

Sponsored by

Child Protective  
Services Unit

Virginia Department  
of Social Services



Editor  
Joann Grayson, Ph.D.

Editorial Director  
Ann Childress, MSW

Editorial Assistant  
Wanda Baker

Computer Consultant  
Phil Grayson, MFA

Student Assistants  
Vanessa Olson  
Jackee Webster  
Michael Zweifel

Spring, 2009

Virginia Child Protection Newsletter

Volume 85

# Mental Health Needs of Foster Children and Children At-Risk for Removal

A few years ago, VCPN featured the health care needs of foster children (in Volume 69). This issue will focus on the mental health needs of children entering foster care and children at risk to enter care. The article will explore the range of mental health needs and ways to address those needs using evidence-based practices. It will discuss ways to work with the children as well as methods for parent and foster parent training.

Evidence-based practice means the conscientious, explicit choice to allow the best available research to guide decision-making about the care of clients. Providers must be able to evaluate the quality of available research and then select methods that are proven to be the most effective in ameliorating the child's difficulties. Clinicians then tailor those proven methods to fit unique social and cultural needs of each particular family.



## How Many Children Reside in Foster Care?

The Children's Bureau released the latest national statistics on adoption and foster care for FY 2006 in May, 2008. They are available in the *Adoption and Foster Care Analysis and Reporting System Report #14*. The number of children in foster care dropped 3,000 from 2005 to 2006 and is approximately 510,000. The number of children entering foster care dropped from 311,000 to 303,000. The number of children exiting foster care increased from 287,000 to 289,000 (U.S. Department of Health and Human Services, 2008).

## What is the Need for Mental Health Treatment?

Studies since the 1970's have found that children in foster care have greater needs for mental health treatment than children in the general population. Typical findings are higher prevalence of developmental delays, conduct problems, language difficulty, attachment disorders, behavioral problems, and neurological impairments (Leslie et al., 2005; Marx, Benoit & Kamradt, 2003; McIntyre & Keesler, 1986; Pilowsky, 1995). Children who experienced episodic placement (placed in foster care, returned home, and then placed in foster care again) and children with multiple placements within foster care have even greater probability of a need for mental health services (Rubin et al., 2004).

In 2004, NIMH funded a national survey of mental health needs and access to mental health services for youth involved in child welfare (Burns et al., 2004). From a sample of 5,504 youth who had been investigated by child protective services, a sample of 3,803 youth ages 2 to 14 years were used for the

analysis. Nearly half (47.9%) of the youth in foster care had clinically significant emotional or behavioral problems.

A literature review for the Casey Family Programs (Landsverk, Burns, Stambaugh & Rolls Ruetz, 2006) concluded that between one-half and three-fourths of children entering foster care exhibit behavior or social competency problems that warrant mental health services. Further, this rate applies to children involved in child welfare who are able to remain in their own homes.

Prior studies had suggested that as many as 80% of youth involved in child welfare had emotional or behavioral disorders, developmental delay, or other indications of mental health needs. For example, Dicker, Gordon & Knitzer (2001) report that nearly 80% of very young foster children are at-risk for developmental and medical problems due to prenatal exposure to maternal substance abuse. Additionally, more than 40% of very young foster children are born with low birth weight or are premature which increases their risk. Over half of young foster children experience developmental delays, four to five times the rate in the general population.

Clausen and associates (1998) examined 267 children ages 0 to 17 in three counties in California shortly after their entry into foster care. They found that 75 to 80% of the children scored in the problematic range in either social competence measures or behavioral measures or were in the problematic range on both measures. On adaptive behavioral measures, the mean scores of the foster children were more than one standard deviation below the norm. In contrast, only about a fifth of youth in the general population are diagnosed with mental disorders (studies cited in Burns et al., 2004).

*continued on page 2*



## Mental Health Needs of Foster Children

*continued from page 1*

In addition to the high rate of mental health problems, children under age seven who enter foster care show high rates of developmental problems (Landsverk, et al., 2006). Developmental problems include cognitive impairments such as learning disabilities, mental retardation, delays in fine or gross motor abilities, social relationship deficits, and language impairments.

The behavioral difficulties may result in a need for specialized educational services. For example, Smithgall et al. (2004; 2005) using a Chicago sample, reported that CPS students in out-of-home care are disproportionately more likely to have an ED classification than students for whom there are no substantiated reports of maltreatment.

The reasons for the high incidence of difficulty and increased need for services are understandable, according to a review by Austin (2004). Children in foster care struggle to cope with the events that brought them into the system such as caretaker abuse, neglect, or sexual abuse, homelessness, exposure to domestic violence, and/or parental substance abuse. The negative effects of these traumatic events are well-documented. VCPN has reviewed this literature in prior issues (see, for example, volumes 53; 54; 60; 64; 79). While children try to heal from such traumatic events, they also process the loss of their family and may even blame themselves for the separation from their homes. At a time when reassurance, understanding, and stability are needed, the child's experience is unpredictable contact with family, multiple placements, and an inability to direct their own lives. The feelings can be overwhelming and isolating.

Mental health needs are a factor in reunification. Children with serious mental health needs are less likely than unimpaired children or mildly impaired children to be reunited with their families (Landsverk et al., 2006).

Unmet mental health needs as children can mean ongoing problems as foster children enter adulthood. According to a study by the Casey Family Programs and the Harvard Medical School (Pecora et al., 2005), a disproportionate number of former foster children have mental health disorders as adults.

Over half of foster care alumni had diagnoses (compared to about 22% of the comparison group). The rate of Post-traumatic Stress Disorder (30%) was nearly double the rate found in U.S. combat veterans and compares to a 6.9% rate in the comparison group. For Major Depression, over 4 % of foster alumni had a prior episode with over 20% having symptoms within the last year. That compares to just under 20% of the comparison group with a prior episode and just over 10% of that group having symptoms within the last year. For Panic Disorder, over 21% of foster alumni compared to 5% of the comparison group had the diagnosis with nearly 15% of the foster alumni having symptoms within the past year compared to 3.5% of the comparison group. Likewise, differences were large and significant for Social Phobia and for Generalized Anxiety Disorder.

Readers should keep in mind, however, that there is considerable variability in the functioning of foster children. Children enter foster care with a variety of both known and undetected problems. While the experience of removal can exacerbate the difficulties, especially if the child is moved frequently, it is suggested that foster care can be a protective factor, resulting in more positive outcomes than reunification. Still, disruption while in foster care is not uncommon with one to two-thirds of placements ending within two years (Harden, 2004).

### What is the Response?

While nearly half of youth in the child welfare system need mental health intervention, only one-fourth of these youth received care during the NIMH study's one-year time period (Burns et al., 2004). For young children, those who were sexually abused were more likely to have intervention than those who experienced neglect. For latency-age youth, being African-American or living in their biological homes meant less likelihood of children receiving mental health services. For adolescents, those living in their homes were less likely to have treatment but those with a parent with serious mental illness had an increased likelihood of intervention. For all children and youth, those with more severe problems were more likely to receive assistance.

The authors (Burns et al., 2004) used the data to extrapolate to national reporting data. In 2000, child welfare agencies throughout the U.S. investigated allegations of maltreatment involving an estimated 1.7 million children. Applying the population estimates obtained in the survey, approximately 814,300 of these children had a substantial need for mental health services but only an estimated 192,175 received the needed services. Thus, an estimated 622,125 children who came to attention of child welfare staff remain with unmet needs for mental health treatment. Although this gap parallels a similar proportion of unmet mental

health needs for the general population of U.S. children (60 to 80% according to Ringel & Sturm, 2001), the magnitude is much greater due to the high prevalence of mental health needs in the child welfare population which is 2.5 times greater than the general population (Burns et al., 2004).

A study of youth in care in Missouri (McMillen et al., 2004) found that 94% of youth in care had used a mental health service in their lifetime. In the past year, 83% had used services and 66% were currently receiving service. Lifetime rates for receiving inpatient care were 42% and 77% had been in a residential program. Youth who had been neglected or who were in kinship care were less likely to have received services.

Landsverk et al. (2006) found five studies of mental health service use by children in foster care. Three studies used Medicaid data from the 1980's to 1990's. A California study (Halfon, Berkowitz, & Klee, 1992a, 1992b) found that children in foster care had an age-adjusted rate of mental health service utilization that was 15 times the overall reference group. The children in foster care were 4% of those eligible for Medicaid, but were 41% of the Medicaid users and incurred 43% of all Medicaid expenses. A Washington state study of children under 8 years of age found that 25% of the children in foster care, compared to 3% of AFDC comparison children utilized mental health services (Takayama, Bergman & Connell, 1994). A Pennsylvania study (Harman, Childs & Kelleher, 2000) compared children in foster care to children in households receiving AFDC (Aid to Families with Dependent Children). Those in foster care had 6.5 times more mental health claims, were 7.5 times more likely to be hospitalized for a mental health condition, and had mental health expenditures that were 11.5 times greater than the AFDC group.

The additional studies reviewed by Landsverk et al. (2006) were investigations in Tennessee (Glisson, 1994; 1996) and in California (Garland, Landsverk, Hough, & Ellis-Macleod, 1996; Landsverk et al., 1996; Leslie et al., 2000). The San Diego study found that 56% of children in foster care had used mental health services. Use differed by age. Of children 2 to 3 years, 21% had used services compared to 41% of children ages 4 to 5, 61% of those ages 6 to 7, and over 70% for children over age 7 to 18. The frequency of visits averaged 15.4 visits in six months, suggesting that many of the mental health services were ongoing care. In contrast to these figures, the Tennessee study found that 14% of their sample of children in foster care had been referred to mental health care.

Using nation-wide data from the National Survey of Child and Adolescent Well-being, Hurlburt et al. (2004) examined 2,823 child welfare cases drawn from 97 U.S. counties. Only 28.3% of children received specialty mental health services during the year, even though 42.4% had clinical-level Child Behavior Checklist scores. Children in group

care were most likely to receive services compared to those in foster care. Children in kinship care or who were receiving services in their home of origin were less likely to receive mental health services. Younger children were less likely to receive services than older children. Minority children were less likely to receive services.

Need appears to be a primary determinant of which children received services according to an analysis of 1,291 children examined by Leslie et al., (2004). Older youth in foster care are more likely to be receiving mental health services. Children who had experienced sexual abuse were almost five times more likely to receive services than children with no sexual abuse history. Still, almost a fourth of children scoring above the 98th percentile on a clinical measure of symptoms did not receive any services (Leslie et al., 2004).

Other studies had similar findings. Foster children had high rates of service use (Breland-Noble et al., 2005; Farmer et al., 2001; Geen, Sommers, & Cohen, 2005; Leslie et al., 2000; dosReis, Zito, Safer & Soeken, 2001). For example, foster children use mental health services at a rate of 8 to 15 times higher than other eligible youth (Geen et al., 2005). Even so, three out of four children in foster care who meet criteria for need for mental health services were not receiving care within 12 months of entering the foster care system (Landsverk et al., 2006). Rosenkranz (2006) notes that many youth do not receive mental health services until they enter the juvenile justice system.

Both clinical factors (such as the severity of the disorder) and non-clinical factors (such as race, age and type of placement) affect the proportion of youth who receive services. Children who experience sexual abuse or physical abuse are more likely to receive services than children with histories of neglect (Garland et al., 1996; Leslie et al., 2004).

## What are the Challenges?

Providing mental health services to children in foster care involves overcoming numerous challenges. The mental health system is taxed because of a shortage of child and adolescent mental health professionals. The shortage is complicated by systematic budget cuts and low insurance rates of reimbursement (Marshall, 2004).

In addition to the overall system challenges, there are specific barriers to consider.

**Training Challenges:** Some authors have found training needs in mental health staff, child welfare staff, and foster parents (Austin, 2005). Staff turnover and foster parent dropout further hinders training efforts. It is difficult to time training efforts so that new staff and new foster parents receive sufficient instruction. Experienced staff also need training updates, particularly as medication management changes.

## American Academy of Child & Adolescent Psychiatry

### Policy Statement on Foster Care Mental Health Values

The AACAP collaborated with the Child Welfare League of American (CWLA) in creating a policy statement on Foster Care Mental Health Values. The policy statement was approved by the Council in January, 2002. The document is meant to guide efforts to improve policies and practices in the various child-serving systems for children in foster care. The statement is divided into Values and Principles. Values are the rationale and the principles suggest how to accomplish the goal.

The statement endorses child-focused mental health and substance use services and supports. The discussion points emphasize a number of points covered in VCPN's main article: involving the biological family or family of origin; creating meaningful attachments; the importance of placement stability; a process for monitoring services; providing foster parents with resources; timing of the interventions; assessable and available services.

The policy endorses a mental health and substance abuse screening within 24 hours of placement and a comprehensive assessment once the child or youth is stabilized. The need for prevention services is discussed. Coordination of services is stressed. Periodic reassessment and screening is recommended. The need for coordinated transitions from foster care back to a family or into independent living is included. The child's human rights are delineated.

Policy makers and human service providers will find this document to be a useful guideline. It reflects findings of current research and offers a blueprint of why and how to provide a responsive and effective system of care.

The policy is available online at the American Academy of Child and Adolescent Psychiatry's website at: [www.aacap.org](http://www.aacap.org)

### Lack of Coordination between Child Welfare and Mental Health Staff:

Increasing the contact and coordination between local foster care social workers and mental health providers can increase service use and can lower disparities in service use (Hurlbeurt et al., 2004 cited in Landsverk et al., 2006).

### Failure of the System to Conduct Screening Assessments:

The best time to document the problems of children entering foster care is immediately prior to or right after entry into care. An early evaluation can allow planning to meet the child's needs. It can also document that the problems were present upon entry into care, rather than developing during the time period in care. An evaluation at the start of care can also serve as a baseline to measure the effectiveness of interventions (Austin, 2005).

According to comments (2003, included in the GAO report "Helping States Reduce the Number of Children Placed Solely to Obtain Mental Health Services") by Dennis J. Duquette, Acting Principal Deputy Inspector General of the U.S. Department of Health and Human Services, the mental health needs of children are often unidentified at the time of case plan development.

### Failure of Community Providers to Identify Mental Health Needs:

Findings indicate that community providers such as pediatricians identify medical and educational needs of youth in foster care but frequently do not recognize developmental and mental health needs of younger children (Horwitz, Owens & Simms, 2000). One example is referral to a psychiatrist for a medication evaluation. In a study of 472 foster children living in California, the authors found that slightly more than half of the foster children whose clinical status merited a medication evaluation had not received one (Zima et al., 1999).

### Limited Collaboration between Providers and Biological Parents:

Approximately 70% of children in foster care

## IMPROVING FOSTER CHILDREN'S MENTAL HEALTH

Extracted from "Findings from the Northwest Foster Care Alumni Study" (Pecora et al., 2005) and from "Improving the Odds for the Healthy Development of Young Children in Foster Care" (Dicker, Gordon & Knitzer, 2002)

### **Implement specialized developmental and mental health assessment**

- Create monitoring methods to ensure that needed services are provided

### **Increase access to evidence-based treatments**

- Increase children's mental health insurance coverage
- Provide specialized training to therapists concerning needs of foster children
- Use evidence-based treatments

### **Help maintain placement stability**

- Strengthen initial placement decisions
- Train foster parents in child behavior management
- Provide opportunities for foster children to form positive attachments
- Teach foster children skills for maintaining relationships
- Provide for continuous relationships

### **Increase educational services and experiences**

- Encourage foster youth to obtain a regular diploma
- Provide tutoring
- Decrease the number of school changes
- Ensure that young children have access to quality early child care and learning experiences

## © Commonwealth of Virginia Department of Social Services

VCPN is copyrighted but may be reproduced or reprinted with permission. Write for "Request to Reprint" forms. Request or inquiry is addressed to: Joann Grayson, Ph.D., Department of Psychology, MSC 7704, James Madison University, Harrisonburg, VA 22807, or call (540) 568-6482. E-Mail: [graysojh@jmu.edu](mailto:graysojh@jmu.edu). When requesting an address change, please include a copy of your old mailing label.



## Mental Health Needs of Foster Children

*continued from page 3*

return to their families. In order for children to continue to receive services after their return home, biological parents must be active in and acquainted with the mental health providers. However, biological parents often are not included in the treatment planning (Austin, 2005; Marshall, 2004).

**Financial Resources:** Funding for child mental health services in foster care is limited (Austin, 2005). When children return home, continued mental health care may be compromised by children and youth losing the automatic Medicaid eligibility that accompanies entrance into foster care (McMillen et al., 2004).

**Children with both Medical and Mental Health Needs:** Children who have high-cost mental health needs are likely to have high costs for medical and non-psychiatric needs (Rubin et al., 2004). Complex children with several disabilities demand increased skill on the part of workers and providers.

**Instability in Placements:** Children with mental health problems have greater instability in both foster care and out-of-home placements (studies cited by Zima et al., 1999). Children who move from placement to placement may lack stability in treatment providers due to being placed too far away to maintain contact. In addition, caretakers with limited contact with a child do not know the child's history or reactions over time.

**Scarcity of Providers:** Low rates of reimbursement, budget cuts, and other disincentives have led to fewer providers of child and adolescent mental health services (Austin, 2004; Rosenkranz, 2006). Even in the private sector, there can be long waiting lists. A 2003 GAO report has identified lack of community-based child mental health services as a major difficulty.

In an effort to understand factors relating to help-seeking, Zima and colleges (2000) examined help-seeking steps and service use of children in the foster care system. Using the data from Los Angeles County DCFS Management Information System, the researchers randomly selected children ages 6 to 12 years who had been in care six months or more and divided them into two groups (those in care 6 to 12 months and those in care more than 12 months). The researchers controlled for other variables such as language spoken and distance from the city. They conducted two home visits, one to gather background information and the other to perform a clinical assessment on the child that included a diagnosis and service recommendations. The child's teacher was also interviewed. A total of 255 children completed the three-part study.

Similar to research described above, the children in foster care had a high incidence of mental health needs with 80% given psychiatric diagnoses and 47% who had two or more disorders. The perception of foster parents for need for services was lower. About 43% of the foster parents perceived a need for services for the child. In the past year, 51% of the children had received mental health care of some sort and 52% of the children had received special services through the school system. Children from Caucasian backgrounds were more likely than Latino children to have received services.

Zima et al. found that boys were significantly more likely to have a caretaker view them as needing services (boys with ADHD were almost 19 more times likely to be perceived as needing service than girls). The educational level of the foster parent was important. Foster parents with four additional years of education were three times more likely to perceive a need for services. Foster parents who had used services in the past for their foster children were more likely to perceive a need for services.

Very few foster parents perceived a need for parent training for themselves. However, the researchers had numerous recommendations for needed training. Foster parent awareness about psychosocial interventions needed to be raised, according to the researchers. Since few of the children diagnosed as ADHD had seen a doctor in the prior year, the researchers suggested that foster parents be given information about the efficacy of medications.

### What Disorders are Likely?

According to a review prepared for the Casey Family Programs, (Landsverk, et al., 2006), externalizing disorders may be more prevalent in the foster care population. Externalizing disorders include conduct problems, defiant behaviors, oppositional disorders, attention-deficit problems, hyperactivity, and aggressive reactions. These collectively are disruptive behavior disorders. Developmen-

## WHAT DIAGNOSES ARE MOST PREVALENT FOR FOSTER CHILDREN?

- Conduct Disorder
- Attention-Deficit/Hyperactivity
- Oppositional Defiant Disorder
- Post-Traumatic Stress Disorder
- Mood Disorders and Depression
- Adjustment Disorder

According to the Northwest Foster Care Alumni Study (Pecora et al., 2005) PTSD and Major Depression may be the most far-reaching conditions for former foster children who are young adults.

Sources: Austin, 2004; Landsverk et al., 2006; Pecora et al., 2005

tal delays are also common, affecting over half of children in foster care. Fewer children in foster care are diagnosed with PTSD (post-traumatic stress disorders), mood disorders, or substance-use disorders, but these disorders are also very significant.

For foster care alumni, the most prevalent disorders are Major Depression and PTSD, followed by Social Phobia, Panic Disorder, and Generalized Anxiety Disorder (Pecora et al., 2005).



### Best Practices for Assessment and Diagnosis

Various organizations and professional groups (the Child Welfare League of America; American Academy of Child and Adolescent Psychiatry; American Academy of Pediatrics) have endorsed the concept that children entering foster care should be assessed for physical, developmental, and mental health problems so that appropriate intervention can begin early. Periodic reassessment is also required as children adjust to new surroundings and relationships (Halton, Zepeda & Inkelas, 2002; Harden, 2004). Further, it is recommended that communities use a standardized procedure for screening and assessment so that information on each child is uniform and comprehensive (Landsverk et al., 2006).

Since community providers refer only the most severe situations for mental health treatment, a number of authors have advocated for the establishment of specialized services for children entering foster care. Such arrangements are thought to be the most cost-efficient and timely method for identifying and providing multiple complex services needed by many children entering foster care (Horwitz, Owens & Simms, 2000). The provision of comprehensive health, mental health, educational and developmental evaluation may be somewhat more expensive in the short-term, but is felt to be the best method to ensure identification and referral. Several Virginia programs are spotlighted in this issue.

The Northwest Foster Care Alumni Study (Pecora et al., 2005) found that placement stability had a large, positive effect on the mental health of foster care alumni. Placement changes, reunification failures, and runaway incidents were negative factors in mental health adjustment. One of the recommendations is to provide foster children opportunities to form positive attachments and to learn and practice social skills.

Shelia Hudd (2005) has proposed an intervention aimed at offering a timely response to children who are at risk for their foster care placement to dissolve. The intervention can enable the child's placement to continue, or, if a move is inevitable, can enable the move to occur in a planned way. The intensive service is brief (up to 12 weeks) and intervenes with the foster parents, the social worker, teachers, and where appropriate, the child.

Hudd states that when foster parents engage in interactions appropriate to the child's developmental level and focus of interest, the child's cognitive and emotional workload is reduced, allowing these resources to be used for development and learning. She uses a narrative play therapy technique to understand how children represent their internal world of relationships. This information is then used to assist teachers and foster parents in understanding the child and facilitating adjustment.

## The Importance of Family Participation in Treatment

Increasingly, there is recognition that family members should be involved and participate in children's mental health treatment, even if the child or youth is placed in foster care or placed through the juvenile justice system. There are many benefits to family participation. Supportive family participation can reduce the child's anxiety level and can reinforce cooperation with treatment. Family can advocate for the child. The family knows the child best and can provide information that can help providers with the treatment plan. Family can help identify prior services and the location of critical health and mental health information (Osher & Hunt, 2002).

Family involvement also benefits the family and can ease strained relationships with the

department of social services. Valid and consistent communication can reduce confusion, frustration and disappointment on the part of the family. Information and involvement in treatment can help families cope with the fear, anxiety, humiliation, anger, and distrust that can result from removal of a child and placement in care. Finally, family involvement can result in better outcomes for children and youth (Osher & Hunt, 2002).

Children in foster care have been removed from their family because of serious problems within the family system. While it is important for the family to be involved in the child's treatment, that goal is not always possible. A biological parent may be incarcerated or in a residential treatment program. There may be a court order prohibiting contact between parent and child. The parent may be unwilling to participate in treatment or the appointments may conflict with the parent's work schedule. Therefore, readers should appreciate that comments in this section may not be pertinent to all biological families. However, if a child is to be returned home, then parent involvement in treatment is highly desirable and should begin as soon as feasible. If the parent is not able to be available or is not allowed to participate in the child's treatment sessions, the therapist can be available at a separate appointment to update and work with the parents.

To the extent possible, family members should be involved in the treatment planning, implementation, and evaluation of services. It is important that parents and caregivers understand the results of any evaluation(s), the child's diagnosis, and the full range of treatment options. In general, family participation improves treatment outcome. Without the involvement of families, it is extremely difficult for service providers to ensure that gains achieved by the child in treatment are maintained and solidified (Virginia Commission on Youth, 2005).

There are several roles that family can assume, according to Freisen & Stephens (1998, cited in Virginia Commission on Youth, 2005). These are:

**Contributors to the Environment:** Treatment providers can identify ways to improve the home environment and the relationships among family members so the child has a stable, supportive environment. Ways for the family to access external support and reduce stress are components of this role.

**Recipients of Service:** The health of the family and its strengths and weaknesses can be explored in order to identify ways to enhance the well-being of family members. When children have special needs, family members must develop skills to address those needs.

**Partners in the Treatment Process:** Family members can help identify goals. They must find ways to implement strategies to achieve goals. For example, family or caretakers must administer medications, keep data about the child, and implement strategies within the

## BEST PRACTICE TIPS FROM MODEL PROGRAMS

- Provide an adequate assessment and treatment plan with biopsychosocial information, a psychiatric evaluation, and a plan for medication, if needed.
- Use multiple sources of information, including: data from the child; input from the family; school/daycare data; medical background; data from members of the community important to the child.
- Maintain a network of qualified, available, and licensed children's mental health professionals, including social workers, psychologists, and psychiatrists.
- Support and encourage family participation in the assessment and intervention.
- Offer services that are sensitive to the child's interests, cultural background, values, strengths, and limitations.

Extracted from: Academy of Child and Adolescent Psychiatry, 2003; Dore, 2005

home. Family needs to be fully informed and their preferences be considered in all treatment decisions.

**Service Providers:** In order for intervention to be effective, caretakers and family members must keep track of appointments, transport and accompany the child to treatment, and communicate information to providers.

**Advocates:** The family knows the child's history and can serve as the child's voice in the mental health system. Local and state advocacy groups can help parents in this process.

**Evaluators and Researchers:** Family can offer insights into which treatments are the most helpful and acceptable.

Adequate mental health care for children in their biological homes can prevent foster care, in some cases. Families stressed by children with serious mental health needs can be at increased risk for abuse and neglect. Giving families support and treatment can lower the risk that the child will need to be removed.

Services prior to removal are cost effective, as well. For example, Capriccioso (2004) cites 2003 cost figures for Kansas. Providing mental health services in the biological home cost approximately \$12,900 per year compared to a \$30,000 cost for foster care and a \$70,000 cost per year for a youth incarcerated in the juvenile justice system.

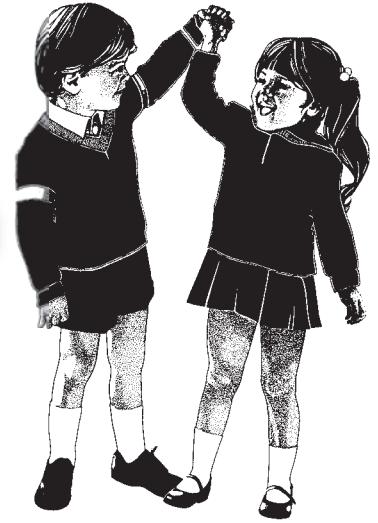
## The Role of Foster Parents

On a daily basis, foster parents are the "front-line" service providers for children in the foster care system. Their input and participation appears vital to the well being and healing of foster children.

*continued on page 18*



# Children's Services System Transformation



Virginia is transforming how children and families receive services. "The concept dates back to the formation of the Comprehensive Services Act," explains Ray Ratke, Special Advisor for Children's Services. "The writers of that legislation envisioned local community agencies working together closely in order to best serve the needs of children and families. What we are doing, 15 years later, is becoming true to that vision."

Launched in November, 2007, the mission of the Children's Services System Transformation is to work across all of Virginia's child-serving agencies to strengthen permanent family connections for children and youth by transforming how services are delivered to them and their families. The goals are fourfold:

- Increase permanency (the numbers and the rate at which youth in foster care move into permanent family arrangements).
- Increase the number of at-risk children and youth placed with kin and foster parents, rather than in congregate care.
- Devote more resources to community-based care.
- Embrace data and outcome-based performance management.

At the state level, this effort is led by Ray Ratke. Appointed by Secretary of Health and Human Resources, Marilyn B. Tavenner, Ratke serves as the Special Advisor of Children's Services. Ratke works in conjunction with staff from the Department of Social Services, the Office of Comprehensive Services, the Department of Education, the Department Mental Health, Mental Retardation and Substance Abuse Services, and the Department of Juvenile Justice to provide leadership for the statewide implementation of the Transformation.

"This effort involves transforming systems at the local level and also changing the way that state government supports localities," remarks Ratke. "We are reconfiguring how we do our work at all levels of the system."

This sentiment is echoed by Paul McWhinney, Director of Family Services for Virginia's Department of Social Services. He explains, "We have to internally reinvent how we support localities. The state office will be providing strong policies based on a sound practice model. We will offer support through training and by having clear, measurable goals with data to support these goals."

The initial pilot aimed to implement a variety of strategies and national best practices

within 13 geographically-diverse localities. The second phase, which has already started, is to implement training and extend the transformation throughout all Virginia localities. "We want to continue the momentum of the original 13 agencies and continue their quality improvements as we 'roll out' the Transformation process statewide. We intend to be fully operational by the end of 2009," McWhinney comments.

The effort is necessary to improve outcomes for Virginia's foster children. A high percentage of children in foster care in Virginia leave care with no permanent family connections. Ratke comments, "Virginia has had the highest percentage in the nation of children who 'aged out' of foster care with no permanent family connections. In 2003, only 44% of Virginia teens in the foster care system achieved permanence, 28 percentage points away from the national average of 72%." According to Ratke, as of July 1, 2008, about 6% of Virginia's foster care youth were placed with relatives. States that have implemented reforms report as many as 50% of foster care children placed with relatives.

Additionally, across the Commonwealth in January 2007, a quarter of youth in foster care were in congregate care placements (group homes or residential placements) while the national average was 18%. In Virginia in recent years, over 50% of teenagers were initially placed in congregate care, an approximate 24% increase from 2000. The use of regular foster homes for teens was 41% in 2000 and decreased to 23% in 2006, while use of kinship placements declined to almost none. The lack of connectedness takes a toll on youth. For example, after "aging out" of foster care, over one-fifth of youth will become homeless at some point and about 40% will fail to complete high school or obtain a GED by age 19 (data cited from a presentation by Holton & Ratke, November 24, 2008).

A commitment to improving outcomes for children and families is not a new idea in Virginia. Organizations such as the Commission on Youth, the State Executive Council, and the Hanger Commission have worked to improve service delivery in Virginia. Inspired by prior efforts and informed by her history as a Juvenile and Domestic Relations Court Judge, First Lady Anne Holton has been a champion of the cause, launching the **FOR KEEPS** initiative (see separate article, page 11) as an effort towards helping youth in foster care to acquire permanent, stable family connections

and community support.

Virginia's efforts garnered the attention of the Annie E. Casey Foundation. The Foundation has partnered with the Commonwealth to support the transformation. As a national leader in the field of child welfare, the Annie E. Casey Foundation brings expertise and resources not otherwise available.

## Phase One

An initial group of 13 diverse localities accounting for approximately 50% of the children in foster care are spearheading the transformation. The localities are called the Council on Reform (CORE): Henrico; Chesterfield; Richmond; Norfolk; Virginia Beach; Charlottesville; Roanoke City; Roanoke County; Prince William; Fairfax; Dinwiddie; Washington County; and Newport News.

Community and state partners such as the Office of Comprehensive Services, the Department of Juvenile Justice, the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Virginia Department of Education, the Virginia Association of Community Services Boards, FACES of Virginia (see Virginia's Picture, page 10), two private providers, as well as many others serve on the CORE.

## Phase Two

In 2009, state leadership is taking the CORE lessons and Transformation expectations to all localities across the Commonwealth. Ratke plans regional "kick-off" meetings as well as training through the Transformation Academy. Regional collaborative groups are being established. "We quickly realized the need to include the Community Services Board, the Comprehensive Services Act, the Department of Juvenile Justice, and other key agencies. We will be asking the regional collaborative events to be co-led by these agencies," notes Ratke. "These are community children and we need an integrated approach and a common vision," he adds.

## Examples of Local Efforts



### Washington County

Washington County is in the southwest section of Virginia. According to Tom Casteel, Director of Washington County's Department of Social Services, the area is rural, has the fewest resources in the Commonwealth, and operates on a long tradition of self-sufficiency.

Traditionally, Washington County had about 25 children a year who needed to enter the foster care system. Only a few children and youth ever needed residential care. That changed, said Casteel, as the drug epidemic spread over the region. "We suddenly went from 25 children a year needing foster care to 85," explained Casteel. "The workload tripled and over-burdened workers left for other jobs. It has put a strain on our community to fund the costs."

Casteel continues, "The Transformation effort is not truly new. We have embraced a family-based strengths model since 1989. Our agency and our partners in mental health and criminal justice have been trained in family systems work and in mediation. Our agency is dedicated towards working with families." To Casteel, the Transformation Model builds on strengths and traditions embedded in his agency's work over the past 25 years.

In order to adapt to the growing substance abuse problem, Washington County's staff are changing. "We have established a substance abuse coalition to help develop intervention models," says Casteel. "We are offering in-home assessments and in some cases in-home interventions. The traditional models take too long. We need a 'rapid-response' model for assisting our families," he adds.

A second effort for Washington County is to find ways locally to serve youth who are in residential placements. While there are only three children from Washington County who are in residential care, a major amount of savings could occur if those children and youth could be served within the locality. Therefore, a worker will concentrate on finding ways that these children can be returned to the community.

Prevention efforts are also crucial, according to Casteel. One prevention effort is "Welcome Home Baby." This intervention is a series of two home visits for all new parents to assist them in referrals, making their home a safe place, and imparting needed information. The first visit is during the pregnancy, and an effort is made to educate the mother-to-be about the sometimes devastating effects of substances on unborn children. Casteel says that substance-exposed children coming into foster care can have serious medical, cognitive, social, and psychological issues that further tax the system.

Casteel believes the data gathered by the Transformation effort will help inform practice and will provide a higher level of accountability. "While data-gathering can be controversial, the benefit is being able to determine trends and understand them," he concludes.

More information about Washington County's efforts is available from: Tom Casteel, Director of Washington County Department of Social Services,

E-mail: [tlc191@western.dss.state.va.us](mailto:tlc191@western.dss.state.va.us)



### Norfolk Department of Human Services

"Our agency has been providing family-centered services for some time," relates Mattie Satterfield, Assistant Director of Norfolk Department of Human Services. "The Transformation effort allows us to go deeper."

According to Satterfield, Norfolk's major effort is to change the emphasis from "compliance" to "investment." "We are using a Family Team approach with neutral facilitators. The team includes whoever the family chooses and is held wherever the family wants to meet." Thus far, meetings have been held at churches, recreation centers, schools, and community centers. "We value what the family brings to the team meeting and we want to listen to them and get them to be truly invested. The meeting is not for blaming or for having fun but is convened to write an action plan," explains Satterfield.

Norfolk began the effort in October, 2008 and they are pleased thus far with the results. Satterfield comments, "If you approach people in a respectful manner, they are willing to work with you." To accommodate family's schedules, meetings can be held evenings, weekends, or whenever the family is available. "We are sincere about engaging our

families, so we are willing to work in a different fashion," says Satterfield.

Vendors and community partners are included in the effort. They are being trained and are expected to work in a different fashion and try to be more helpful to families that are referred for services. Norfolk plans a community survey to identify gaps in services, and then they will help develop community-based services. Satterfield hopes that the agency can offer additional services to families to help prevent children from coming into foster care. "We are committed to helping children and families," she concludes.

More information about Norfolk's efforts is available from Mattie Satterfield, Assistant Director of the Norfolk Department of Human Resources, E-mail: [mxs710@dss.state.va.us](mailto:mxs710@dss.state.va.us)



### Chesterfield-Colonial Heights

"The entire transformation effort came after we were already started. It is supporting us in where we were already going," explains Suzanne Fountain, Ph.D., Assistant Director of Social Work for Chesterfield-Colonial Heights Department of Social Services.

The crux of the efforts in Chesterfield-Colonial Heights is their Systems of Care Initiative. Since 2003, in response to concerns about permanency, the Community Policy and Management Team embraced developing a local Systems of Care approach. A System of Care is not a particular program or service but rather a philosophy and shared set of values in which the needs of the child and family dictate the type of services provided. Services are best provided in the local community, when possible in the home. A collaborative, flexible approach to service delivery allows for customization of services to support children and families.

"Funding had an influence. Residential placements are extraordinarily expensive, and they are not the most effective way to help children," explained Dr. Fountain. "It is labor-intensive to serve these children and a residential placement is 'one-stop shopping.'" Dr. Fountain relates that their locality has become very creative in applying "wrap-around" services in order to bring children back from residential care into the community. For example, some children receive "virtual residential" services with a team of in-home providers. This has been done successfully for a few families up to 50 hours per week. Residential placement was prevented and, more importantly, the children and families are

## Special Thanks to...

*Clare Badgley*

*Hannah Buschini*

*Katie Eves*

*Raymond Ratke*

*continued on page 8*



## Transformation

*continued from page 7*

thriving in the community. Given this level of success, in-home staff 24 hours a day for a limited time would be considered.

Dr. Fountain notes that the children the community is serving are not solely children in the care of the department of social services. Some children in out-of-state placements were placed due to educational needs. Children from the juvenile justice system are also served. A special FAPT (Family Assessment and Planning Team) called the "Blue FAPT" was created which meets more frequently than the regular Team and allows more time per case. The initial focus was children in out-of-state placement and those with multiple failed residential placements. Now, all out-of-state children have been returned to the community. The statistics show a reduction in DSS place-

ments in residential facilities and group homes from 30% to 15% over the past year. However, the Chesterfield-Colonial Heights DSS does not have a certain target goal. "Instead, we are trying to find the best solution for each child," explains Dr. Fountain. "If a family comes asking for their unmanageable child to be placed in care, we would rather put wrap-around services in their home than place the child in a foster home."

To support the effort to serve children and families more effectively, in 2008 all DSS social workers as well as invitees from the Community Services Board, schools, and CASA (court-appointed special advocates) received training in strengths-based practice. Another initiative is a workgroup that is exploring family-centered meetings, a best-practice strategy to bring together immediate and extended family members and other concerned persons to help with case planning through a team meeting.

Dr. Fountain summarizes, "By promoting a shared philosophy of child-centered, family-focused, community-based services, our array of activities is strengthening collaboration across agencies and with families and we are improving outcomes."

More information about the Chesterfield-Colonial Heights efforts is available from Dr. Fountain at: [fountainsu@chesterfield.gov](mailto:fountainsu@chesterfield.gov)

### Charlottesville

Buz Cox, Director of Charlottesville Department of Social Services and Dana Neid-

ley, Chief of Social Work, are enthusiastic as they describe the local transformation initiatives of the Tri Area team that includes Greene and Albemarle counties.

"Our Intensive Care Coordination is in the early stages," says Cox. "Our workgroup determined that a local assessment and diagnostic/crisis stabilization service was lacking." Neidley explained that the local Community Services Board hired a clinician to do intensive care coordination to augment what is typically possible. They obtain and compile existing information about the child, manage complex situations, and implement new strategies. If the youth does need a temporary secure facility, the team is partnering with a local provider, Whisper Ridge, to secure licensing for an assessment and crisis management stabilization unit. "This way, our youth will remain in the local area," says Neidley.

A second prong is foster care prevention. Charlottesville had a significantly high number of older youth entering care due to CHINS and delinquency. "That observation led us to launch an effort to collaborate with Judges, the Court Services Unit, and school attendance officers to support orders for Foster Care Prevention Assessments rather than direct transfer of custody to the department." Cox added that prevention services are now keeping about 80% of referred youth out of care. "We have an emphasis on delivering services to the families," he relates.

A third effort is an aggressive effort to locate kinship placements. The Community



### **Building Solutions in Child Protective Services**

by Insoo Kim Berg and Susan Kelly, 2000, 313 pages, \$32.00 (hard), ISBN- 0-393-70310-X

Available from: W.W. Norton & Company, Inc., 500 Fifth Avenue, New York, N.Y. 10110 Website: [www.wwnorton.com](http://www.wwnorton.com)

Berg and Kelly hope to transform the child welfare system. They want workers to feel a sense of accomplishment and they want clients to emerge stronger and more competent, with long-lasting changes. They advocate a solution-focused style of relating to families that is respectful and that builds on the family's strengths.

The volume is very readable. It offers creative ways to build alliances with families. It offers ideas about how to use language and motivational interviewing to help parents focus on problem-solving. It offers workers and supervisors practical help in restructuring their ideas and approaches. The philosophy fits well with Virginia's Transformation efforts and the volume may be a valuable resource for workers.

### More Book Reviews are Posted on VCPN's Website

### **No More Stinking Thinking: A Workbook for Teaching Children Positive Thinking**

by Joann Altiero, Ph.D., 2007, 58 pages, \$19.95 (paper).

Available from: Jessica Kingsley Publishers, 400 Market Street, Suite 400, Philadelphia, PA 19106 Website: [www.jkp.com](http://www.jkp.com)

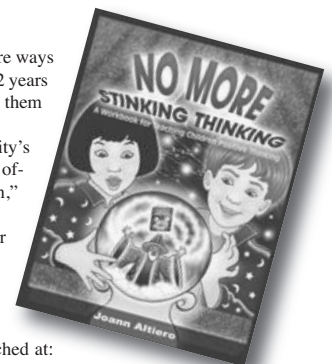
This workbook, developed after 23 years of work with children, is designed to help children change their "Stinking Thinking". "Stinking Thinking" are ways children think that cause them to be anxious, depressed, angry, guilty, frustrated, embarrassed insecure, or jealous. The exercises help children ages 6 to 12 years develop cognitive skills, positive thought patterns, and resilience to cope with daily hardships. The wizard theme is attractive to children and encourages them to interact with parents or therapists as they practice the concepts.

The author is a clinical psychologist, a faculty/skill development coordinator within the College of Social and Behavioral Sciences at Walden University's doctoral program, and a psychology professor at the University of Maryland, University College. At the start of her career, Dr. Altiero counseled violent offenders in the criminal justice system. "Working with teens like these exposed me to the distortions in thinking that exist within the entire family system," she comments. The need to change those thought patterns early was also apparent.

The author suggests covering one lesson a week so children have time to grasp one concept at a time. Dr. Altiero says, "Children need time to discover the applied value of each lesson and to practice the new thinking pattern. Also, doing just one lesson a week seems more like play and leaves children curious for the following week."

Therapists and parents will find this workbook user-friendly, attractive, and fun. It is a valuable adjunct to cognitive behavioral approaches. Children are fascinated with wizards and enjoy the exercises.

Dr. Altiero trains professionals on cognitive and behavioral interventions for the prevention and treatment of childhood disorders. She can be reached at: [JAltiero@umuc.edu](mailto:JAltiero@umuc.edu)



Planning and Management Team designated both the Court Services Unit and the Community Services Board to provide relative placements wherever possible and to strengthen parental involvement and responsibility. To that end, Neidley is developing a local Federation of Families to assist families in becoming empowered and invested in the system. "Families who have successfully navigated the system assist families who are new to the system," she explains.

Charlottesville has been successful in lowering the number of youth in congregate care from 55 to 50, a 9% decrease. One method with promise is their foster home enhancement plan. The agency has redesigned foster parent recruitment and training based on feedback and is developing additional supports for foster families.

Neidley and Cox emphasize the community aspect of the changes. "Child welfare needs are a community issue and rest on community participation," says Neidley. Cox adds, "It is gratifying that the response has been so positive. We have partnered well and are doing some very creative problem-solving!"

More information is available from:  
Buz Cox, (434) 970-3408,  
E-mail: [coxb@charlottesville.org](mailto:coxb@charlottesville.org)  
or Dana Neidley, (434) 970-3400,  
E-mail: [neidley@charlottesville.org](mailto:neidley@charlottesville.org)

### Other Promising Practices

The four featured areas offer examples of innovative ways that local agencies can offer effective service to children and families. There are many other ideas being piloted, for example:

- Richmond City has instituted a case review process for every single child in congregate care and has implemented Team Decision-Making to engage families in the placement process.
- Virginia Beach has begun collaborating with the Court Services Unit to develop services designed to help prevent youth from coming into care on CHINS petitions.
- Fairfax County has created a supervised, structured after-school program for middle and high school boys to allow them to remain in the community.

### DATA Highlights

During the first year of operation (October, 2007 to October, 2008), CORE agencies reduced congregate placements by 133 children. In contrast, the remaining agencies not in CORE saw a rise in congregate placements of 61 children and youth. In the first year, CORE agencies decreased the total number of children in care by 4% and increased their discharges to permanency by 9%. Specific localities showed impressive data. For example, during the first year, Roanoke County/Salem decreased their youth in congregate care by 51% (placing them at the 10% national best practices mark) and also decreased their total foster care population by 21%.

Data released in January, 2009 show a decrease in foster children of 11.68% in CORE agencies and a decrease of 7.01% in non-CORE agencies. Children in congregate care declined 30.93% in CORE agencies and 18.55% in non-CORE agencies. For CORE agencies there has been an increase in kinship placements of 20.19% while non-CORE agencies have actually seen a decrease of 17.76% in kinship care. Their percentage of children and youth in congregate care remains high. Of the 6888 children in care statewide, 1,471 (21.36%) are in congregate care. The target for the agencies was 20%, therefore, the Transformation appears to be "on target" for achieving goals.

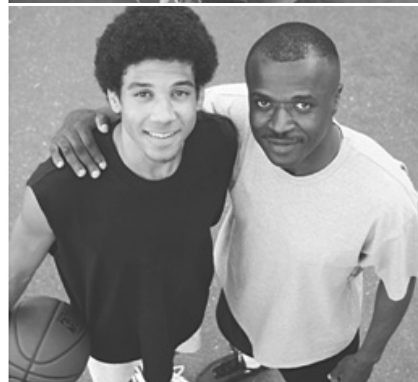
The early results are very promising. Ratke summarizes the progress. "We have adopted a philosophy and model based on national best practice. The results should be positive for children, youth, and their families throughout the Commonwealth."

Those interested may keep abreast of the resources and progress of the Children's Services Transformation by visiting the website at: [www.vafamilyconnections.com](http://www.vafamilyconnections.com)

More information is available from:  
Marianne S. McGhee, Director of Public Affairs,  
Virginia Department of Social Services,  
(804) 726-7105,  
E-mail: [Marianne.mcghee@dss.virginia.gov](mailto:Marianne.mcghee@dss.virginia.gov)

Raymond R. Ratke, (804) 786-7287,  
E-mail: [ray.ratke@co.dmhmsras.virginia.gov](mailto:ray.ratke@co.dmhmsras.virginia.gov)

Paul McWhinney, (804) 726-7590,  
E-mail: [paul.mcwhinney@dss.virginia.gov](mailto:paul.mcwhinney@dss.virginia.gov)



### Improving the Odds for the Healthy Development of Young Children in Foster Care

by Sheryl Dicker, Elysa Gordon & Jane Knitzer, 2001, 31 pages, \$5.00 or download for free from the website.

Available from: National Center for Children in Poverty, Mailman School of Public Health, Columbia University, 154 Haven Avenue, New York, NY, 10032, (212) 304-7100, FAX: (212) 544-4200, E-mail: [nccp@columbia.edu](mailto:nccp@columbia.edu) Website: [www.nccp.org](http://www.nccp.org)

Over 30% of children in foster care are under age five. Nearly 80% are at-risk for a wide range of health and mental health difficulties. Yet, little attention has been devoted to linking child welfare practice with health care, early intervention, and other strategies to address the risks and vulnerabilities of this age group. This volume reviews the key research findings on young foster children. It describes promising strategies to promote healthy development and offers action steps and key recommendations.



# Virginia's Picture

On any given day in Virginia, over 7,000 children receive care through the foster system. Data as of February 1, 2009 showed that 7,135 children were in care. About 48% were female and 52% were male. Half of the children were white, 43% were African-American and 6% were multi-racial. Consistent with national trends, African-American children, who are about 24% of the child population in Virginia, are over-represented in Virginia's foster care system.

Teenagers comprised nearly half (47.8%) of the foster care population. Infants are 2.8% of foster children, 19.1% are ages 1 to 5, 13.3% are ages 6 to 9, 10% are ages 10 to 12. An additional 7% are youth 18 or over who choose to continue to receive foster care services and who live in localities that allow young adults to receive independent living services and support until their 21st birthday.

The goal for 1,459 of youth in foster care (20.4%) is to progress to independent living. Adoption is the goal for 1520 of the children (21.3%). For 812 children (11.4%) the plan is permanent foster care. There are 326 children (4.6 %) in placements with relatives. For 2,154 children (30.2%), the goal is to return home.

Voices for Virginia's Children ([www.vakids.org](http://www.vakids.org)) reported on why children are entering the foster care system. While there are many reasons a child might be in foster care, the predominant cause is neglect (46%). The second most frequent reason is "child behavior" (25%). This broad category includes children involved with the court system and whose behavior adversely affects their socialization, learning and development. Other reasons for foster care include: parental substance use (22%); physical abuse (14%); relinquishment/abandonment (13%); "parent unable to cope" (12%); and sexual abuse (4%).

Voices for Virginia's Children reports that the Casey Strategic Consulting Group (CSCG), a branch of the Annie E. Casey Foundation, has granted Virginia multi-year technical consulting support. CSCG staff is collaborating with the Office of the Secretary of Health and Human Services to facilitate measurable and enduring reforms in Virginia's child welfare system. Some of the initial trends reported in Voices for Virginia's Children are discussed below.

Compared to any other state, Virginia has the highest percentage of youth who "age out" of the foster care system without permanence (reunification, adoption, or a legal guardian). Virginia is below the national average in

timely adoptions. Among youth who enter foster care at age 12 or older, only a small percentage (2%) are ever adopted.



## Health and Mental Health Insurance

In terms of health insurance for children and foster children, Virginia participates in the State Children's Health Insurance Program (SCHIP). This program was created by Congress in 1997 and is funded by the federal government and the states. The program funds health and mental health services.

A problem in Virginia's system occurs when a youth turns age 18. Those youth ages 18 to 20 who remain involved in foster care must navigate complex criteria in order to qualify for Medicaid health coverage. Even very modest earnings of as little as \$2,500 can disqualify a youth from coverage (Voices for Virginia's Children, 2008).



## Virginia Youth Advisory Council

The Virginia Youth Advisory Council is a network of young people currently in foster care and those aging out of foster care, who want to help themselves and each other become successful independent adults. Through service and group activities, members develop skills such as decision-making, working as a member of a team, and effective communication.

To become a V-YAC member, youth must be recommended by their local department of social services. They then complete an orientation and four required workshops (youth leadership; advocacy; youth council; communication skills). For teens in foster care who are at least 15 years of age, there is a quarterly conference. Teens connect with others in foster care. They also develop a network of support for a successful future.



## FACES of Virginia Families

FACES is the only statewide family-based organization in Virginia dedicated entirely to advocacy, collaboration, empowerment, and support for foster, adoptive, and kinship families. The mission of FACES is to provide a united voice for children, youth, and families involved in foster, adoptive, and kinship care so that all children and youth in the foster care system are treated with dignity, respect and equality.

FACES next Annual Conference will be September 12-14, 2009 in Southeast Virginia. The conference theme is "Give Children Wings and Their Futures Will Soar." Reserve your space by contacting Kim Barbarji, Conference Chair at (757) 258-7731 or by e-mail at: [kbarbarji@facesofvirginia.org](mailto:kbarbarji@facesofvirginia.org)

More information about FACES is available at <http://facesofvirginia.org/>



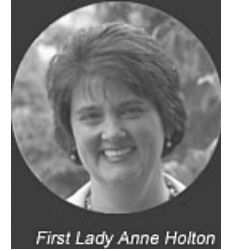
## Voices for Virginia's Children

Voices for Virginia's Children is a statewide, privately-funded, non-partisan awareness and advocacy organization. Voices builds support for practical public policies to improve the lives of children. Voices mobilizes support for initiatives by conducting research, developing policies, building coalitions, and helping people articulate their support for children.

More information is available at: [www.vakids.org](http://www.vakids.org)



# Spotlight: For Keeps



First Lady Anne Holton

Every year, hundreds of young people in Virginia's foster care system begin their journey as independent adults. Many of these former foster children are alone as they face the challenges of jobs, housing, and personal relationships. Some overcome the problems they encounter and lead lives as productive community members. Others do not fare as well. Foster children "aging out" of the system are more likely than other young adults to become homeless, unemployed, be involved in the criminal justice system or develop a serious mental illness or substance abuse problem.

**For Keeps** was created to identify and develop ways to find and strengthen permanent families for older children who are in foster care or who might be at risk of entering foster

care. **For Keeps** is grounded in the belief that everyone deserves and needs permanent family connections in order to become successful.

**For Keeps** has three primary objectives:

- Strengthen the Voices of Youth in Foster Care and Their Foster Parents
- Find Permanent Family Connections for Older Children in Foster Care or At Risk of Coming into Care
- Champion Efforts to Improve Family and Community Supports for All Children

**For Keeps** was launched in January, 2007.

Through the First Lady's leadership, the initiative has generated key partnerships with local, state, and national organizations and foundations that are providing technical assistance and funding to promote foster care

reforms in Virginia.

**For Keeps** engaged Child Trends, a national, non-profit research center focused on improving outcomes for children. During the summer and fall of 2007, Child Trends worked with Virginia stakeholders and For Keeps to conduct intensive analyses of data from the Virginia Department of Social Services and the Office of Comprehensive Services. These data provide a description of the characteristics, experiences and permanency outcomes of older youth in the foster care system.

The **For Keeps Initiative** can be reached at: Office of the First Lady of Virginia, The Executive Mansion, Capitol Square, Richmond, VA 23219  
E-mail: [contactus@forkeepsvirginia.org](mailto:contactus@forkeepsvirginia.org)



Since 2007, the Virginia Early Childhood Foundation (VECF) has coordinated a statewide collaboration to enhance learning and development for Virginia's youngest citizens. The Foundation provides funding and technical assistance to local communities. "Each local community is different," explains Scott Hippert, president of VECF. "Therefore each local community determines its own strategies and services." Across the Commonwealth there are 16 local or regional initiatives working to build a comprehensive network of early care and education services.

VECF has developed a comprehensive plan that endorses several goals. The hope is that all families of children prenatal to age five will have the information and supports needed to promote their child's optimal development and ensure school readiness. All families should have access to high quality early care and education, as well as access to a full range of treatment and prevention services. VECF wants all Virginians to recognize the importance of early childhood and to act to support policies and investments that promote smart beginnings for all children.

One local effort in South Hampton Roads is coordinated by Lisa Howard. She explains the

# Spotlight: Smart Beginnings

community focus. "One in five of our children is not ready to enter kindergarten and be successful," asserts Howard. "We want to raise public awareness of the problem," she adds. The South Hampton Roads area includes five communities: Chesapeake; Norfolk; Portsmouth; Suffolk; and Virginia Beach.

Howard says Smart Beginnings has four initiatives in the community. First, the community is adopting a quality rating system, a sort of "consumer reports of child care." The centerpiece of the effort is to work collaboratively with child care providers to improve the quality of their care. Howard says that 28 centers and 10 home providers are voluntarily participating in the initial effort. Each will be rated on the quality of their teachers, the interactions with the students, and the structural aspects of the program. Then, based on the ratings and after consultation with the staff, an improvement plan will be developed. Over \$1 million will be invested to provide mentorship for teachers, scholarships to allow staff to complete degree programs or obtain credentials, or to purchase early learning materials, upgrade the facility and purchase curriculum.

The second initiative is public awareness. Capitol One is helping with the statewide campaign. Over \$600,000 will be invested

over 2 years to provide the public information about quality child care. The third initiative is to implement universal screening for newborns to determine whether or not additional support is needed. There are screening mechanisms, says Howard, but nothing that is universal. Howard wants hospitals to implement a single, universal tool and referral system by January 2010 so that families can immediately be served. A total of \$500,000 will be invested over a 2-year period to identify, pilot test, and implement the tool. The fourth initiative is to assist the cities in implementing their individual early childhood plans. Each of the cities will receive \$500,000 over five years as a matching grant to help the locality implement their specific plans.

On October 22, 2008, Governor Tim Kaine announced \$4.6 million in grants will fund the four initiatives. The Batten Educational Achievement Fund of the Norfolk Foundation will provide Smart Beginnings South Hampton Roads \$4.1 million in grants and the Norfolk Foundation's unrestricted funds will provide another \$585,000 to support the initiatives.

Charlottesville Smart Beginnings has several areas of focus, according to John Nafziger, Vice-President for Community Ini-

*continued on page 13*



# Spotlight:

## CATCH: Child Assessment & Treatment Center for Health



CATCH is a “one-stop” service that provides comprehensive mental health, developmental, health and dental evaluations for foster children and CPS clients. Located in Alexandria’s Health Department, it is a collaborative effort among Alexandria’s Health Department, Community Services Board (CSB) and Department of Human Services. In their first fiscal year, 2006-07 CATCH screened 134 children. They have rapidly expanded their capacity and in the last fiscal year (2007-08), they reached 432 children.

Suzanne Chis, MSW, Director of Social Services at the Alexandria Department of Human Services, explained the program’s beginnings. “In 2005, federal legislation, the Child Abuse Prevention & Treatment Act (CAPTA) was amended to require that any maltreated child under the age of 3 had to be referred to early intervention services. We have taken that mandate and expanded it!” she exclaimed. “We started talking about a collaboration between the health department, mental health, and child protective services,” added Deborah Warren, DCSW, Division Director of Child, Family and Prevention Services for the Alexandria Community Services Board. “CATCH is also addressing the medical and dental needs of children who are in foster care which is part of the well-being outcomes being assessed in the Federal Child and Family Service Reviews,” mentioned Jackie Lusk, Supervisor with Alexandria Department of Social Services.

Veronica Aberle, MSN, RN is the Nurse Manager for the Alexandria Department of Health. She worked in Illinois prior to moving to Virginia. “In Illinois, there was state legislation enacted as a result of a consent decree after some children died while in state care. That legislation required the department of children and family services to find a method to track medical needs of foster children. In Illinois, the decision was to have the Department of Health partner with the Department of Children and Family Services to provide case management for children in foster and substitute care. I was very familiar with this effort and was well-positioned to assist in developing a collaborative effort in Alexandria,” said Aberle.

Chis comments, “In the Commonwealth of Virginia, there is no standardized way to assess and manage mental health and medical

needs of children entering foster care. The CATCH team often serves children with very complex medical needs that exceed the training of most foster care workers. We have referrals of children with brain damage from shaken baby syndrome, children with serious heart abnormalities, children who require multiple operations, and children with ongoing medical concerns such as HIV or diabetes. We serve children with serious behavioral problems, extreme developmental delay, and post-traumatic stress symptoms. Social workers can’t be expected to have detailed knowledge of every complex mental health or medical need.”

Peggy Stypula, MSW, LICSW, is the CATCH coordinator. One of the benefits to workers from the Division of Social Services is that Stypula can bridge the gap between the medical and mental health experts and the workers, foster parents, and biological parents by translating the mental health and medical information into understandable terms and can help implement in-home strategies for care and management. “We are able to pay attention to the coordination of care and consider the ‘whole child’ and his or her history. This case management prevents children’s need from being overlooked,” adds Aberle.

CATCH is located in a city-owned building where they have a wing. It is physically part of the health department. Mental health services such as the Infant-Toddler Connection (see VCPN, volume 72 for a more complete description of this program), are co-located in the building. CATCH added a social worker from the Division of Social Services and a therapist who can perform psycho-social assessments. “Staff has a great relationship that was built ‘block-by-block.’ We are all enthusiastic about the development of this model program,” says Aberle.

“The old method was that children three and under who were subject to a child abuse investigation were referred to PIE (the Community Service Board’s Parent-Infant Education Program) but by that point the 45-day investigation time frame was ending and the families were disengaged. Follow-through was problematic,” relates Stypula. “Now the team receives information on a weekly basis. In addition, every foster child ages 0 to 12 who is placed in our jurisdiction physically comes into the clinic for the comprehensive screening,” she explains. “For children who are not placed locally, we retrieve health care information and make certain they have had an updated physical. We review all their health and mental health information to be

certain that there are not unmet needs,” adds Warren.

After a referral is received, the team undertakes a comprehensive assessment. Background data and medical records are obtained and the parents provide historical information. Children are screened for developmental, social, and behavioral problems. Parents, foster parents, and the child complete assessment instruments and rating scales. Youth ages 13 to 21 are seen in a separate adolescent clinic for medical screening while children 0-12 are seen in the pediatric clinic. Dental screenings (often a neglected area) are performed on all children and youth. The clinic does not obtain teacher data, but does make referrals to child study committees in schools, if the child appears to require cognitive and academic testing.

An important component of the services is the inclusion of the biological parents or caretakers, even if the child has entered foster care. “We are beginning a process to meet with the biological parents at the 5-day hearing and invite them personally to attend,” explains Stypula. “We tell them that even though we work for social services, we are located in the health department and focus on the services that the CATCH team provides. We tell them that the team needs their input and assistance to develop the best plan for the child.”

Lusk notes that all local agency foster parents and all contract foster parents are now being trained in “Bridging the Gap” methods. This training teaches foster parents how to interact with biological parents and equips them to assist the biological parents in adjusting to having children in foster care. The training deals with how to handle visitation and how foster parents can be appropriate role models for biological parents. The desire is to form relationships so that services for the children can continue once the child is returned to the family of origin.

CATCH does have some data about their impact and effectiveness. In 2008, early intervention referrals were completed on 100% of Alexandria children with founded CPS cases. A stakeholder satisfaction survey found that 94.7% thought that CATCH “effectively ensures the physical, mental and developmental health of referred children.”

The staff emphasize that the CATCH model is replicable. They have even won an Honorable Mention award from CityMatCH, an association of local health department Maternal and Child Health Directors who serve urban populations, for replication potential. Their model was presented as a Promising Practice

Model at the City MatCH Leadership Conference in Albuquerque, New Mexico. Nearby agencies have approached the team for consultation and training.

One helpful aspect is the funding methods employed by the CATCH team. The health department and dental clinic are serving populations they would normally serve and are reimbursed through Medicaid or children's



health insurance programs. The Division of Social Services maximizes other worker's time by having one worker coordinate the needed medical, dental, and mental health services. The only additional funds are for the part-time administrative assistant and the child and family therapist. Revenue is received by the Alexandria Community Services Board to offset part of the therapist costs. By co-locating the services in one place, time and effort is saved and each agency can better provide the services that they already offer to foster children.

The model has been so efficient and so successful, that CATCH has expanded their focus to offer their comprehensive services to children in homeless shelters and domestic violence shelters by staff referral. They have also started some proactive efforts. For example, for February (Dental Health Month), Stypula conducted a dental health awareness program for all children in foster care and for all families seen in juvenile court that month. She provided toothbrushes, toothpaste, and information about how to properly brush teeth. The team also creates a monthly newsletter to foster parents covering topics such as how to deal with bed bugs; the latest information on attention-deficit disorder; and the importance and rationale for flu shots and other vaccines. A recent workshop for the community on medical and dental "red flags" attracted over 200 participants.

For more information, contact: Peggy J. Stypula, MSW, LICSW Coordinator of CATCH, 4480 King Street, 4th Floor, Alexandria, Virginia 22302 (703) 838-4708, E-mail: [Peggy.Stypula@alexandriava.gov](mailto:Peggy.Stypula@alexandriava.gov)



*continued from page 11*

initiatives with the Thomas Jefferson area United Way. Their efforts are led by a 26-member Leadership Council that meets two-to-three times a year with "Action Teams" meeting monthly. The Leadership Council is comprised of influential representatives from government, business leaders from banks, hospital representatives, legal experts, and teachers from the nearby community college. The Leadership Council decides upon the initiatives and is responsible for public awareness activities.

Similar to South Hampton, Charlottesville is involved in examining quality child care, implementing a rating system, and assisting local child care providers in doing an excellent job. Nafziger relates that 1,200 children (20% of all children in center-based child care) are now in centers that meet the quality control standards. Nafziger says the Leadership Council is also addressing the issue of child care affordability.

Charlottesville's Smart Beginnings Program is part of a larger effort called Partnership for Children that began 10 years ago. The Partnership for Children effort focuses upon home visits and an infant development project. Three program serve 750 children a year and most are followed up to age six. One service of the home visitors is early developmental screenings, which are done at approximately 18 months of age. Currently, over 200 children have been screened and 22% of those children have been referred for additional services based on the screening data.

Richmond Smart Beginnings is part of Richmond's United Way. They are expanding their home visiting and parenting education efforts with the help of a grant from the City. According to Barbara Cauto-Sipe, the Early Childhood Initiative has coordinated five different home visiting organizations and offered a centralized referral process. The central office can assist with the various eligibilities for benefits such as WIC, Medicaid, CHIP, and DSS assistance. One example of their assistance is to make families aware of the earned income tax credit and help families take advantage of this benefit. They maintain a website with financial resources and they assist home visitors in adding this expertise to their "tool kit." Smart Beginnings staff has developed expertise with parents who experience maternal depression, with limited English families, and with special needs parents. They also maintain a calendar of free and low-cost child activities.

There is an active parent education component to Richmond's Smart Beginnings. In the past year, 300 parents have participated. They offer the Nurturing Parenting Program and have a special section for foster parents. They

even track the numbers of children entering and exiting the foster care system. Their long-term goal is to improve children's school readiness and reduce the costs to the CSA (Community Services Act) that funds foster care needs.

Richmond, similar to South Hampton and to Charlottesville, is involved in the quality rating and improvement program for child care centers. They have helped 20 programs become state-rated. They do program assessment and provide a mentor who helps the child care center develop an improvement plan and then helps the program to increase its rating.

South Hampton, Charlottesville, and Richmond are but three examples of the work of local coalitions. Exceptional work is being implemented in many local communities. The Smart Beginnings website provides informa-



tion and resources for parents of young children, employers, community leaders, and early childhood professionals. There is information about child health as well as children's developmental stages. Localities and others can use the website as a resource for program design and service delivery.

When asked about the state-wide impact of the program, Hippert explained, "dramatically improving the school readiness of young children starting kindergarten across the Commonwealth of Virginia is our major goal. Right now, one in five children who enter Kindergarten is simply not ready to begin the school experience for a variety of reasons. Ultimately, we want to improve this statistic and help these children to eventually become productive members of Virginia's workforce." Hippert concludes, "The hope is to have Smart Beginnings initiatives in every corner of Virginia so that every child has the opportunity to enter Kindergarten prepared to succeed."

More information is available from:  
Scott Hippert, President of VECF, 2201 West Broad Street, Suite 109,  
Richmond, VA 23220,  
(804) 358-8323, ext. 107,  
E-mail: [scott@vecf.org](mailto:scott@vecf.org)  
Website: [www.smartbeginnings.org/](http://www.smartbeginnings.org/)

Lisa Howard, (757) 226-8826,  
E-mail: [lhoward@smartbeginningsshr.org](mailto:lhoward@smartbeginningsshr.org)

John Nafziger, United Way, 806 East High Street, Charlottesville, VA 22902, (434) 972-1703, E-mail: [jnafziger@unitedwaytja.org](mailto:jnafziger@unitedwaytja.org)

Barbara Couto-Sipe, (804) 771-5869,  
E-mail: [coutob@yourunitedway.org](mailto:coutob@yourunitedway.org)



## Spotlight: Rappahannock Area Child Development Center



Since October, 2003, Rappahannock Area Child Development Center has been providing prescriptive evaluations for children entering foster care. Their efforts are an example of a collaborative relationship between health, mental health and social services.

Edward Gratzick, MSW, LCSW (now retired) helped with the initial planning. "We started the ground work several years ago, after reading the **Virginia Child Protection Newsletter** about the health needs of foster children," he said. "We did a survey of foster children and met with every juvenile court judge for the 15th district. We decided to offer prescriptive evaluations."

The evaluations involve a multidisciplinary approach. The team members include components of pediatric health, nursing, psychology, social work, and education. The evaluations typically require about a 4-hour clinic visit (2 hours from psychology, 30-60 minutes from social work, a 30-minute educational consult and a 45-minute medical

workup). Medicaid reimburses approximately \$370 for each evaluation. The clinic makes one evaluation slot available per week.

The team reaches out to all the adults in the child's life, including foster parents, biological parents, grandparents, and the department of social services worker. The report includes a medical and nursing assessment (medical history; medication history; physical exam findings), a psychosocial assessment, a brief psychological assessment (behavior observations; interview; intellectual screening; behavior ratings; clinical impressions), a brief educational assessment, a provisional diagnosis, and the child-specific prescription. A feedback session, usually within 10 days, is held with the DSS worker and sometimes the foster parent to review the results and plan the intervention strategy.

Kay Murphy, MSN, RN heads the prescriptive team. She feels the effort has been very worthwhile. "The prescriptive evaluation is very valuable. It gives the caretakers and social workers a 'snapshot' view of the child that allows for systemic planning."

The model offered by the Rappahannock Area Child Development Center is an example of the sort of intervention effort that is discussed in the main article. By providing a screening evaluation at the child's entry into foster care, problems and coping strategies can be identified early. The screening may be sufficient for effective intervention and prevention efforts or the screening may reveal the need for a more comprehensive evaluation. Both the timing and structure of the evaluation meets the needs for immediate consideration of the individual child's situation.

More information is available from:  
Kay Murphy, Rappahannock Area Child Development Center, 10708 Ballantraye Drive, Fredericksburg, VA 22401  
(540) 891- 3151 Ext. 19,  
FAX: (540) 891-3152,  
E-mail: [kay.murphy@vdh.virginia.gov](mailto:kay.murphy@vdh.virginia.gov)

## Spotlight: The Childhelp Children's Center of Virginia (CCCV)



CCCV is a public/private partnership that provides a continuum of integrated services for an efficient and effective intervention for child abuse victims. All services needed by victims are available at this child-friendly children's advocacy center, including: forensic interviews; forensic medical examinations; crisis therapy; victim advocacy; and legal assistance. Partnering agencies such as law enforcement, child protective services personnel, sexual assault nurse examiners, victim advocates, and the commonwealth attorney work together when a report of child maltreatment is received. The coordinated response means that investigations proceed swiftly and children receive care promptly. Key evidence is collected and preserved and is available to the entire team so prosecution of offenders is

more likely to be successful. Most important is that by delivering services in one place, CCCV minimizes the secondary trauma to victims that can be caused by the intervention process itself.

CCCV offers trainings for clinicians and mandated reporters. For more information contact: Childhelp Children's Center of Virginia (CCCV), 11230 Waples Mill Road, Ste 105, Fairfax, Virginia 22030 (703) 208-1500.FAX: (703) 208-1540, Website: [www.childhelp.org](http://www.childhelp.org)

Virginia also has The Alice C. Tyler Village, a Childhelp residential facility located near Culpeper, VA. It offers a multitude of services including individual, group, expressive, recreational, and animal-assisted therapies; a com-

plete academic program with a special education component; full time psychiatry services; and 24-hour nursing coverage. In addition, there is a day treatment program for children who live in the surrounding areas. Residential treatment services are offered to children between the ages of 5 and 13 who experience mental illness, emotional disturbance and/or developmental delays. Many of these children are also abuse victims. The program uses volunteers for hands-on work with the children, community outreach, and fund-raising.

Contact information for the Alice C. Tyler Village is: 23164 Dragoon Road, Lignum, Virginia 22726, (540) 399-1052, Website: [www.childhelp.org](http://www.childhelp.org)

# Foster Care as a Mechanism to Access Mental Health Services



The child welfare system was designed to serve children who have been abused or neglected and the juvenile justice system was designed to serve youth who have committed delinquent acts. However, both systems have served some children who simply need mental health services and parents relinquish custody in order to obtain these services.

According to a guide from the Bazelon Center (2002), there are many potential negative effects of a reliance on child welfare and juvenile justice systems as a way to access mental health services for children. Parents are forced to yield control of their children's treatment to an agency and children and youth might come to believe that their family has abandoned them. The bond between parents and child can be harmed. Public funds can be wasted if the family could provide for the child's basic needs. Children may be unnecessarily placed in residential care when less expensive services in their home might be feasible.

The General Accounting Office was asked to study the phenomena of parents' custody relinquishment in order to obtain mental health services for children. They published the results in 2003. The GAO was asked to determine the number and characteristics of children placed voluntarily in child welfare or juvenile justice for the sole purpose of obtaining mental health services. They were asked to examine the factors that influenced such

placements and to identify promising state and local practices that might reduce the need for these placements.

The state child welfare officials in 19 states and the county juvenile justice officials in 30 counties who responded to the survey estimated that in 2001, parents in their jurisdictions placed 12,700 children with either child welfare or juvenile justice in order to obtain mental health services. Of these, 3,700 are estimated to have entered child welfare and approximately 9,000 entered the juvenile justice system. Those responding to the surveys said that males comprised 65% of those placed and most children placed were adolescents (67%). Children who were placed came from all socio-economic levels. Some officials reported that middle class families had the greatest risk of placement because they were not eligible for Medicaid and the family funds could not stretch to cover the treatment costs.

The Department of Justice, commenting on the study's methodology, noted that the report stated that there is no formal or comprehensive federal or state identification and tracking of these placements. Thus, this data, at best, is anecdotal and highly speculative. The Department of Health and Human Services noted in their comments that the report does not address whether or not the children placed into care did, in fact, receive services and whether or not parents were satisfied with the services received. The question of whether or not the children and youth improved and had better lives was not addressed.

The GAO study found a combination of factors driving parents to conclude that their only option for their child or youth was placement in foster care or in the juvenile justice system. The primary reason discussed was the scarcity of community-based mental health services. These scarce services are underfunded and the payment mechanisms for the services have limitations, both in public and private mental health coverage. Thus, the problem is not within the child welfare system or the juvenile justice system, but stems from

lack of appropriate community mental health services and the inadequacy of mental health insurance coverage.

The GAO findings mirror what the AF-CARS (Adoption and Foster Care Analysis and Reporting System) has found to date. They are also similar to the findings of the Bazelon Center (2002) which reports that 94% of health maintenance plans and 96% of other plans have restrictions on mental health benefits and the limits have risen over time. Moreover, private insurance plans rarely cover the full array of intensive community-based rehabilitative services that children with the more severe mental and emotional disorders need. These include intensive in-home services, behavioral aides, day treatment, and independent living skills training.

Other factors that contributed to custody relinquishment included gaps and limitations in mental health coverage. Some policies do not cover certain disorders and others may limit the amount and type of services covered. Low reimbursement rates by Medicaid may restrict mental health providers' participation in the program and further restrict services. Eligibility for services provided by various agencies also differs. In addition, some officials and service providers were found to have misunderstood the role of their own or other agencies and offered incomplete or incorrect information to parents.

An aspect of the problem is the high cost of care needed by some children. In 2006, Georgetown University Training Institutes hosted a special forum about financing children's mental health services. A summary paper presents information from presentations by Sheila Pires of the Human Service Collaborative in Washington, DC and Chris Koyanagi, Policy Director of the Bazelon Center for Mental Health Law. Pires noted that in a state in which 2-5% of the population of children have serious mental disorders, these children account 60% of the dollars spent on children's mental health services. Since men-

*continued on page 16*

## Report Document No. 90: Follow-up Report: Custody Relinquishment and the Comprehensive Services Act

by the Joint Legislative Audit and Review Commission, 2007, Available at: [jlarc.virginia.gov/reports/Rpt352.pdf](http://jlarc.virginia.gov/reports/Rpt352.pdf)



On December 11, 2006, the Joint Legislative Subcommittee Studying the Comprehensive Services Act asked JLARC staff to examine the extent to which the opinion issued by the Attorney General (December 6, 2006) would impact the size of the caseload and expenditures of the Comprehensive Services Act (CSA) program. In this opinion, the Attorney General (AG) concludes that the Code of Virginia requires the State and localities to serve the children who are at risk of foster care placement without requiring their parents to relinquish custody. The opinion indicates that some localities have chosen to interpret the Code of Virginia too narrowly, and are improperly requiring parents to relinquish custody in order to obtain services. The review confirmed this finding, but notes that the fiscal impact of the opinion may be limited given the high percentage of localities that already apply the law in a manner consistent with the AG's interpretation.

The study concluded that Virginia law appears to provide access to all needed services for children who are at risk of foster care placement and meet other eligibility criteria for CSA funding without parents having to relinquish custody or enter into non-custodial agreements. Consequently, the State's policy of allowing access only to community-based services for children who are at risk of foster care placement appears to be inconsistent with State law.



## Custody Relinquishment

continued from page 15

tal health expenditures are finite, there is little remaining for children with less serious problems or for children who are at risk to develop serious problems.

The issue has come to the attention of the New Freedom Commission on Mental Health, established in 2002 on the federal level to examine the nation's mental health delivery system and make recommendations. The Commission decried the fact that some parents have been forced to relinquish custody in order to obtain needed mental health services for their children. HHS is leading an effort among Federal agencies to initiate a multifaceted approach across systems with the goal of ending this tragic practice and increasing access to home- and community-based services and systems of care for children with serious emotional disturbances. The Commission planned to develop model legislation clarifying the position of State child welfare agencies and prohibiting custody relinquishment in order to access mental health services.

The GAO report identified practices that provide a continuum of care and improve community-based treatment for children with serious mental illness. These practices included: early intervention; diversion from juvenile justice placements; transitional services to children leaving residential care; crisis intervention; support services to families. Involving parents in the care and decision-making was seen as fundamental to change.

In response to the GAO report, the *Keeping Families Together Act* was proposed and introduced on January 24, 2007. It was referred to the House Committee on Energy and Commerce and to the Senate Committee on Health, Education, Labor and Pensions. The Act was an attempt to amend the Public Service Act and award competitive grants to states who established "systems of care." These systems are designed to treat and provide intervention services to children at risk of entering custody of the state in order to receive mental health care or who are already in state custody for that reason.

The Act hoped to end the practice of parents relinquishing custody of children in an attempt to receive mental health services through three efforts. First, public health insurance programs would be expanded to cover community-based mental health and family support services. Secondly, the Act provided for out-

reach and education. Third is the provision of training for those who work with these high-risk children.

The Act proposed to offer grants to states to build infrastructure to help serve the children while keeping them in their families. An interagency federal taskforce will examine mental health issues. Also, children returning from residential facilities would remain eligible for Medicaid home or community waivers.

The *Keeping Families Together Act* was not enacted. There was no comparable bill in the Senate. The bill's sponsor is no longer in the House of Representatives. The Act would need to be re-introduced and reconsidered.

There have been some court decisions that impinge on the issue. On March 23, 2007, a California court (*Katie A. v. Bonta*; U. S. Court of Appeals for the Ninth District) affirmed the state's obligation to provide effective mental health services such as wraparound services and therapeutic foster care (TFC) to prevent institutionalization. However, the decision was reversed on appeal. In a similar case in Massachusetts (*Rosie D. v. Romney*) a federal court ruled in January 2006 that Medicaid-eligible children with challenging mental health needs are entitled to comprehensive assessments, developed with their participation and their family's, and to receive case management and in-home behavioral support services.

Recent legislation offers some promise. Although it does not directly address mental health, the *Fostering Connections to Success and Increasing Adoptions Act* will help hundreds of thousands of children and youth in foster care by improving education and health care as well as promoting stable families through supports for relatives who assume guardianship or adopt. The Act allows older youth without permanent families to remain in State care until age 21. The Act requires that States ensure that youth in foster care attend school and facilitates maintaining school placements. Health care coordination will improve as child welfare agencies work with Medicaid to create a plan for better coordination of health care and better prescription medication oversight. The plan will also ad-

dress appropriate screenings, assessments, and follow up treatment as well as information updating and provision for sharing of critical information among providers. The bill was signed by President Bush on October 7, 2008.

## Virginia's Picture

According to the Virginia State Executive Council, in 2004, between 23 and 27 percent of Virginia's foster care population were children admitted voluntarily by parents or caregivers so that the children could access mental health services. Nearly 2,400 children were placed voluntarily in foster care in Virginia between 2003 and 2005.

In 1992, Virginia passed the Comprehensive Services Act (CSA) which took several funding streams and combined them into a community management system so that children with problems that were handled by multiple agencies (such as schools; mental health; child welfare) could be considered and served in a comprehensive fashion. Because federal law mandates mental health services for children in foster care, these children began to receive first priority for assessing these limited funds. It was estimated that foster children and children who required special education in residential settings used up to 95% of the budget, allowing limited funding for other children (Developments in Mental Health Law, 2007).

An inquiry was posed to Virginia Attorney General, Robert F. McDonnell as to whether or not parents are required to relinquish custody of their children in order to gain access to CSA monies for mental health services. In an official advisory opinion, the Virginia Attorney General said that parents were not required to relinquish custody. The CSA was intended to make services available to any child, regardless of who has custody. McDonnell described the practice of custody relinquishment as "wrenching and potentially tragic" and said it may violate the U. S. Constitution. He wrote, "It is inconceivable that the best way to provide such services to a child and his family is by an interpretation that tears the family asunder."

According to Raymond Ratke, Chair of the



## Developmental Issues for Young Children in Foster Care

The AAP Committee on Early Childhood, Adoption and Dependent Care issued these recommendations in 2000. Pediatricians have an important role in assessing children's needs, providing comprehensive services, and advocating for the child. The Committee reviewed information about the importance of early brain development and the crucial role of attachment in the normal development of young children. They discuss children's sense of time and their responses to psychological stress. They review some of the effects of neglect.

The document outlines the components of a comprehensive assessment of children prior to and after placement in foster care and offers guidance on the minimum assessment necessary. The document discusses treatment, placement issues, contact with parents and the need for stability. It ends with recommendations and concepts to guide pediatricians in their work.

Available from: Pediatrics, volume 105, No. 5, November, 2000 or it can be downloaded from the internet at: <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;106/5/1145>

study group, additional funding was provided to the CSA to address the potential need. In 2007, the Joint Legislative Audit and Review Commission published Report Document No. 90 "Follow-Up Report: Custody Relinquishment and the Comprehensive Services Act". The report found that some localities had chosen to interpret the Code of Virginia too narrowly and were improperly requiring parents to relinquish custody in order to obtain services. The fiscal impact was difficult to estimate, however, because of the high percentage of localities that were already applying the law in a manner consistent with the Attorney General's opinion.

Further, the Commonwealth's policy of allowing only community-based services (and not residential services) for children at risk of foster care placement appeared inconsistent with State law. The report suggested that the Office of Comprehensive Services take the lead in ensuring that current policies are consistent with State law and issue any needed clarifications to localities. They suggested that guidelines be developed to ensure that localities fairly and consistently determine eligibility for services funded through CSA Foster Care Prevention and provide services to those children who are eligible for them under Virginia law.

Charlotte McNulty currently heads the office that administers the Comprehensive Services Act (CSA). She explained that, as a result of the Attorney General's letter, policy was changed to be in compliance with the law. The changed policy, which clarified that services to children can be provided without parental custody relinquishment, still included court involvement, as required by the Virginia Code.

Families wanted the court involvement requirement to be removed, reasoning that they should not have to go to court in order to obtain services for their child. As a result of the families' concerns, House Bill 1489 was passed by the 2008 General Assembly and enacted in Chapter 678 of the Code of Virginia. This legislation removes the statutory language which had required submission of the Individual and Family Services Plan to the court and ongoing periodic court reviews of the plan for children placed through a CSA parental agreement. Readers should note that all court requirements, including the submission of the plan and ongoing reviews, remain for children who are placed through a non-custodial agreement with the Department of Social Services. Only children placed through a CSA parental agreement are exempt from the court requirements.

The document *Final Interagency Guidelines on Foster Care Services for Specific "Children in Need of Services" Funded through the Comprehensive Services Act (CSA)* was revised and became effective on July 1, 2008. It is available on the CSA website ([www.cs.state.va.us](http://www.cs.state.va.us)), then click on "CSA Manual/CSA Publications."

References Available Upon Request

## Resources on Custody Relinquishment

U.S. General Accounting Office Report to Congressional Requesters: 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, April, 2003 (GAO-03-397).

Available from: United States General Accounting Office, Washington, DC 20548 or on the web at: [www.gao.gov/cgi-bin/getrpt?GAO-03-397](http://www.gao.gov/cgi-bin/getrpt?GAO-03-397)

The GAO was asked to determine: 1) the number and characteristics of children voluntarily placed in the child welfare and juvenile justice systems to receive mental health services; 2) the factors that influence such placements; and 3) promising state and local practices that may reduce the need for child welfare and juvenile justice placements.

**GAO**  
U.S. Government Accountability Office



Avoiding Cruel Choices: A Guide for Policymakers and Family Organizations on Medicaid's Role in Preventing Custody Relinquishment, Bazelon Center for Mental Health Law, 2002, \$10 (shipping and handling included) or can be downloaded online for free at: [www.bazelon.org](http://www.bazelon.org)

Available from: Bazelon Center for Mental Health Law, ATT: Publications Desk, 1101 15th Street, NW, Suite 1212, Washington, DC 20005 or from Bazelon's Center's online bookstore at: <http://store.bazelon.org>

This work explains Medicaid and its coverage and state options for providing access to care. It discusses ways to improve state systems.

## Resources on Mental Health Care for Children and Adolescents

**Center for Effective Collaboration and Practice:** <http://cecp.air.org/>

The mission is to support and promote the positive development of children at risk of developing serious emotional disturbance. The Center is dedicated to promoting and facilitating the production, exchange, and use of knowledge about effective practices.

**Child Welfare League of America (CWLA):** [www.cwla.org](http://www.cwla.org)

A powerful coalition of hundreds of private and public agencies serving vulnerable children and families since 1920, CWLA offers standards for foster and out-of-home care. They partnered to develop the innovative foster parent training program, The PRIDE Program.

**National Federation of Families for Children's Mental Health,** 9605 Medical Center Drive, Suite 280, Rockville, MD 20850, (240) 403-1901, FAX: (240) 403-1909, Website: [www.ffcmh@ffcmh.org](http://www.ffcmh@ffcmh.org)

The Federation provides leadership to develop and sustain a nationwide network of family-operated organizations. They seek to change how systems respond to children with mental health needs. They try to help policy-makers, agencies, and providers become more effective in delivering services and supports that foster healthy emotional development for all children. They are promoting the first full week in May as National Children's Mental Health Awareness Week.

**National Technical Assistance Center for Children's Mental Health,** Georgetown University Center for Child and Human Development, Box 511485, 3330 Whitehaven Street NW, Suite 3300, Washington, DC 20057, (202) 687-5000, FAX: (202) 687-1954, Website: [http://gucchd.goergetown.edu/programs/ta\\_center/index.html](http://gucchd.goergetown.edu/programs/ta_center/index.html)

The center is dedicated to helping tribes, territories, and communities discover, apply, and sustain innovative and collaborative solutions that improve social, emotional, and behavioral well being of children and families. The Center offers training events as well as individualized technical assistance and consultation. Several documents pertinent to this issue of VCPN are "Meeting the Mental Health Needs of Children in the Foster Care System: Strategies for Implementation" and "Meeting the Mental Health Needs of Children in the Foster Care System: Summary of State and Community Efforts." A Family's Guide to the Child Welfare System can be purchased for \$10.

**National Resource Center for Family-Centered Practice and Permanency Planning,** 129 East 79th Street, New York, NY 10021, (212) 452-7053, FAX: (212) 452-7475, Website: [www.nrcfcppp.org](http://www.nrcfcppp.org)

Contains many resources including: "Information Packet: Mental Health Care Issues for Children and Youth" by Barbara Rosenkrantz, April, 2006.

**Portland Research Training Center,** Website: [www.rtc.pdx.edu](http://www.rtc.pdx.edu)

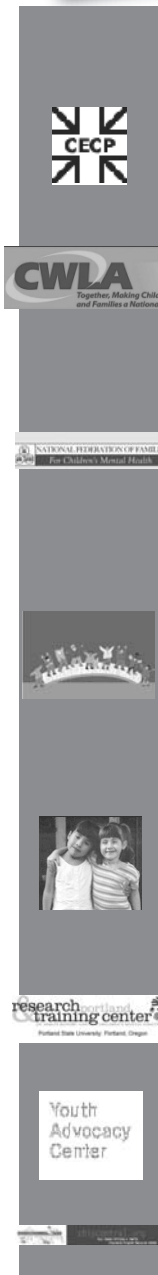
Its mission is to promote the transformation of mental health care by increasing knowledge, supports, services, and policies that: build on family strengths; are community-based, family-driven, and youth-guided; promote cultural competence; are based on evidence of effectiveness. They have a research review, Focal Point, published semi-annually and distributed for free.

**Youth Advocacy Center,** Website: [www.youthadvocacycenter.org/](http://www.youthadvocacycenter.org/)

The Center is dedicated to teaching teens how to turn their dreams for the future into concrete goals and how to develop skills to reach their goals. Gives ordering information for "Beyond the Foster Care system: The Future for Teens."

**Your State Children's Health Insurance Resource Center,** Website: [www.chipcentral.org/](http://www.chipcentral.org/)

Contains information on state's plans for children's health and mental insurance.



## Mental Health Needs of Foster Children

*continued from page 5*

In an effort to determine how foster family characteristics intersected with the adjustment of the children they foster, Orme and Beuhler (2001) conducted a review of the literature from 1965 to 2000. They found only 34 empirical studies that focused on children's psychosocial functioning in foster family care. Thus, results should be considered preliminary.

Orme and Beuhler found that foster children's positive social and emotional adjustment was associated with: a) higher levels of foster parent acceptance; b) lower levels of harsh discipline; c) higher levels of monitoring; d) lower levels of inparent inconsistency; e) lower levels of intrusive psychological control, and f) lower levels of parent-child conflict. The authors stated that the limited evidence suggests a link between foster parent and foster family characteristics and behavioral and emotional problems of foster children. However, given the long history of foster family care and the millions of children placed in foster care over the years, it is startling how little is known about how foster parents and foster families vary on important characteristics.

### What Agencies can do to Improve Outcomes for Youth in Foster Care

Historically, the child welfare system has not measured the experiences and functioning of foster children, but has instead concentrated upon safety and upon permanency. Developmental outcomes or optimizing child functioning were not considered as measurable goals (Harden, 2004). Now, the developmental needs of the children are a focus as well. As a result of the Adoption and Safe Families Act (ASFA), child well-being is now a performance measure by which state and local child welfare will be assessed.

The Northwest Foster Care Alumni Study examined the outcomes for 659 alumni of the foster care system who were in young adulthood. The youth had been in foster care between 1988 and 1998 and 479 of the 659 were also interviewed. Based upon the findings, the researchers made several recommendations about what agencies can do to improve outcomes for youth in foster care.

First, given the number and severity of the mental health problems for foster youth, it is imperative to examine barriers to mental health treatment and remove them. Medicaid and other insurance coverage must expand so that youth who require mental health treatment can be linked with affordable and as-

sessable treatment. Mental health providers require additional training concerning the foster care population and how to screen for mental health disorders in this population. Evidence-based treatments need to be made available to foster children and new interventions should be validated.

As part of the process, Landsverk et al. (2006) stress the importance of monitoring referrals to be certain that youth in foster care receive the services and that the services are addressing the mental health needs. Follow up with the child or youth, with foster parents, with the providers, with teachers and with the biological parents or caretakers can determine if symptoms are stabilized and if the child or youth is showing progress in growth and development. Research by Hurlburt et al. (2004) suggest that interagency coordination can lead to more efficient allocation of resources to foster children with the greatest need and can also lead to decreases in racial/ethnic disparities.

Second, it is vital to maintain placement stability. Placement stability (e.g., few placement changes, no reunification failures, and no runaway episodes) resulted in a 22% decrease in negative mental health outcomes in the Northwest study. Placement stability can be improved by using several procedures. First, strengthen the initial placement decision so that children are placed in homes where the foster parents are equipped to meet their needs. Train foster parents in social learning and behavioral interventions. Teach the foster children skills for maintaining positive relationships and give them opportunities to form healthy and positive relationships. Where appropriate, help the youths maintain family connections.

The third set of recommendations concern educational success. A low number of school changes and the availability of tutoring and supplemental educational experiences resulted in a 13% decrease in negative mental health outcomes. Youth should be encouraged to complete a regular diploma rather than a GED credential. Foster care alumni in the Casey Family study obtained a GED rather than a high school diploma 28.5% of the time (nearly six times the 5% rate of the general population). While a GED is preferable to no high school completion, youth who earn a diploma have higher incomes than those with a GED, are 1.7 times more likely to complete an associate's degree and are 3.9 times more likely to complete a bachelor's degree. Treatment for mental health problems can increase the likelihood of success in the classroom. School personnel can be educated about each foster child's challenges so they are prepared to individualize the learning environment as needed.

Harden (2004) adds an additional goal, that of racial/ethnic identity development. At each stage of development, racial and ethnic identity formation is critical in helping children develop a positive sense of self and collective belonging. Due to the disproportionate repre-

sentation of minority children in foster care, children of color in foster care are often placed in homes with families with a different racial or ethnic background. Thus, foster children can face additional challenges in the developmental task of identity formation.

For children who are adopted, post-adoption services are sometimes necessary. According to the North American Council on Adoptable Children, more than 308,000 children in foster care have been adopted since 2000. While the majority of adoptions succeed, 10 to 25% disrupt before finalization and a small percentage disrupt after finalization. While the average age of a child adopted from foster care is 6.7 years, children range from less than 1 to 20 years old. One-third of children adopted from foster care in FY 2005 were age 9 or older. Supporting families who adopt foster children is an important public responsibility. Successful post-adoption programs assist families in meeting the mental health needs of the children they adopt.

For youth "aging out" of foster care, providing appropriate health and mental health care is a critical component of a successful transition to adulthood (English, Stinnett & Dunn-Georgiou, 2006). Even if adequate services are available during growing years, some former foster children suffer from permanent chronic and disabling conditions due to maltreatment and these conditions require ongoing attention of health and mental health professionals (English et al.).

Changes in attitude and approach are also necessary, according to Betsy Krebs of the Youth Advocacy Center in New York City. She believes that the current system of care includes a "culture of low expectations for teens in foster care" and "a lack of accountability for their success or failure." These factors, according to Krebs, mean that youth "age out" of the foster care system unprepared to start a career or to attend higher education. Krebs maintains, "We should no longer tolerate treating teens as problems to be solved, cases to be diagnosed, managed and restrained. If they remain objects of treatment teams, of case planning meetings, of behavior modification and management, of training programs, there is no reason for teens to respond positively." Rather, she says, "They must be independent thinkers and lifelong students who carve out their own paths to the future." Krebs suggests that foster parents and others support teens in learning for themselves and use motivational interviewing to discover what each teen wants to learn. She has described the philosophy and approach in a book "Beyond the Foster Care System: the Future for Teens," available through the Youth Advocacy Center website.

Additional suggestions come from the alumni of the foster care system. For example, La Terra Cole (2006) writes about her thoughts on 11 years living in foster care. She talks about the damaging stereotypes that

*continued on page 20*

## WHERE TO FIND REVIEWS OF EFFECTIVE TREATMENTS

**California Evidence-Based Clearinghouse for Child Welfare:** [www.cachildwelfareclearinghouse.org](http://www.cachildwelfareclearinghouse.org)

Rates treatments, interventions, and child welfare practices on the basis of efficacy as shown by scientific evidence.

**Casey Family Programs:** [www.casey.org](http://www.casey.org)

Contains many resources including “Mental Health Care for Children and Adolescents in Foster Care: Review of Research Literature” by Landsverk et al. (2006) and “Improving Family Foster Care: Findings from the Northwest Foster Care Alumni Study” by Pecora et al. (2005). Also check the “Family’s Guide to the Child Welfare System.”



**Center for Effective Collaboration and Practice:** <http://cecp.air.org/center.asp>

Supports and fosters the development of children with or at risk for serious emotional disturbance.

**Chadwick Center for Children and Families:** [www.chadwickcenter.com/kauffman.htm](http://www.chadwickcenter.com/kauffman.htm)

The aim of the Kauffman report is to identify the leading interventions for children with abuse histories.

**Chaffin & Friedrich (2004), “Evidence-based Treatments in Child Abuse and Neglect”:**

[www.cachildwelfareclearinghouse.org/files/EBP%20in%20child%20abuse%20and%20neglect--Chaffin%20and%20Friedrich.pdf](http://www.cachildwelfareclearinghouse.org/files/EBP%20in%20child%20abuse%20and%20neglect--Chaffin%20and%20Friedrich.pdf)

The aim was to present the most rigorously researched and most commonly provided interventions organized by type of trauma (eg. neglect; physical abuse; sexual abuse)

**Foster Family-Based Treatment Association:** [www.fftta.org/](http://www.fftta.org/)

Publishes an Evidence-based Practices Resource Guide.



**National Child Traumatic Stress Network:** [www.nctsn.org/](http://www.nctsn.org/)

Check the Empirically Supported Treatments and Promising Practices sections. Their listing includes treatments for all types of trauma, not only child maltreatment.

**National Crime Victims Research & Treatment Center at the Medical University of South Carolina:** <http://academicdepartments.musc.edu/nctsc/>

The Center has a variety of reports available, including:

- \* Kaufman Best Practices Project report (2004) from the Chadwick Center for Children and Families (“Closing the Quality Chasm in Child Abuse Treatment: Identifying and Disseminating Best Practices,” 48 pages).

- \* A review by Saunders (2002, revised 2004) titled “Child Physical & Sexual Abuse: Guidelines for Treatment” (137 pages).

- \* Kolko & Saunders (2002) “Assessing & Treating Physically Abused Children and their Families”

**National Implementation Research Network:** <http://nirn.fmhi.usf.edu/>

Summarizes findings from the review of the research literature on implementation and proposes frameworks for understanding effective implementation processes.

**Office of Juvenile Justice and Delinquency Prevention's Model Programs Guide (MPG):** [www.dsgonline.com/mpg2.5/mpg\\_index.htm](http://www.dsgonline.com/mpg2.5/mpg_index.htm)

The Model Programs Guide (MPG) database of evidence-based programs covers the entire continuum of youth services from prevention through sanctions to reentry. It addresses a range of issues, including substance abuse, mental health, and education programs.

OJJDP Model Programs Guide

**Office for Victims of Crime (OCV):** [www.ojp.usdoj.gov/ovc/](http://www.ojp.usdoj.gov/ovc/)

This site contains many resources. Not all are empirically-based.

**Promising Practices Network:** [www.promisingpractices.net/programs\\_evidence.asp](http://www.promisingpractices.net/programs_evidence.asp)

This site provides descriptions of evaluated programs that improve outcomes for children and has reports including: “Developmental Status and Early Intervention Service Needs of Maltreated Children” (February, 2008).

**SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP):** [www.modelprograms.samhsa.gov/](http://www.modelprograms.samhsa.gov/)

NREPP is an online registry of mental health and substance abuse interventions that have been reviewed and rated by independent reviewers. These are programs that have been scientifically tested and can readily be disseminated to the field. Information on general mental health issues is available through SAMHSA's Mental Health Information Center at: <http://mentalhealth.samhsa.gov/>

**Society of Clinical Psychology, American Psychological Association, Division 12:** [www.psychology.sunysb.edu/eklonsky-/division12/](http://www.psychology.sunysb.edu/eklonsky-/division12/)

Provides information about effective treatments for psychological disorders and the research to support the treatment.

**The Campbell Collaboration:** [www.campbellcollaboration.org/](http://www.campbellcollaboration.org/)

An international research network that produces systematic reviews in education, crime and justice, and social justice.

**The Cochrane Collaboration:** [www.cochrane.org/](http://www.cochrane.org/)

Improving healthcare decision-making through systematic reviews of the effects of healthcare interventions.

**U.S. Department of Health & Human Services,** Human Services Policy, Room 404E, Assistant Secretary for Planning & Evaluation, 200 Independence Ave SW, Washington, DC 20201, FAX: (202) 690-6562 or download from <http://aspe.hhs.gov/hsp/07/Children-CPS/litrev/report.pdf>

Literature Review: “Developmental Problems of Maltreated Children and Early Intervention Options for Maltreated Children,” by Wiggins, Fenichel & Mann, 2007. This document reviews developmental problems of maltreated children and interventions that are proven or may prove useful. Also check for “Systems of Care: Promising Practices in Children's Mental Health” (2000), a three-volume series.

## PLUS—

Check the VCPN website for a review of effective treatments!

<http://psychweb.cisat.jmu.edu/graysojh/>



Department of  
PSYCHOLOGY

MSC 7704  
800 S. Main Street  
Harrisonburg, VA 22807  
Attn: J. Grayson

Nonprofit Organization  
U.S. POSTAGE PAID  
Harrisonburg, VA 22802  
PERMIT NO. 161

*Return Service Requested*



540-123

## Mental Health Needs of Foster Children

*continued from page 18*

were only too apparent during her lengthy time in foster care. She asks agencies to “showcase” successful foster children and their accomplishments as a way to give the public better information about the potential in foster children and as a recruiting tool to bring more parents into the foster care system. She writes, “Much of the resistance to fostering kids is the belief that their behavioral problems will overwhelm parents” (p. 2). She encourages parents to view these problems as symptoms of displacement that can be resolved once a stable family home is procured.

Another consideration is providing services to children and families who provide kinship

care. VCPN considered this issue in Volume 81 (Winter, 2007). There is suggestion that it is more difficult for kinship providers than for ordinary foster parents to meet children’s needs.

Finally, workers need to be educated about the diagnostic and treatment process. Not only must the foster care workers make the referrals, but they are the ones who monitor the child’s placement and adjustment. Workers need to realize the importance of evidence-based treatments and be acquainted with psychotropic medications, their effects, and their side effects. Workers are responsible to follow up and determine if referrals have been completed, and if the services are effective. Workers have a critical role in helping children and families achieve positive outcomes and they must have the support and time to adequately perform these tasks.

*References Available Upon Request*

### Go Green

*If you prefer an electronic notice when VCPN is published rather than a hard copy, please e-mail your preference to Joann Grayson at [graysojh@jmu.edu](mailto:graysojh@jmu.edu). We are exploring starting a list serve notification option.*

### More Articles are Available on the Website!

Reviews of Books for  
Children about Foster Care

A Brief History of Children’s  
Mental Health Policy

Evidenced-based Treatments

Parent Training and  
Intervention

Spotlight on the UCLA Ties  
for Adoption

Resources for Adoption

More Book Reviews

**VCPN is on the web – Visit us at:  
<http://psychweb.cisat.jmu.edu/graysojh/>**