Nationwide, there are over 400,000 children in foster care. The experience of being removed from the familiar home environment and placed into foster care is a significant stressor for any child. The impact of this experience is compounded by the fact that children often enter the foster care system due to a history of child abuse or neglect, and many of these children have experienced multiple or chronic trauma throughout their lives. Due to their history of trauma, children in foster care are at greater risk of developing behavioral problems compared to the general population of children ranging from sleep disturbances and tantrums to ADHD and oppositional-defiant disorder. Those intimately involved in caring for children in foster care, including parents, psychologists, caseworkers, and physicians, agree that special attention should be paid to these children’s mental health needs.

National data have shown that 40-80 percent of children entering the foster care system have significant mental health or behavioral problems, but as few as half of these children ever receive mental health services. There are a number of potential barriers that may contribute to this unmet need. One barrier is the screening and evaluation process; many systems fail to identify children in need of mental health treatment. Those children who are identified often have trouble accessing services due to challenges in coordinating the many individuals on the child’s team and delays in obtaining the guardian consent for treatment. Families also routinely face long waiting lists for treatment by limited numbers of child psychologists and psychiatrists.

For those families who do successfully gain access to mental health care, the ability to access quality evidence-based treatments is often limited. A number of evidence-based treatments with proven success for managing the mental and behavioral health needs of children in foster care have been identified, including Trauma-Focused Cognitive Behavioral Therapy and Parent-Child Interaction Therapy. To date, these evidence-based treatments have not been widely implemented across the community mental health settings most commonly accessed by children in foster care. This is largely due to the lack of sufficient resources being dedicated to the successful implementation of such programs, including funds for staffing and training.

One concern regarding the limited resources for quality therapeutic intervention is the potential for children in foster care to receive pharmacological intervention in the place of other mental health services. Recently, there has been considerable controversy surrounding the use of psychotropic medications to address the behavioral problems exhibited by children in foster care. The percentage of children in foster care who receive psychotropic medications (13-52 percent) is much higher than that for children in the general population (4 percent). While medications may manage these children’s externalizing behavioral problems, they do not treat the underlying trauma at the...
The Mental Health Needs of Children in Child Welfare

National Children’s Mental Health Awareness Day this year focused on building awareness in young children dealing with trauma. As part of the observance, the Substance Abuse and Mental Health Services Administration issued a report on “Helping Children and Youth Who Have Experience Traumatic Events.” This report noted that more than one-fourth of children in the United States witness or experience a traumatic event before age four.

The report also referenced the Adverse Childhood Experiences (ACES) study by the Centers for Disease Control from the 1990s. That study of more than 17,000 people showed that two-thirds of the participants reported at least one ACE and 20 percent reported three or more. Adverse childhood experiences include emotional, physical and sexual abuse; emotional and physical neglect; as well as domestic violence, substance abuse, mental illness, parental separation or divorce, and incarceration. The study also showed that more ACES in childhood increase the risk of things like alcohol and drug abuse, depression and suicide attempts later in life.

The reference to trauma and the ACES study in an edition of the newsletter on “The Mental Health Needs of Children in Child Welfare” is because many of the children in the child welfare system have experienced significant trauma. In large part because of the trauma they have experienced, these children are at much higher risk for mental health problems.

This point is clearly made in a report issued last year by the National Center for Children in Poverty, entitled “Addressing the Mental Health Needs of Young Children in the Child Welfare System.” The report focuses particularly on young children because they are “the most likely of all children to be involved with child welfare services” and have the greatest unmet needs. A few facts:

- As many as 80 percent of children in the child welfare system have mental health problems, the majority of whom are under age six.
- Young children are less likely to access needed services.
- Almost 10 times as many children under age three in foster care have disabilities and developmental delays than in the general population.
- Many parents of young children involved in child welfare also have mental health needs.

The report lists a number of policy recommendations that would help to address the identified issues:

- Promote and fund behavioral health screenings and assessments for children in child welfare (see page 3 for information about Pennsylvania’s efforts in this regard).
- Increase prevention and early intervention mental health services for children who have been victims of traumas like child abuse and neglect.
- Prioritize the development of effective strategies to meet the mental health needs of young children who are in or at risk of involvement in the child welfare system.

At the heart of these recommendations is the importance of collaboration between the mental health and child welfare systems. One of the core principles of Pennsylvania’s children’s mental health system is that “services are planned in collaboration with all the child-serving systems involved in the child’s life.” With increasing understanding of the significant mental health needs of children in the child welfare system, stemming in large part from the trauma these children have experienced, this core principles emphasizing collaboration is all the more important.

Harriet S. Bicksler, editor
In 2009, Pennsylvania’s Office of Children, Youth, and Families mandated that young children referred from child welfare services be screened for developmental and social-emotional concerns. The mandate specified that all children under the age of three with substantiated abuse be screened using the Ages & Stages Questionnaires® and the Ages & Stages Questionnaires®: Social-Emotional. Since research has shown that a child’s substantiation status does not predict the presence of developmental or mental health concerns (Casanueva, Cross, & Ringeisen, 2008; Leslie, Gordon, Ganger, & Gist, 2002; Rosenberg & Smith, 2008), the state highly recommends that every child under the age of five with an open child welfare case be screened using these tools.

The University of Pittsburgh, School of Social Work, Child Welfare Education and Research Programs received a grant from Pennsylvania’s Office of Children, Youth, and Families to evaluate three main components of this screening initiative: 1) How are the counties implementing the screening mandate? 2) What are the characteristics of children involved with child welfare across the state? and 3) Are children who screen with developmental and/or social-emotional concerns receiving appropriate services? To answer these research questions, a three-phase study was developed. During Phase I, 67 Children and Youth Services (CYS) workers and 57 Early Intervention workers (representing 66 out of 67 Pennsylvania counties) were interviewed concerning the implementation of the screening initiative. Phase II involves child welfare workers entering data into an online database for all children in their counties who received the screenings since July 2009. In the third and final phase, which began in June 2010, a random sample of caregivers across the state of Pennsylvania are being interviewed regarding their experiences during the screening, their access to services, and their opinions of CYS.

The results of Phase I show that child welfare agencies in 67 percent of counties complete the screenings. Less than half (43 percent) of the counties are screening only the mandated group (under the age of three with substantiated abuse), while 40 percent are screening all children under the age of five. Eighty-four percent of screenings are conducted by caseworkers within all units of the agency. A small percentage of CYS agencies use specialized units to conduct screenings. Overall, CYS participants reported that the screening tool is used to engage families and increase the workers’ and caregivers’ knowledge of child development. It also increases the likelihood of children receiving services.

Preliminary results of Phase II indicate that 23 percent of children who were screened indicated a developmental concern. The most frequent concern was communication (13.2 percent) followed by fine motor abilities (11.4 percent). In addition, 33.6 percent of children had a social-emotional concern. When comparing screening results from children screened by Early Intervention with CYS, a clear distinction can be seen in the rates of positive screens. Early Intervention has more children screening with concerns than CYS. This may be because the Early Intervention screeners have more expertise in child development and with screening than their CYS counterparts (McCrae, Cahalane, Fusco, 2011, in press).

Phase III will be concluding in December 2011. At this point, the majority of the interviews with caregivers have taken place in rural counties across Pennsylvania. Thirty-four percent reported not completing high school or receiving a GED; 23.4 percent report experiencing interpersonal violence in the last year, and approximately 33.6 percent are taking medication for anxiety and depression. In addition, 32 percent are currently receiving mental health services, and 18.8 percent have received mental health services as an adult. Half of the caregivers interviewed were involved in the child welfare system as children. A smaller number (23.4 percent) reported they spent time in foster care.

Research shows that 30-35 percent of 0-3-year-olds who are investigated for maltreatment have developmental scores that may qualify them for Early Intervention services, but only 13 percent receive such services (Casanueva, et al., 2008). Approximately one-third of children ages 2-5 who are investigated show behavioral problems, but only 7 percent were receiving mental health services at the time of intake to child welfare services or in the preceding 12 months (Burns et al., 2004).
These overwhelming figures indicate a need for children involved with child welfare to be periodically screened for developmental and social-emotional problems and receive the necessary services that will enable them to thrive. Studies show that maltreatment is not predictive of developmental or social-emotional concerns among children; therefore the recommendation is that all children receiving child welfare service should be screened regardless of whether there is substantiated abuse or neglect.

Rachel Winters is an evaluation coordinator at the University of Pittsburgh School of Social Work. More information about this project is at http://www.pacwcbt.pitt.edu/ASQ.htm.

References:


How Screening Helped One Family

by Rachel Winters

Amanda and Stacey, two sisters ages four and two respectively, were screened using the Ages & Stages Questionnaires® and the Ages & Stages Questionnaires®: Social-Emotional after their family was referred to Children and Youth Services (CYS). The screening was conducted by a CYS caseworker 10 days after the family’s case was accepted for services.

Amanda’s Ages & Stages Questionnaires® results showed that she scored below the threshold for gross motor abilities and above the threshold on the social-emotional screener, indicating concerns in both of these areas. After completing the screenings, the caseworker referred Amanda to the county intermediate unit for further evaluation. The intermediate unit completed a full multi-disciplinary evaluation. They felt the problems were more behavioral in nature, and recommended speech therapy. Amanda was then evaluated by a mental health agency, and was diagnosed with Attention Deficit Hyperactivity Disorder and Pervasive Developmental Disorder. At the time of the interview related to the University of Pittsburgh’s research on the use of the questionnaire, the caregiver was working with county agencies to start therapy and therapeutic staff support services for Amanda. In addition, she was taking her to the county’s learning center to enhance Amanda’s ability to play and follow a sequence of events.

Stacey’s scores on the Ages & Stages Questionnaires® also showed concerns in communication and fine motor and gross motor areas. In addition, she scored above the threshold on the Ages & Stages Questionnaires®: Social-Emotional, indicating concerns. Stacey was referred by the caseworker for a full multi-disciplinary evaluation through Early Intervention. She was found to have a delay in speech and gross motor skills. Both speech therapy and physical therapy were provided for Stacey. She is also seeing a neurologist to rule out any medical conditions and is scheduled to receive a more extensive evaluation.

Amanda and Stacey’s mother feels that services are beneficial for the well being of her children: “I am a mother of two girls under five. My husband works long hours and is gone all day. Early Intervention has been a blessing in helping my daughters get the early therapies they need before entering school where it’s a competitive race to keep up with the other children. The one-on-one speech and physical therapy has given my little one more self confidence in her movement and communication challenges.”
Multidimensional Treatment Foster Care in Pennsylvania

Venango County
by Shaun Burke

Multidimensional Treatment Foster Care® was launched in Venango County in June 2008. The first client was accepted into the program at the end of October 2008 with the first graduate on June 29, 2009. In November 2010, Venango County was certified in Multidimensional Treatment Foster Care, indicating that we are providing the model with fidelity. Venango County's program is one of 23 certified programs worldwide.

Multidimensional Treatment Foster Care (MTFC®) is an evidence-based solution for youth with emotional and behavioral problems and their families and communities. It is listed with the Center for the Study and Prevention of Violence as one of their Blueprint Model Programs (www.colorado.edu/cspv/blueprints/modelprograms.html). The goal of Multidimensional Treatment Foster Care is to stabilize the child and ultimately reunite him or her with a parent, relative or other permanent caregiver. The program focuses on decreasing antisocial behavior and increasing developmentally appropriate social skills and behaviors, in order to allow the child to experience success at home, at school and in the community. This is accomplished by:
• close supervision
• fair and consistent limits and predictable consequences for rule breaking
• a supportive relationship with a least one mentoring adult
• reduced exposure to peers engaged in delinquent behavior

The MFTC model was developed by the Oregon Social Learning Center in Eugene, Oregon in 1983. It was originally developed for youth in the juvenile justice system and was later extended to encompass work with youth in the mental health and child welfare service systems. The program has been shown to decrease risk factors and increase protective factors, reduce arrests, increase high school graduation rates, reduce teen parenthood, decrease antisocial behavior, reduce recidivism, and reduce high-risk behavior among siblings of participants.

The model is based on social learning theory and draws from over 30 years of longitudinal research on the development of antisocial behavior and how living environments influence attitudes and emotions. MTFC involves surrounding a child with an environment that prevents the development of antisocial behavior and promotes the development of positive skills and behaviors that help the child to be successful at home, at school and in the community. MTFC works within a foster care setting where the foster parents are specifically trained in social learning theory. The child’s behavior is changed through a point and level system. The child also receives individual therapy, a skills coach, and psychiatric treatment (if needed). Family therapy is also offered.

Tom is one of our success stories since we’ve implemented MTFC in Venango County, in contrast to the many sad stories there are today about teenagers—especially those in the mental health and/or child welfare systems. Recently, Tom entered Venango County’s Multidimensional Treatment Foster Care program (MTFC). He joined the basketball team and quickly starting making a difference. His coach routinely commented on how impressed he was with the Tom’s enthusiasm and how he encouraged his teammates. At a recent awards banquet, Tom received the first ever “Team Spirit” award. The award in future years will be named after him.

MTFC has been adopted throughout the United States and is currently operating in 14 states. It is also being implemented in other countries, including the United Kingdom, Sweden, the Netherlands, Ireland and Norway.

Shaun Burke is director of the Multidimensional Treatment Foster Care program for Venango County.

Children’s Home of York
by Steve Schuch

Children’s Home of York (CHOY) was established in 1865 as a home for children orphaned by the Civil War. In 1973 foster care services were developed and in 2008 the foster care program added Multidimensional Treatment Foster Care® (MTFC).

Sixteen-year-old Don entered the home’s MTFC program upon referral from County Juvenile Probation and by order of the Juvenile Court. He had a history of delinquent behavior including weapons possession at school, throwing a rock into an occupied vehicle, criminal mischief, and disorderly conduct. Don’s relationship with his mother was conflicted. He had poor academic skills and was described as socially awkward. He demonstrated poor conversational skills, did not make eye contact, and was outwardly passive.

In keeping with the MTFC model, Don
was carefully matched and placed by himself with a well-trained and supported foster family—a single parent and her three young daughters. He received consistent discipline, close supervision, positive encouragement, and engagement with his treatment parent and MTFC team.

MTFC teams are comprised of the treatment parent(s), program supervisor, individual therapist, family therapist, skills coach, and a treatment parent coordinator who supports the treatment parents and the team. Team roles are explicit and stratified. Treatment parents have daily phone monitoring with the treatment parent coordinator; the program supervisor is available around-the-clock to offer support. Intensive support decreases the likelihood of placement disruption.

MTFC placements last about 6-9 months and include multi-level interventions in family, community, and school settings. Don received weekly individual therapy, weekly social skills coaching, and academic supports. His family received family therapy with emphasis on preparing everyone for post-MTFC life. All intervention was orchestrated by the program supervisor.

MTFC aims to eliminate interaction with the child’s or adolescent’s peers who are involved in delinquent behavior since most juvenile crime is committed in groups. Vital adult support and mentoring sets the stage for learning new skills, modeling appropriate social behavior, and taking the risks necessary to change patterns of behavior in the community and with peers.

Expectations are clear about limits on behavior, and they are fair and consistently implemented. Don’s well-defined points and levels system permitted him to know his status in the program daily and over time. A “school card” facilitated behavioral and attendance accountability. Ultimately, the points and levels system guided Don through the program to discharge.

Support and opportunities for successful living in the community are provided and prepare parents, relatives, or other family members to use skills that help maintain gains when the youth returns home. Specific outcomes are planned to decrease the likelihood for rearrest post-discharge and to improve school attendance and grades.

Before his MTFC placement, Don was shy, rarely making eye contact, and typically responded with “I don’t know.” Isolated from positive peers, he demonstrated a pattern of poor judgment. In MTFC, Don had opportunities to learn, practice, and improve communication and pro-social interaction skills. His mother-son relationship, coping mechanisms, and independent living skills are healthier today because of his treatment.

MTFC advocated for Don’s attendance in regular education at a public school, thus creating increased opportunity for interaction with pro-social peers and less interaction with peers who could lead him into trouble. Don’s academic success was supported through the use of daily school cards, daily “read and study” time at home, and by maintaining close contact with school personnel. MTFC teams provide rapid response to youth at school to avert potentially serious negative incidents. Don also participated with pro-social extracurricular activities including football, weight lifting, and track and field.

Don’s motivation for success was continuously encouraged and rewarded. Team members counseled, taught, and coached him in how to identify and make pro-social choices. This was accomplished through individual therapy, skills coaching, and parental reinforcement. Don learned and demonstrated improved communication skills. He started making eye contact and asserted himself with others. Don became a positive model for the girls in his foster home. He assumed the role of big brother and became communicative, forming a complete family connection.

Family therapy concentrated on improving his relationship with his birth mother. Don’s mother learned strategies to provide structure, routine, clear rules, and limits. Even though she experienced challenges that interfered with attaining the goals of the program, Don showed improved tolerance and explored other discharge options. With his individual therapist and skills coach, he considered independent living programs and foster care, and eventually concluded that entering a traditional foster care placement was his best option.

As discharge approached, Don improved his ability to verbalize his feelings and plans to the MTFC team and his probation officer, a difficult feat for a young man who previously could barely make eye contact and limited his communication to “I don’t know.”

At admission, Don set a goal to be discharged by his 17th birthday. His resolve and the support and encouragement of his mother and the treatment team helped him achieve graduation on the day before his birthday. His stay was just under eight months. He transitioned to a foster home where he continues to flourish. He remains successful in school and participates in extracurricular activities. He also continues to demonstrate sound judgment while he and his birth mother work toward reunification.

Steve Schuch is director of program services at the Children’s Home of York in York. More information about MTFC is available at www.mftc.com
A Story of Resilience

by Colin McShane

I was sexually abused by my biological mother when I was 5-8 years old. At the time, my parents were separated and in the middle of their divorce. My mother was also a severe alcoholic and would take me with her to bars and liquor stores. Often she would get arrested for driving under the influence or public drunkenness. I would have to sit at the precinct and wait for my father to come pick me up.

When I was eight years old my father was awarded full custody and I went to live with him. Within the next year, he met, dated and married my stepmother. Shortly after my dad, stepmother, stepsister and I moved in together, my stepmother became physically abusive to me. This lasted until I was 12 years old and ended only because my dad and stepmother sent me to the child welfare system because I was acting out from being abused. Shortly after being sent into placement, my abuse was revealed, which destroyed my relationship with my parents. I spent six years in placement and did not have any contact with my parents for the first four years. Two years ago I entered into independent living and began rebuilding my relationship with my parents.

I am now the youth representative to Valley Youth House’s Board of Directors, the chair of Valley Youth House’s Youth Advisory Board, and a member of Pennsylvania’s Youth Advisory Board’s Northeast Region. I work to ensure that youth in care don’t lose their childhood like I did and that they get treated the way they deserve. My dream is to open a social work agency that helps kids who have been abused and neglected as well as others in need in the community.

In May 2011, I was invited to attend the Children’s Mental Health Awareness Day national event in Washington D.C. The theme for this year was resilience in youth dealing with trauma. As a youth who had been in the substitute care system, I believe resilience is the biggest key to success. When youth show resilience, they show that they will never give up, no matter the circumstances, and will survive if for no other reason than to be able to say they did. That is exactly what I saw at the national event in May: youth who refused to give up, and insisted that they could make a better life for themselves. With that kind of determination, nothing can stand in the way.

The best and most touching part of the whole event was the enthusiastic and respectful reaction from the audience. As a youth advocate, I work with people who try to make a difference. But that night, I felt as though we finally got through to others, like politicians, who don’t normally see these things for what they are. On May 3, the light bulb finally clicked on for those people. I was never so proud or felt so accomplished as I did that night. I think everyone else who was there felt the same way.

Colin McShane was one of seven youth recognized at the National Children’s Mental Health Awareness Day event in Washington, DC on May 3, 2011. View the event, including Colin’s presentation, at www.samhsa.gov/children/webcast/index.asp.

continued from page 1

One component of CSAW is a behavioral health intervention that uses evidence-based programs to better support children and caregivers in the foster care system. In particular, this intervention focuses on enhancing the child-foster caregiver relationship and provides foster parents with strategies to promote positive behaviors with children in their care. This program provides skills training to all foster parents and caseworkers within the agencies involved in this project. In addition, for children identified with behavioral or mental health concerns, a multisession evidence-based therapy protocol, Parent-Child Interaction Therapy, is provided. Parent-Child Interaction Therapy has over 30 years of evidence demonstrating its success in reducing negative behaviors in young children. The CSAW program co-locates these services within two foster care agencies in order to increase caregivers’ access to mental health services. The researchers hope that accessible, high quality therapy and training will more effectively address many of the behavioral problems facing children in foster care and, in turn, lead to increased placement stability.

Cody Dashiel-Earp is a graduate policy fellow at PolicyLab of the Children’s Hospital of Philadelphia. She is completing her MD and MBA at the University of Pennsylvania. Sarah Slotnik is senior strategist for communications and partnerships at the PolicyLab, Children’s Hospital of Philadelphia.
Selected Resources on the Mental Health Needs of Children in the Child Welfare System

Addressing the Mental Health Needs of Young Children in the Child Welfare System: What Every Policymaker Should Know, by Janice Cooper, Patti Banghart, and Yumiko Aratani. National Center for Children in Poverty, 2010. Explores what we currently know about the prevalence of young children (ages birth to five) in the child welfare system, how the occurrence of maltreatment or neglect affects their development, and the services currently offered versus needed for these young children. Available at http://tinyurl.com/4yag7pv

Best Practice Framework for Addressing the Mental Health and Substance Abuse Needs of Children and Their Families. Child Welfare League of America, 2003. Defines a set of theories, methods, and goals that child welfare systems can use so all children receive fair, appropriate, and accurate screening, assessment, treatment, and supports. Available at http://tinyurl.com/3g2c2bg

Healthy Beginnings, Healthy Futures: A Judges’ Guide. National Council of Juvenile and Family Court Judges and the Zero to Three National Policy Center, 2009. Addresses the wide array of health needs of very young children in the child welfare system; includes tools and strategies to help judges promote better outcomes for babies, toddlers, and preschoolers who enter their courtrooms. Available at http://tinyurl.com/32avwam


Post-Adoption Services, Meeting the Mental Health Needs of Children Adopted from Foster Care. North American Council on Adoptable Children, 2007. Highlights issues related to needs, barriers and funding for mental health services. Available at http://tinyurl.com/3kovmrv

Promising Practices in Adoption-Competent Mental Health Services. Casey Family Services and the Casey Center for Effective Child Welfare Practice, 2003. Focuses on the perspectives and experiences of adoption professionals and families who have adopted children through the child welfare system. Stories by adoptive families on how child welfare and mental health systems can be more collaboratively integrated. Available at http://tinyurl.com/3gm8em9