system.

in this issue

A Young Child's Point of View on Foster Care and Adoption

So, are you wondering what I need? Are you wondering what I would do about all of this if I had the power?

First of all, it would help if you would start with one simple, clear commandment to yourself: Never forget that I am watching. Never forget that every single thing you do matters immensely to me (even when I work like crazy to make you think that it does not). And I will remember. You may be able to get away with treating me as if I am invisible for a while (perhaps long enough to "disrupt" me or move yourself to a different casework job). But in your heart of hearts you know I was there, watching. I was having deep feelings about what was happening to me and I needed someone to act if it mattered, hugely.

Second, don't imagine that I will ever stop yearning for my birth family (even though, as in other things, I will pretend otherwise). Help me find some way to keep a connection with them, even if I never see them again. Bring out pictures, or a life book, and hold me while I rage or sob or stare or all of these at once. And understand that none of this is a reflection on you. Don't

be surprised when I come back from a visit with them peeing in my pants or throwing tantrums in the bath that night. I told you: things matter to me. So I am going to have feelings about things that matter to me.

Third, it would help a lot if you would make the decisions that you need to make and stick with them. Some days I think my mind is going to explode because I know something is going on in my life but I can't tell what it is; later I'll learn that there was a court hearing that day and everybody in my life was wrought up and then it was "continued" (whatever that means, except mostly that nothing is getting decided and I still don't have a family). I don't get to make the decisions. You do. So have the courage to make them so that I can get a life.

Fourth, it would mean a lot to me if you would take good care of my foster family. They have their hands full. Sometimes they don't know what to do with me. So make sure someone is there to answer their questions, to encourage them, to help them understand me better. You won't like what will happen if I keep getting dis-

rupted, and the only way I can think of to prevent that is to take extra care of the people that are taking care of me.

So have I told you anything that you wanted to know? Have I helped you understand how all of us feel who fell into this rabbit hole that is the world of foster care and adoption?

Adapted from Multiple Transitions: A young child's point of view on foster care and adoption

"Growing numbers of children are suffering needlessly because their emotional, behavioral, and developmental needs are not being met by those very institutions which were explicitly created to take care of them." *Report of the Surgeon General's Conference on Children's Mental Health: a National Action Agenda.* Many children in the child welfare system grow up in environments characterized by poverty, instability, or parents or caregivers with limited psychological well-being. The traumatic experience of abuse, neglect, and separation as well as environmental factors can lead to a variety of emotional problems for children and a greater likelihood of poor child well-being outcomes.

Results of a few research studies indicate that children in the child welfare system, especially those in foster care, represent a high-risk population for maladap-

tive outcomes, including socio-emotional, behavioral, and psychiatric problems warranting mental health treatments. Foster care children represent an extremely high-risk population for mental health problems. Half of the children in foster care have adaptive functioning scores in the problematic range; among children ages 0 to 6, about 50 to 65 percent are in the problematic range in terms of developmental status. Among 2 to 27 year olds, about 50 to 60 percent have behavior problems, and among the 6 to 17 year olds, about 40 percent meet the criteria for any diagnosis with moderate impairment.

Children with emotional problems present challenges to child welfare staff. These children have more service needs and are in greater need of caseworkers' attention. Ever increasing caseloads, gaps in services and disparities in access, and little understanding of mental health problems in children make it difficult to meet these needs. Foster parents and relatives require services and caseworker time to deal with the challenges of parenting troubled children. The mental health problems of these children are not likely to disappear once they are adopted or reunified with their families. Therefore, children and parents need post-adoptive or post-reunification services to help them deal with lifelong effects of abuse, neglect, and separation.

In terms of mental health service use, children in the child welfare system use these services up to fifteen times more than other children in the Medicaid system. Foster children with behavioral problems are most likely to be seen. Data also show that children with a history of sexual abuse are three times more likely to receive mental health services, while children with a history of neglect are least likely to receive treatment. African-American and Hispanic children are least likely to receive services, and they need to display more pathology to be referred for mental health services. Developmental services are accessed significantly less than would be expected based on the high rate of developmental problems observed.

Resiliency and Vulnerability

There are many factors that can make a child vulnerable to the negative effects of abuse and neglect. Some children who grow up with seemingly so little have survived, healed, and recovered from much in their childhood. Other children who seem to have "everything" may be troubled, unproductive, and uninvolved later in life. There are several factors to consider.

First, there is seldom a simple cause-and-effect relationship in the ways children develop. Usually it depends on several other things in their lives. For example,

Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence

Recent evidence compiled by the World Health Organization indicates that by the year 2020, childhood neuropsychiatric disorders will rise proportionately by over 50 percent internationally to become one of the five most common causes of morbidity, mortality, and disability among children. The mental health problems affecting children and adolescents include the following:

Depressive Disorders

Depressive disorders, which include _major depressive disorder, dysthymic disorder_, and _bipolar disorder_, adversely affect mood, energy, interest, sleep, appetite, and overall functioning. In contrast to the normal emotional experiences of sadness, feelings of loss, or passing mood states, symptoms of depressive disorders are extreme and persistent and can interfere significantly with a young person's ability to function at home, at school, and with peers.

Major depressive disorder (major depression) is characterized by five or more of the following symptoms: persistent sad or irritable mood, loss of interest in activities once enjoyed, significant change in appetite or body weight, difficulty sleeping or oversleeping, psychomotor agitation or slowing, loss of energy, feelings of worthlessness or inappropriate guilt, difficulty concentrating, and recurrent thoughts of death or suicide.

Dysthymic disorder, a typically less severe but more chronic form of depression, is diagnosed when depressed mood persists for at least one year in children and is accompanied by at least two other symptoms of depression (without meeting the criteria for major depression). Youth with dysthymic disorder are at risk for developing major depression.

Although _bipolar disorder_ (manic-depressive illness) typically emerges in late adolescence or early adulthood, there is increasing evidence that this illness also can begin in childhood. Bipolar disorder beginning in childhood or early adolescence may be a different, possibly more severe form of the illness than older adolescent- and adult-onset bipolar disorder. Research has revealed that when the illness begins before or soon after puberty, it is often characterized by a continuous, rapid- cycling, irritable, and mixed manic and depressive symptom state that may co-occur with disruptive behavior disorders, particularly attention-deficit hyperactivity disorder or conduct disorder or may have features of these disorders as initial symptoms. Diagnosis and treatment of depressive disorders in children and adolescents are critical for enabling young people with these illnesses to live up to their full potential.

Anxiety Disorders

Anxiety disorders, as a group, are the most common mental illnesses that occur in children and adolescents. Researchers estimate that the prevalence of any anxiety disorder among children and adolescents in the U.S. is 13 percent in a six-month period.

Generalized Anxiety Disorder: characterized by persistent, exaggerated worry and tension over everyday events.

Obsessive-Compulsive Disorder (OCD) is characterized by intrusive, unwanted, repetitive thoughts and behaviors performed out of a feeling of urgent need.

Panic Disorder is characterized by feelings of extreme fear and dread that strike unexpectedly and repeatedly for no apparent reason, often accompanied by intense physical symptoms, such as chest pain, pounding heart, shortness of breath, dizziness, or abdominal distress.

Post-Traumatic Stress Disorder (PTSD) is a condition that can occur after exposure to a terrifying event, most often characterized by the repeated re-experience of the ordeal in the form of frightening, intrusive memories; brings on hypervigilance and deadening of normal emotions.

Phobias: social phobia—extreme fear of embarrassment or being scrutinized by others; _specific phobia_—excessive fear of an object or situation, such as dogs, heights, loud sounds, flying, costumed characters, enclosed spaces, etc.

Other disorders: separation anxiety—excessive anxiety concerning separation from the home or from those to whom the person is most attached; and _selective mutism_—persistent failure to speak in specific social situations.

ADHD

Attention deficit hyperactivity disorder (ADHD) affects an estimated four percent of children and adolescents in the U.S. in a six-month period. Its core symptoms

include developmentally inappropriate levels of attention, concentration, activity, distractibility, and impulsivity. Children with ADHD usually have impaired functioning in peer relationships and multiple settings including home and school. Untreated ADHD also has been found to have long-term adverse effects on academic performance, vocational success, and social-emotional development.

Eating Disorders

Eating disorders involve serious disturbances in eating behavior, such as extreme and unhealthy reduction of food intake or severe overeating, as well as feelings of distress or extreme concern about body shape or weight. In the U.S., eating disorders are most common among adolescent girls and young adult women; only an estimated 5 to 15 percent of people with *anorexia nervosa* or *bulimia nervosa* and an estimated 35 percent of those with *binge-eating disorder* are male. Eating disorders often co-occur with other illnesses such as depression, substance abuse, and anxiety disorders. In addition, eating disorders are associated with a wide range of other health complications, including serious heart conditions and kidney failure, which may lead to death.

Eating disorders are not due to a failure of will or behavior; rather, they are real, treatable medical illnesses in which certain maladaptive patterns of eating take on a life of their own.

Autism and Other Pervasive Developmental Disorders

Autism and other pervasive developmental disorders (PDDs), including *Asperger's Disorder, Rett's Disorder, Childhood Disintegrative Disorder, and Pervasive Developmental Disorder-Not Otherwise Specified (PDD-NOS)*, are brain disorders that occur in an estimated 2 to 6 per 1,000 American children. They typically affect the ability to communicate, to form relationships with others, and to respond appropriately to the outside world. The signs of PDDs usually develop by 3 years of age. The symptoms and deficits associated with each PDD may vary among children. For example, while some individuals with autism function at a relatively high level, with speech and intelligence intact, others are developmentally delayed, do not speak, or have serious language difficulty.

Research has made it possible to identify earlier those children who show signs of developing a PDD and thus to initiate early intervention. While there is no single best treatment program for all children with PDDs, both psychosocial and pharmacological interventions can help improve their behavioral and cognitive functioning.

Schizophrenia

Schizophrenia is a chronic, severe, and disabling brain disorder that affects about one percent of the population during their lifetime. Symptoms include hallucinations, false beliefs, disordered thinking, and social withdrawal. Schizophrenia appears to be extremely rare in children; more typically, the illness emerges in late adolescence or early adulthood. However, research studies are revealing that various cognitive and social impairments may be evident early in children who later develop schizophrenia. These and other findings may lead to the development of preventive interventions for children. Only in this decade have researchers begun to make significant headway in understanding the origins of schizophrenia. In the emerging picture, genetic factors, which confer susceptibility to schizophrenia, appear to combine with other factors early in life to interfere with normal brain development. These developmental disturbances eventually appear as symptoms of schizophrenia many years later, typically during adolescence or young adulthood.

From NIMH *Brief Notes on the Mental Health of Children and Adolescents available at www.nimh.nih.gov. For further information contact NIMH.*

several years ago researchers were asked if children born with minor brain damage were more likely to become violent teenagers. Scientists found that if those children were growing up in well-functioning families and communities, they were no more likely than other children to end up as violent teenagers. If they were growing up in abusive families and dysfunctional communities, however, they were four times more likely to end up as violent teenagers.

Second, there is often an accumulation of risk and opportunity in a child's life. One event or circumstance does not lead to trouble in a child's life, but a combination of things can. These risk factors include low intelligence, poverty, absence of a parent, child abuse in the home, low educational level of parents, parental substance abuse, parental mental illness, and large family size. A child can grow up in a family where there are several of these risks and can deal with adversity. But research shows that children who grow up in situations where there are four or more risk factors can have significant troubles later.

As a complement to risk, there are opportunities, or assets, for children in their families, too. Assets are inside the child—their personality, their abilities, and their talents. Assets are also around the child—their family, their peers, in the school, and in the commu-

nity. The more of these opportunities that a child has the less likely that they will be troubled.

Third, we need to understand about a child's ability to cope and adapt to changes, called resilience. Being resilient allows a child to overcome difficulties in their life. What makes a child less resilient, less able to cope with problems or stress or become violent?
- Dealing with abuse and neglect at home
- Living in violent and impoverished communities
- Being between 13-15 years old (a critical age for many children)
- Being a boy. Boys are the most vulnerable.
- Facing issues of racism

Fourth, we need to understand temperament. Children have different attributes and personalities that color the way they deal with others. We need to learn how to work with or be parents to children with different temperaments.

Temperament does not doom children or guarantee their success, but it sets the probabilities and the terms of engagement.Some children who are most likely to develop into violent teenagers are temperamentally difficult or slow-to-warm children because they are children who, unless they are managed well, will gravitate to the negative behavior.

Fifth, we need to understand the need for spirituality. We need to understand and to help children understand that human beings are not simply animals with complicated brains, but are spiritual beings having a physical experience in life. Many children who are involved in spiritually promoting religious experience tend to be buffered.

Challenges
There are several barriers to providing mental health services to children in child welfare that include:

- Fragmentation of responsibility and funding
- Gaps in services
- Unmet need and disparities in access
- Lack of family partnerships and support
- Lack of workers' understanding of mental health problems of children and adolescents in the child welfare system
- Lack of focus on screening, prevention, and early intervention

Additional challenges in addressing and serving the mental health needs of children exist.

Access. Perhaps the greatest barrier to children receiving mental health care is access. This is especially true for low-income, minority families who are supposed to receive coverage under Medicaid in the child welfare system. The services are often unavailable, inaccessible, and inappropriate. Waiting lists are often very long.

Diagnosis. Another challenge is diagnosing mental health problems in children and youth. Abused or neglected children or youth with emotional problems are often looked at as acting up or being aggressive. In addition, caseworkers and parents many times look to a doctor to medicate the problem away.

Assessment Practices. The lack of consistent assessment too often results in children not being identified as having mental health problems. Instead they are funneled into the special education

and juvenile justice systems—especially if the child is low-income and from minority background. Black youth, for example, are more likely to be referred for mental health services because of behavior problems they present rather than because someone identified warning signs that may have emerged much earlier. More often, they are sent to correction facilities because of these undiagnosed problems instead of receiving psychiatric treatment.

Recommendations

Screen children entering the child welfare system and link them with services when needed. Systematic procedures to identify mental health problems and treatment should be implemented for children entering child welfare where there is known to be a high prevalence of mental health disorders. Screening should be implemented upon entry into the system and periodically thereafter during the life of the case. When mental health needs are identified, children should be linked with appropriate services.

Focus on the needs of the early childhood population. Recent research highlights the importance of environmental factors in very young children in shaping brain development and subsequent behavior. This points to the importance of early identification and prompt intervention, as well as prevention, of mental health

problems of young children who are entering the child welfare system. This is especially important for children in foster care.

Coordinate services with other public and private services and supports. Child welfare staff should coordinate work with other systems to address other child and family needs, such as income assistance or health care, and incorporate services and supports from all necessary agencies and systems.

Children spend most of their day and receive most of their services through "educational" systems, such as child care centers, schools, and after-school programs. Therefore, it is important to educate the staff in these systems about the mental health needs of children in the child welfare system and to coordinate early intervention services.

Improve access to mental health services for children and their families. This includes provding services that are culturally sensitive, affordable, close by, and at accessible times for families.

Promote awareness in families and train staff working with children and adolescents for earlier recognition and appropriate identification of mental health disorders and referral to mental health services.

Attachment and Children's Mental Health

"Each stage in a child's life makes unique demands on the caregiver, and each stage brings with it a set of specific developmental needs and vulnerabilities. Because children are a part of a changing and developing system that includes their parents, caregivers, community members, extended families, and so on, they get into increasingly complex experiential realms as they grow and mature, and each of their reactions to a new experience is informed by those that have come before. For a young child whose attachments to significant adults are in a crucial stage of development, an abusive experience will have far different effects on him or her, and on the family, than will a similar incident when the child is ten or a teenager or a young adult." From _The First Three Years and Beyond: Brain Development and Social Policy_, 2002.

Attachment is important. It is the base upon which the emotional health, social relationships, and one's worldview are built. The ability to trust and form relationships will affect the emotional health, security, and safety of the child, as well as the child's development and future relationships. Normal attachment develops during the child's first two years of life. Problems with the parent-child relationship during this time, or breaks in the consistent caregiver-child relationship, prevent attachment from developing normally. A wide range of attachment problems may result in varying degrees of emotional disturbance in the child. The severity of this attachment disorder seems to result from the number of breaks in the bonding cycle and the extent of the child's emotional vulnerability and their resiliency. Therefore, interventions that attempt to promote high-quality caregiver-child relations and secure attachment patterns are effective in enhancing the resiliency of vulnerable children. Because attachment lies at the root of many emotional and mental disturbances, it is important to understand its significance.

Resilency, Risk Factors, and Attachment

Resilience: An individual's competence and successful adaptation, or "bounce back," following exposure to significant adversity and stressful life events. Vulnerability is the susceptibility to negative developmental outcomes under high-risk conditions.

Risk and Protective Factors: Conditions that increase (risk factors) or decrease (protective factors) the likelihood that an individual or a family will later develop problems. Studies of resiliency in children have consistently found the most basic and important protective factor is a history of a caregiver-child attachment.

A child's emotional vulnerability can be affected by a variety of factors including genetic factors; prenatal development, including maternal drinking and drug abuse; prenatal nutrition and stress; Fetal Alcohol Syndrome and Fetal Alcohol Effect; temperament; and birth parent history of mental illness, such as schizophrenia or manic depressive illness. If an infant's needs are not met consistently in a loving, nurturing way, attachment will not occur normally.

The attachment-disordered child does whatever she feels like, with no regard for others. She is unable to feel remorse for wrongdoing, mainly because she is unable to internalize right and wrong. This child may be savvy enough to speak knowledgeably about standards and values, but cannot truly understand or believe what she is saying. The child may tell you that something is wrong, but that will not stop her from doing it.

Foster or adoptive parents need support in preparing for and dealing with attachment issues. For many children, the trauma causing this disorder occurred long before their involvement with foster or adoptive parents. The parents also need to know and understand that the child's behavior is not caused from their parenting, but from past traumas. From this base, new parenting interventions can be designed from a cooperative relationship to fit a child with special needs. While not all children in foster care or those who are adopted develop this disorder, parents need to be aware of this possibility. The child also needs to understand what force is driving his or her feelings and controlling the child's behavior.

A Cautionary Tale and Five Hard Lessons:

Foster Families as Partners in Child Mental Health or "We have Alice…but it is Wonderland that really needs support."

By Roger Friedman, Ph.D., LCSW

Why is it that foster families play minimal roles in the mental health treatment of foster children? In what ways do social workers and therapists contribute to this pattern of exclusion? Is it important to change the situation? Most professionals in child welfare recognize that foster parents are in a central position to know about and care for the foster child's emotional well-being. The mental health of children in foster care is closely linked to the relationships in the foster family, the birth family, and with all the providers that are supporting the placement. When a foster child has challenging psychological problems, like major depression, bipolar disorder, or serious anxiety reactions, the role of foster families as emotional stabilizers and mediators is critical. So why does mental health treatment of foster children remain such a medical, child-centered model? If foster parents were to be real partners in mental health treatment for their foster children, how would their behavior and roles change and what would social services need to do to support them? If a foster child is like Alice caught in a confusing and scary Wonderland, can a partnership with fos-

ter families and mental health providers help her find a way back home? This "Cautionary Tale" explores these important questions and offers some challenging recommendations for change.

Wonderland…we have a problem here!

Child welfare programs view foster parents and foster families as valuable child care resources, but usually not as partners in the process of helping children cope with major mental health issues. A variety of well-intentioned though unexamined reasons for this exist. First, when children enter foster care with serious emotional problems it is unlikely they have ever been assessed or treated for mental health issues. The lack of family-centered, in-home mental health services and the tendency of social workers to view child mental health problems through a medical lens leads to referrals that focus on the child's symptoms and ignore the potential strengths in a foster family. The child is the client, and the family is in the background. If the birth family is included in the assessment at all, it is defined in deficit terms as a toxic force. In this medical model, the foster family

may be relegated to the role of chauffeur, bringing the child to and from appointments. This approach to mental health problems places the professional in complete charge of goal setting and therapy. Foster parents are encouraged to look to the therapist to "fix" their foster child. Mental health experts reinforce this "fix it" approach by caring for the child client in a centripetal manner, that is, continuing to provide clinical services that only experts can deliver.

The stated goal of reducing symptoms in the child is well intentioned but foster families are excluded and disempowered from the treatment process. The sad result is that although children may get better temporarily, those who are caring daily for the child have little idea of how to maintain this higher functioning.

The needs of the foster family and their primary role in helping the foster child with his problems are usually ignored. Furthermore, the great challenge of how to find a permanent home, which may or may not include reunification with the birth family, may be overlooked. We have Alice in treatment, but Wonderland needs our support.

The Color of Mental Health in Child Welfare

"The court process was found to play a significant role in referring children to services. Significant differences by race and ethnicity were found in mental health service utilization prior to the child's protective placement, as well as service orders and post-placement service use.

Caucasian youth were more likely to receive orders for psychotherapy and to have documented use of psychotherapy than were African American and Hispanic youth, even when the possible confounding effects of age and type of maltreatment were controlled.

Caucasian youth were more likely to enter the system with a history of counseling and to receive counseling during the first eight months of out-of-home care. Although no statistically significant racial/ethnic differences of frequencies of other types of service use were found, there were higher rates of use by Caucasians on almost every type of service use prior to and post-removal from the home." — Garland, Ann F. and Besinger, Bridgett A. (1997). Racial/Ethnic differences in court referred pathways to mental health services for children in foster care. *Children and Youth Services Review,* 19, 651-666.

The Need for Mental Health Services

One of every five children and adolescents in the general United States population has a mental disorder, which, if left untreated, is often debilitating. Effective treatments exist for many types of mental health disorders, such as attention deficit hyperactivity disorder, conduct disorder, mood disorders, and anxiety disorders. Yet most children and adolescents who need a mental health evaluation and/or services do not get them. For example, in a 12-month period, 2 to 3 percent of children ages 3 to 5 and adolescents 6 to 17 used mental health services. Of children and adolescents between the ages 6 and 17 who were defined as needing mental health services, nearly 80 percent *did not* receive mental health care. This trend is more pronounced for Latinos and the uninsured. Mental health services are seldom used among preschool children.

Most public and private human service systems do not appropriately serve children and families from racial and ethnic minorities. This results in increased rates of infant mortality; learning, emotional, and physical disabilities; school drop-out; and teenage pregnancy. In addition, minority populations are also more likely to enter the child welfare system, be placed out of their homes and communities, be incarcerated in youth detention facilities, and be "rehabilitated" into adult correctional systems. These racial/ethnic disparities are important because entry into child welfare may represent an important "gateway" into rehabilitative and supportive services, such as mental health services.

Disparities in the Use of Mental Health Services

Many factors are related to the use of mental health services, for example, the child's age (older: *higher use*), gender (male:*higher use*), type of abuse (sexual and physical abuse: *higher use*), severity of emotional or behavioral problems (severe: *higher use*), kinship care (*lower use*), and stranger care.

Most youth who have experienced maltreatment and removal from their homes are at extraordinarily high risk for mental health problems. It is generally accepted that the majority of them should receive mental health services regardless of current observable, or reported, behavior problems. If African American, Native American, and Latino youth are using services at lower rates, then they are being underserved relative to Caucasian youth.

Some studies conducted with the general population have shown no relationship between severity of mental health problems and likelihood of referral to mental health evaluation and services; others have addressed more specifically the extent of unmet need by race/ethnicity by examining the rates of service by severity of emotional or behavioral problems for race/ethnic groups. One of these studies, for example, showed that:

• Caucasians were much more likely to get services even when the total problem score was relatively low.

• African Americans demonstrated the strongest relationship between problem severity and use of services.

• Latino youth received relatively low service use across all problem severity categories.

• The rate of use for Caucasian in the lowest "need" group is about the same as the rate of service use for Latinos in the highest "need" group.

Several explanations have been offered to these disparities:

• Caucasian children are receiving services when clinical necessity is not apparent.

• The threshold for the perceived need (by parents or other sources) for mental health services is higher for ethnic minority youth compared to Caucasian youth.

• "Referability" of different types of behavior problems may be different in diverse cultures.

Barriers

Many different and potentially interacting factors, ranging from culturally driven differences in patterns to seek help, receptivity, and accessibility of providers to bias in referral and service delivery, create barriers to services including:

• Lack of minority mental health providers

• Cultural and language barriers

• Biased assessment techniques resulting in triage to alternative services

• Lack of knowledge about available services

In addition, biased referral patterns from "gateway" providers, such as teachers, health care professionals, juvenile probation workers, and caseworkers or judges in the child welfare system, may exist. These "gatekeepers" play an important role in getting children into mental health services.

But help-seeking patterns may influence the referral decision. While ethnic minority caregivers are as likely as Caucasian caregivers to identify children in need of treatment, they were not as likely to seek services. This may be due to cultural beliefs and preferences about formal mental health treatment or practical issues such as transportation or other children in the home needing care.

Differences in referral patterns may be based on perceptions of a family's interest in mental health services. Caseworkers who are responsible for making recommen-

12 Steps to Lessen Disproportionality in Child Welfare

1. Establish a leadership group on cultural competency. Include executive leaders with visionary commitment to structural transformation.

2. Conduct an assessment: demographics of community, service population, governance, staff; current utilization patterns, client satisfaction rates, grievances; linguistic proficiency, interpretive and translation capacity; cultural knowledge of service population; organizational attitudes about culture, difference, and cross-cultural work.

3. Establish an organizational change plan tailored to the organization, with principles and values regarding cultural competency that might be unique to the organization.

4. Evaluate, refine, and create policies to promote principles that support the plan at the administrative and practice levels.

5. Institute human resource policies and practices that promote diversity among staff at all levels, establish cultural competency as an expectation of all staff and address the conflicts that arise among a diverse staff.

6. Establish strategies to accommodate the linguistic needs of the client population.

7. Establish ongoing training programs for all staff, including content on cultural knowledge of the service population; social and political issues of interest to the population; informal and formal resources in the community; personal attitudes, beliefs, biases and prejudices that promote or interfere with cross-cultural work; and cross-cultural skills.

8. Establish culture-specific intervention strategies to include traditional providers as indicated.

9. Create service strategies to promote easy access and a welcoming atmosphere.

10. Involve clients and community members in planning and evaluation.

11. Conduct ongoing evaluation and improvement.

12. Create a strategy for advocacy on behalf of and in conjunction with diverse communities to improve access, affordability, and appropriateness of service.

Vivian Jackson, "Cultural Competency," *Behavioral Health Management* March/April 2002, vol. 22, no. 2, pgs 24-26.

dations for referrals may be influenced by the family's or child's preferences or perceptions of the availability of culturally responsive (or linguistically appropriate) services. Caseworkers may also make assumptions about the benefits of psychotherapy for others of different cultural or racial/ethnic backgrounds.

Notes

Excerpted from papers and presentations at Research Roundtable on Children of Color in Child Welfare, September, 2002, sponsored by the Children's Bureau and Chapin Hall, Paper written by Ann F. Garland, Ph.D., John A. Landsverk, Ph.D., and Anna Lau, Ph.D. Presentation made by John Landsverk, Ph.D.

Sheryl H. Kataoka, Lily Zhang, and Kenneth B. Wells, "Unmet Need for Mental Health Care Among U.S. Children: Variation by Ethnicity and Insurance Status," *American Journal of Psychiatry*, September 2002, 159:1548-1555.

Elena P. Cohen, "Framework for Culturally Competent Decision-making in Child Welfare," *Child Welfare*, Vol. LXXXII, #2, March/April 2003.

Tough Questions and No Easy Answers
A mother talks about children's mental health

CINDY: My son, age 12, is now in a residential treatment center about 3 hours away from home. His current diagnosis is bi-polar disorder and obsessive-compulsive disorder. He has been in treatment in the mental health system since he was about 4 years old. He has been in residential treatment twice and hospitalized once in the past seven years. When we first entered into the system we were Medicaid eligible so it was a little easier to get services and get them paid. Since then we have been on private insurance, but private insurance has caps for their services. Families who need extensive mental health services, like us, usually reach their cap in the first three months of each year. This year was no exception. As we started school this fall we realized that his transition to middle school was going to be especially challenging for him because of his illness. His condition began deteriorating in school and at home. He had severe depression and suicidal ideation. We realized that long-term residential care was going to be the key, but I did not have the means to pay for it and my insurance would not cover it.

BP/NP: You said that he was Medicaid eligible and now he is not. What made him Medicaid eligible earlier?

CINDY: I was teaching school full-time. Then, because of his illness, I changed to substitute teaching to give me the flexibility I needed to help my son. But by not working every day, it put us in a lower income bracket so that we were eligible for Medicaid for two or three years. We have been on private insurance for six or seven years, now.

BP/NP: Has private insurance covered his mental health service needs?

CINDY: It covers a psychiatrist, therapy, in-home intensive therapeutic services, but there are limits. My insurance covers only 15 psychiatrist or therapist visits a year, so all our insurance benefits are used within three months. After that, families like us supplement it ourselves or your child doesn't get the services he needs and deteriorates.

BP/NP: What about public services?

CINDY: That's also available, but often on a sliding scale. Sometimes I could afford to continue and sometimes I cancelled his appointments because they were cost prohibitive. This really became a problem when we realized that he was going to need residential care. And we applied for special coverage insurance, but they won't cover it, and the public area mental health system could not cover long-term residential care either.

BP/NP: What options were presented to you?

CINDY: In one of our child and family team meetings at mental health, the team suggested that the best way for us to get the services our son needed was to have child welfare take custody of him. They explained that child welfare could mandate the services he needed. This team is made up of a case manager from the mental health system, my son's teacher and principal, and his therapist. Often the school system suggests relinquishing custody when they know that more help is needed than can be offered at school.

BP/NP: What was your reaction to this suggestion?

CINDY: "Absolutely not!" was my first reaction. But, as his condition deteriorated, I thought "Maybe we need to think about this." It was a matter of his safety. We feared his possible suicide more than anything. He was aggressive, and he could have injured his siblings, but mostly his aggression was self-inflicted. As a parent you have to think, "What is going to save his life? To get him help, I may have to give up custody of my child. So I had to think 'maybe.'"

BP/NP: While you were considering this option, were you looking for others?

CINDY: I looked for other funding to pay for his residential treatment. We began the admissions process. I knew he needed this care even if it meant relinquishing custody. But I had not spoken to child welfare. The mental health center did talk to child welfare about my son, but I was holding out, refusing. But they were gathering information. They were making sure that I would be involved in any decisions being made about his care, I would have visitation, that my son was not being removed from my care because of neglect or abuse, and they tried to explain that the situation was not as grim as I thought it was. If he became a ward of the state or child welfare, it was about funding, not about my parenting. I was still unsure about it, but I knew I had to consider this.

BP/NP: Was child welfare trying to present relinquishing custody as a positive option, that was not a judgment about you, but a service to you?

CINDY: Yes, but I found out that our state had some money for a comprehensive treatment program, that it was a system of care state program. Monies to help pay for treatment were set aside for children who were not eligible for Medicaid. But I had to find this out on my own, it was never offered to me as an alternative or to anyone I know. I talked with the mental health system myself. I have an advantage over other families, because I worked in a related mental health field, I am part of a statewide family advocacy group and have attended some of the statewide system of care collaboratives, so I just got wind of some of these possibilities.

BP/NP: Did the mental health staff on your team know about this program, or did they think that you were not eligible?

CINDY: The case manager may not have known it was available, and the others on our team

just didn't think about it. This program doesn't pay for all of his care; I will probably be paying off this debt for as long as I live, but I decided I was willing to go into that level of debt. I don't know what this is going to really cost me monthly, or what is the total cost for his care. I just try to pay off some of it. I have been asking for itemized bills, but have never received one.

BP/NP: Do you object to the idea of relinquishing custody?

CINDY: Absolutely! I don't understand why relinquishing custody has to be an option. There should be other ways to get the services you need for your child even if you have the inability to pay. Everyone should be able to find out what these options are.

BP/NP: Do you have any specific recommendations that might affect the public policy for changes?

CINDY: The state employees should be informed about what is available for assistance to families, and that relinquishing custody should only be offered as a funding opportunity only as a last resort, if at all. There should be public policy about educating families about available options. The average family would not have known where to look, as I did, to find funding to care

for a child like mine. Families and staff need more advocacy, more training, more educating.

BP/NP: What do you see in the future for your son?

CINDY: My future is really just one day at a time. Now, I am focusing on his transition when he comes home. We have been working hard to have a more successful transition to home and school.

BP/NP: What is his attitude about school?

CINDY: Middle school was hard for him. He went into shock around the culture of middle school. He likes the environment of residential care because it is more structured and disciplined. But the strategies he has learned there to deal with peers, bullying, and teasing will not work in his middle school and he knows it. So, we have not prepared these kids to reenter society. He has been a victim of coming home and working his way back into residential or hospitalization. He and others are caught in a cycle. Culturally, we have not fixed that part of the system. Being in a residential home where there are very few African American kids, it's easier for him to say to them, "Hey, you are hurting my feelings." But he comes back to a middle school that is predominately African

American and Hispanic. It is a very different world.

BP/NP: Did the team understand his concerns about this?

CINDY: Yes, but they realize that they do not have the training, the knowledge, to help him with that. And that it's going to be a difficult transition. He even asked, "How am I going to explain to my classmates where I have been for the last 6 months?" We have to get the script together.

BP/NP: Anything else we should convey to the child welfare community about this issue?

CINDY: Do they realize how humiliating relinquishing custody is to a family? It is not empowering to families. The message you give families is that you are not able to provide and care for your family. And we can. There should be a way to provide the funding without relinquishing custody. I don't know how that is done. It has to do with the stigma of what the child welfare system represents to most families. When you live in a community, in a neighborhood, when your child does not live with you, is not in your custody, people assume it is neglect and abuse. How do families retain their dignity in that process?

National Child Welfare Resource Center for Family-Centered Practice

Contact Us . . .

If you have questions about the information in this publication or want to contribute an article, contact:

Editor, *Best Practice/Next Practice*
1150 Connecticut Avenue, NW
Suite 1100
Washington, DC 20036
202.638.7922
202.742.5394 Fax

Learning Systems Group
1150 Connecticut Avenue, NW
Suite 1100
Washington, DC 20036

Best Practice
Next Practice