Child Advocates
CASA OF SILICON VALLEY

Mental Health Advice & Resources for CASAs

"When we think about a healthy start, we often limit our focus to physical health. But…mental health is fundamental to overall health and well-being. And that is why we must ensure that our health system responds as readily to the needs of children's mental health as it does to their physical well-being." David Satcher, M.D., Ph.D, Surgeon General, U.S. Surgeon General's Conference on Children's Mental Health: A National Action Agenda, 2000

1. Trauma-Informed Approach to Foster Care:

"I wish that the people who I was working with in my school were more trauma informed and that they were focused - instead of on the disruptive behavior - on what was causing the disruptive behavior." — LS, "Implementing a Trauma-Informed Approach for Youth across Service Sectors." Youth.gov

- **Trauma-informed approach.** "Association between trauma and mental health and substance use disorders, and how it can derail the healthy development of youth" (youth.gov, p.1). Approach the foster youth with the idea that they have already experienced trauma and operate from that mindset. How has that trauma impacted their current behavioral, social, physical, and educational issues/problems? And what can be done to address the trauma without reopening the wound?
- The "Three E's" concept of trauma: **1. Event**, objective and measurable. Can include: abuse, domestic or community violence, an accident or natural disaster, and war or terrorism. **2. Experience**, subjective and difficult to measure because it relates to how someone reacts to an event. Overwhelming and varies in intensity. The way one person experiences an event might differ from the way another person does: culture, gender, and age all influence one's experience of the event. Resilience, risk and protective factors, and supports may contribute to this experience. **3. Effects**, the reactions a person has to an event and the ways an experience changes or alters that person's ongoing and future behavior. Some symptoms include experiencing hyperarousal, re-experiencing the event as nightmares or flashbacks, and avoiding a situation by having a fight, flight, or freeze reaction. Can have a long term impact and contribute to negative changes due to stress responses (youth.gov, p.2).
- Youth who have experienced trauma may develop coping strategies to help them survive. These ways of coping are necessary and effective in emergencies such as traumatic events, but they interfere with ordinary day-to-day life. **Ex: Chronic Survival Coping** (reaction to stressors; i.e. staying on edge, hypervigilance, or using indifference to mask hopelessness), **Posttraumatic Survival Coping** (a change in the body, not just a mental or psychological change, brain functions different, only focus on basic survival needs), and **Neurobiological Brain Research** (alarm→search engine→computer hard drive, if alarm does not "turn off" easily, leads to difficulty relaxing, trusting, focusing, and handling things appropriately) (youth.gov, p.3).

- When trauma occurs early in childhood, critical aspects of brain and personality development may be disrupted. The ability to self-regulate, which is critical to success in late childhood and adolescence, can be compromised (Ford, Chapman, Hawke, and Albert, p.2).
- Youth exposed to traumatic events exhibit a wide range of symptoms, presenting with not just **internalizing problems,** such as depression or anxiety, but also **externalizing problems** like aggression, conduct problems, and oppositional or defiant behavior. Although trauma does not necessarily cause these problems, **traumatic stress can interfere with a child's ability to think and learn**, and can **disrupt the course of healthy physical, emotional, and intellectual development**. Further, traumatic stress among children and youth is associated with increased utilization of health and mental health services and increased risk of involvement with the child welfare and juvenile justice systems (Ford, Chapman, Hawke, and Albert, p.1).
- **Strategies for recovery from trauma** include: recognizing one's own and others' alarm reactions, sweeping one's mind clear before judging and acting, focusing on what is most important and positive, and being aware of stress and personal control levels. These strategies activate the thinking center and reset the alarm (youth.gov, p.4)
- **Align with community members and partners, strengths-based approach!**
- According to SAMHSA's concept of trauma, a program, an organization, or a system that is trauma informed is based on **four key assumptions**: • **Realizes** the widespread impact of trauma and understands potential paths for recovery. • **Recognizes** the signs and symptoms of trauma in clients, families, staff, and others involved with the system. • **Responds** by fully integrating knowledge about trauma into policies, procedures, practices, and settings. • **Resists** re-traumatization of clients as well as staff (youth.gov, p. 5).
- **SAMHSA's six principles support a framework for understanding trauma and developing a trauma-informed approach: 1. Safety, 2. Trustworthiness and transparency, 3. Collaboration and mutuality, 4. Empowerment, 5. Voice and choice, 6. Culture, historical and gender issues** (youth.gov, p.6).
- **Implementation elements**! **Element 1**: Maximize Physical and Psychological Safety for Children and Families, **Element 2**: Identify the Trauma-Related Needs of Children, **Element 3**: Enhance Child Well-Being and Resilience, **Element 4**: Enhance Family Well-Being and Resilience, **Element 5**: Enhance the Well-Being and Resilience of Those Working in the System, **Element 6**: Partner with Youth and Families, **Element 7**: Partner with Agencies and Systems That Interact with Children and Families (youth.gov, p.6-7).
- Aftercare teams need to provide consistent and ongoing planning with youth to address the after effects of trauma, (e.g., anxiety, sadness, depressions, feelings of hopelessness, anger, shame, guilt) and to build upon their strengths to instill good self-esteem and a belief that they are worthy of and can achieve goals in their life (youth.gov, p.7).
- Aftercare teams need to provide ongoing assistance for children and youth to learn skills for daily life, safety planning to address potential re-traumatization, and development of goals for the "here and now" and in their future (youth.gov, p.8).

2. <u>The Intersection of Foster Care and Mental Health:</u>

"Mental disorders and mental health problems appear in families of all social classes and of all backgrounds. No one is immune. Yet there are children who are at greatest risk by virtue of a broad array of factors. These include physical problems; intellectual disabilities (retardation); low birth weight; family history of mental and addictive disorders; multigenerational poverty; and

caregiver separation or abuse and neglect." Mental Health: A Report of the U.S. Surgeon General, 1999.

- Research shows that early childhood trauma and adversity, especially if frequent and not tempered by care from a responsive, nurturing caregiver, affect the neurobiology of the developing brain (Szilagyi, Rosen, Rubin, and Zlotnik, p.e1144). This frequently occurs when a child is in foster care.
- An older study from 1998 claimed, "**Two major factors** lead one to expect that children in foster care would exhibit significantly higher risk for mental health problems than children who are not in foster care. **First, most of these children have experienced one or more forms of maltreatment sufficiently severe to bring them to the attention of Child Protective Services.** For example, of the 93,294 children who received public social services in the state of California from January to March of 1987, 87% had experienced some form of documented child maltreatment (California State Department of Social Services, 1988). The short term (Browne & Finkelhor, 1986; Downs, 1993; Friedrich, 1993) and long term traumatic effects (e.g. Briere & Runtz, 1993; Finkelhor, Hotaling, Lewis, & Smith, 1990; Saunders, Villeponteaux, Lipovsky, Kilpatrick, & Veronen, 1992) of child maltreatment are well documented. **Second, children in foster care are at heightened risk for mental health problems due to the negative effect of separation from their family.** When an abused child, who has likely experienced difficulty developing appropriate attachment to his abusing caretakers, is removed from home and placed in foster care, he/she suffers further due to an inability to separate in a healthy way (Charles & Matheson, 1990; Kadushin, 1980). Indeed, the movement from his own home to the foster home engenders feelings of rejection, guilt, hostility, anger, abandonment, shame and dissociative reactions in response to the loss of a familiar environment and the separation from family and community (e.g., Katz, 1987). Clearly, a child who is abused or neglected and is subsequently removed from home is at great risk for the development of mental health problems" (Clausen, Landsverk, Ganger, Chadwick, and Litrownik, p. 284).
- **Mental health outcomes among alumni appear to be disproportionately poor in comparison to the general population.** The twelve-month rate of panic disorder among alumni was over three times that of the general population. Alumni experienced over seven times the rate of drug dependence and nearly two times the rate of alcohol dependence experienced in the general population. The alumni rate of bulimia was seven times higher (The Foster Care Alumni Studies.)
- This expanded analysis of data from the Casey National Alumni Study contributes new findings: PTSD, generalized anxiety, depression, social phobia, and panic disorder are highly prevalent among alumni of foster care who have spent a year or more in care. This may contribute to difficulty gaining or maintaining employment and to poor educational outcomes (The Foster Care Alumni Studies).
- **In fact, 61% of adolescents in the foster care system meet diagnostic criteria for at least one psychiatric disorder during their lifetime, including major depression, separation anxiety disorder, and oppositional defiant disorder (McMillen et. al. 2005).** Baker and colleagues (2007) found that 51% of their sample of youth in foster care had a history of psychiatric hospitalization, while 77% were prescribed psychiatric medication. In addition, rates of disruptive behavioral disorder and major depression disorder among this population are three times higher compared to non-foster care youth (McMillen et. al. 2005; Stevens, Brice, Ale & Morris, 2011). These significantly high rates may be due to previous family history of psychological disorders, abuse, or the stress of placement disruptions within the foster care system (McMillen et. al. 2005) (Hazen, NYU Steinhardt).

- Children in the child welfare system experience unique challenges. **85 percent of children in need of mental health services in the child welfare system do not receive them. Children with mental health issues in the child welfare system are less likely to be placed in permanent homes. They are also more likely to be placed out of their home environments in order to access needed services (Children's Defense Fund).**
- Recent research continues to find **that children and teens in the foster care system have disproportionately high rates of psychiatric disability**. One study by the National Institute of Mental Health found that **nearly half (47.9 percent) of youth in foster care were found to have clinically significant emotional or behavioral problems**.
- Likewise, researchers at the Casey Family Programs estimate that between one-half and three-fourths of children entering foster care exhibit behavioral or social competency problems that warrant mental health services. (Orlando and Powell, Disability Blog).
- Another study echoes this finding. According to a report by the Urban Institute, children in foster care have higher levels of behavioral and emotional problems and are more likely to have a mental health condition. More than 500,000 children live in foster care, and 50 percent of children in the child welfare system have mental health issues (Children's Defense Fund).
- **The disproportionate level of mental health diagnoses is perhaps most evident with post-traumatic stress disorder (PTSD)**. Thirty percent of foster alumni are diagnosed with PTSD, which is about twice the rate of U.S. combat veterans (Orlando and Powell, Disability Blog). (?)
- **Childhood trauma and adversity underlie various health issues**. Therefore, many youth in foster care experience physical conditions that could be attributed to trauma and neglect. "Overall, 30% to 80% of children come into foster care with at least 1 physical health problem, with fully one-third having a chronic health condition. In addition, 46% to 60% of children younger than 6 years have a developmental disability that qualifies them for services. Up to 80% of children in foster care enter with a significant mental health need" (Szilagyi, Rosen, Rubin, and Zlotnik, p.e1146).

3. <u>Challenges and Barriers for Youth Seeking Mental Health Services:</u>

"…A fragmented services system is one of several systemic barriers impeding the delivery of effective mental health care. Our interim report describes other problems, including…our failure to intervene early in childhood, and our Nation's failure to recognize mental health care as a national priority." Michael F. Hogan, Ph.D, Chair, President's New Freedom Commission on Mental Health, 2002.

- The complex trauma histories of children who enter foster care and their poor access to appropriate health care services compound their significant unmet health needs. In fact, limited health care access and unmet health needs may persist in foster care (Szilagyi, Rosen, Rubin, and Zlotnik, p.e1146)
- In addition to system challenges such as shortage of child and adolescent providers, **there are some specific barriers to providing mental health services to foster children and children at risk for removal** (Austin, 2005; Horwitz, Owens & Simms, 2000; Landsverk et al., 2006; Marshall, 2004; McMillen et al., 2004; Rosenkranz, 2006; Rubin et al., 2004; Zima, Bussing, Crecelius, Kaufman, & Belin, 1999): • Training of providers, foster care workers, and foster parents. • Lack of coordination between child welfare staff and mental health providers. • Failure of the system to conduct screening

assessments. ● Failure of community providers to identify mental health needs. ● Limited collaboration between providers and biological parents. ● Financial resources. ● Children with both medical and mental health needs. ● Instability in placements. ● Scarcity of providers and long waiting lists (CYF News, p.3).

- Pediatricians often face significant barriers in providing appropriate health care services to children in foster care. The health care of this population is time-consuming and challenging, and care coordination is particularly difficult because of the transient nature of the population and the diffusion of authority among parents, child welfare professionals, and the courts and requires at least some coordination across disciplines**. The health care children receive while in foster care is often compromised by lack of health information; consent and confidentiality barriers; insufficient funding; poor care coordination; prolonged waits for community-based medical, dental, and mental health services; and poor communication among pediatricians, child welfare professionals, parents, and legal professionals.** Receipt of health care is often on a crisis-oriented basis, rather than planned, preventive, and palliative. Lack of health information at the time of placement coupled with complicated physical, mental health, and developmental conditions and complex social dynamics makes the care of this population challenging (Szilagyi, Rosen, Rubin, and Zlotnik, p.e1148).
- The child's health history is often unavailable or incomplete at the time of placement in foster care. Birth parents may be absent or uncooperative, and caseworkers may be unable to elicit information from them. Before removal from their home of origin, children may have had multiple previous health providers or limited contact with the health care system. Caseworkers and/ or pediatricians may have to contact schools, child care providers, and former health care providers, if known, to obtain health information (Szilagyi, Rosen, Rubin, and Zlotnik, p.e1148).
- **Medicaid, which funds health care for nearly all children in foster care, should, but fails to, cover the intensity and complexity of services and care coordination** (eg, obtaining consents, locating health histories and immunization records, referrals, team meetings, caregiver education) these children require (Szilagyi, Rosen, Rubin, and Zlotnik, p.e1150).
- Coordination of health care for the individual child in foster care, whose health needs may be complex and intense, is extremely challenging. This is compounded by the lack of clear systems for communication among families, youth in care, and multiple professionals, including child welfare caseworkers, health and mental health care providers, legal professionals, early intervention providers, educators, and others involved in the care of the child (Szilagyi, Rosen, Rubin, and Zlotnik, p.e1150).
- **Although mental health services may be provided in formal child welfare settings, they may not be provided in a culturally appropriate manner or adapted to the unique needs of diverse families**. Researchers have suggested that the development of nonculturally appropriate services may lead to African American youth underutilizing mental health care (Miller & Gaston, 2003; Queener & Martin, 2001; Yeh et al., 2002). The lack of culturally appropriate mental health service provisions may compound the sense of marginalization and shame experienced by African American families involved in the foster care system (Prelow & Weaver, 2006; Pumariega, Rogers, & Rothe, 2005) (Briggs and McBeath, p.38).

4. <u>Solutions to These Challenges:</u>

"The importance of a competent, caring, nurturing, stable foster or kinship parent and [person] in supporting and advocating for a child's health and well-being cannot be stressed enough" (Szilagyi, Rosen, Rubin, and Zlotnik, p.e1145).

- **Children with mental health problems who have access to quality health care and comprehensive age appropriate mental health screens and assessments have improved health and development. Recognizing the importance of prevention, emphasizing early detection, and receiving proper treatment are important to managing mental health problems. Intervening early avoids more complex and expensive problems later in life (Children's Defense Fund).**
- Mental health services specifically designed to target deficits in social competency and adaptive behavior, such as **group psychotherapy, recreational interventions, and social skills building,** should be utilized (Clausen, Landsverk, Ganger, Chadwick, and Litrownik, p. 294).
- Medicaid and other insurance coverage must expand so that youth who require mental health treatment can be linked with available and affordable treatment providers. **Health providers may require additional training concerning the foster care population and how to screen for mental health disorders in this population. Evidence-based treatments should be available to foster children and new interventions should be validated (Pecora et al., 2005). Second, it appears vital to maintain placement stability.**
- **A low number of school changes and the availability of tutoring and supplementary educational experiences resulted in a 13% decline in negative mental health outcomes** (Pecora et al., 2005). Youth should be encouraged to complete a regular diploma rather than a GED credential.
- In addition, systems of care models of mental health services delivery seek to operationalize a philosophy about the way in which services should be organized for children and their families, with three core characteristics: **(a) child- and family-centered, (b) community-based, and (c) culturally competent (Stroul, 2002; Stroul & Friedman, 1996)**. These service delivery systems, by implementing these core values, are attempting to reduce barriers to service, more extensively involve parents and children, and increase the coordination of services. More recently, these approaches are being reformulated to include better integration with child welfare services (Pecora, Jensen, Romanelli, Jackson, and Ortiz, p. 7-8).
- Increase access to mental health treatment for youth in care and alumni. Increase mental health insurance coverage and Medicaid, including an age extension through the Chafee Medicaid option. Federal and state governments should examine barriers to mental health care—including funding eligibility. 2. Provide effective mental health screening, assessment, and treatment of children and adolescents in foster care. Provide specialized training to Medicaid-funded and other therapists working in foster care to increase their capacity to identify and treat mental health disorders. Increase use of evidence-based medical and mental health treatment such as cognitive-based therapy and systematic desensitization modeling.
- **Factors that predict mental health problems can be identified during early years of childhood**. • Treating mental health problems early reduces disability for children, before mental illness becomes more severe. • Preschools that have access to mental health consultation have lower expulsion rates. • Early detection and intervention strategies for mental health issues improve children's resilience and ability to succeed in life. • **Children living with major depression who receive combined behavioral therapy and medication have significantly better outcomes and marked decrease in suicidal thinking compared with children who do not receive such**

comprehensive treatment. • In Washington state, treatments like functional family therapy and multi-disciplinary therapy for children in the juvenile justice system reduce costs, crime, and re-offending rates. In addition, such proven and cost-effective treatments allow children to return safely to their homes, schools, and communities. • According to a study by the National Institute of Mental Health, preschoolers at high risk for mental health problems showed less oppositional behavior, less aggressive behavior, and were less likely to require special education services 3 years after enrolling in a comprehensive, school-based mental health program.

- In the primary care setting, the pediatrician can administer a validated mental health screening as an initial assessment, but the consensus among experts in foster care health calls for a **mental health evaluation within 30 days of placement, ideally by a child mental health professional trained in trauma-informed care.** Periodic reassessment of mental health should occur whether the child is in receipt of mental health services because of the many uncertainties and transitions that can occur. Children should receive recommended mental health services consistent with their diagnoses. **Trauma-informed, evidence-based therapies, such as parent-child interaction therapy, child-parent psychotherapy, and trauma-focused cognitive behavioral therapy, have been shown to be effective in the management of childhood trauma symptoms (Szilagyi, Rosen, Rubin, and Zlotnik, p.e1147).**
- The use of psychotropic medication is appropriate for some children in foster care with specific mental health diagnoses. Conditions, such as depression and anxiety, diagnosed after a full mental health evaluation and trauma assessment, respond to treatment with indicated psychotropic medications. **Psychotropic medication use should be but one part of the mental health treatment plan, and children should receive other recommended mental health interventions.** The medication should be appropriate to the diagnosis, initiated at the lowest appropriate dose, and increased slowly while monitoring for efficacy and adverse effects (Szilagyi, Rosen, Rubin, and Zlotnik, p.e1147).

5. Community Resources:

1) http://steinhardt.nyu.edu/appsych/opus/issues/2014/fall/hazen
- A very brief look at the social, mental, and physical risks that foster youth face. Important to read if you have not had much experience with foster care.
2) http://www.fcservices.org/overview/
- The courthouse is connected with DFCS. The Department of Family & Children Services provides counseling for children, teens, adults, families, and couples. Available in English, Spanish, Vietnamese, Cambodian, and American Sign Language. Accepts Medi-Cal and private insurance. Sliding scale fees.
3) http://www.namisantaclara.org/findingtherapy/
- Tips for finding a therapist in your area!
4) http://t4etrainingcollaborative.org/calendar.php
- Amazing (and free!) training classes related to mental health. The classes are located in either Campbell or Saratoga (both near San Jose). CPR & First Aid classes as well as classes on crisis intervention, treating youth with depression, emotional awareness, etc. are available.
5) https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Mental-and-Behavioral-Health.aspx
- The American Academy of Pediatrics has a great webpage on mental and behavioral health in regard to foster youth. It contains a lot of information about the circumstances that lead to mental health issues in youth.
- In addition, there is an amazing resource video library which demonstrates techniques to discuss mental health issues in youth (substance use, suicide/self-harm, aggression, depression, inattention, and social emotional problems in children 0-5). You will probably not be having these conversations with youth but the videos are helpful nonetheless: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/introduction.aspx

6) http://www.sjsu.edu/counseling/students/Additional_Resources/Community_Resources/
- This webpage is from the San Jose State University website but it provides numerous resources that could be useful for you as a CASA. Some resources on this page include: culturally oriented community resources, low-fee counseling services, substance abuse support, sexual assault resources, and low income housing resources.
7) http://upliftfs.org/press/library/websites/
- This webpage is from Uplift Family Services, an organization that we work with frequently. It provides information on topics such as: ADD/ADHD, Autism Spectrum Disorder, Bipolar Disorders, Conduct Disorders, and overall information regarding mental health/mental health disorders.
8) http://www.kidsmentalhealth.org/behavioral-therapy-for-children-with-emotional-disorders/
- This webpage from kidsmentalhealth.org is extremely helpful in regard to understanding how the disorders described above manifest in children and how to recognize the signs so you can better help your CASA child.
9) http://www.reachprotutoring.com/
- Tutoring specifically for foster youth. Could be a useful resource for foster children struggling in school or for children with learning disabilities or mental health problems. There are many locations in Santa Clara County.
10) http://www.namisantaclara.org/wp-content/uploads/2015/03/list-mental-health-contract-agencies.pdf
- A large compilation of mental health agencies in Santa Clara County.

11) http://www.alumrockcc.org/programs/
12) http://ywca-sv.org/our-services/therapy-school-based-counseling-valor-training-center/
13) http://www.billwilsoncenter.org/services/services_for_children.html
14) http://upliftfs.org/services/katie-a/
- For KATIE A.
15) http://www.communitysolutions.org/programs-and-services/children-and-youth/katie-a.html
- For KATIE A.
16) https://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime?language=en

The Role of the CASA/GAL Volunteer in Helping Youth With Mental Illnesses Staff, National Court Appointed Special Advocate Association

Summary: Mental health problems seriously affect foster children and youth. These young people benefit from their relationship with a caring CASA/GAL volunteer.

The Court Appointed Special Advocate (CASA) or volunteer guardian ad litem (GAL) has four important duties in a dependency case:

• Fact finding and reporting to the court

• Advocating for the child's best interests

• Facilitating appropriate resolutions between stakeholders

• Monitoring the child's safety and compliance with court orders

"Anywhere from 40 to 85% of kids in foster care have mental health disorders, depending on which report you read," says Stephen Hornberger, director of behavioral health for the Child Welfare League of America. Research shows that the CASA/GAL volunteer spends considerable time in direct contact with the child. Research also shows that when a CASA volunteer is appointed in dependency proceedings, the children and families receive more services.

While diagnosing mental health disorders is the job of professionals, the CASA volunteer is in a unique position to observe the child's behavior and to secure information from social workers, teachers, foster parents, parents and extended family members that indicates the need for a mental health assessment of the child or parent.

The CASA volunteer is a partner in the collaborative efforts of the stakeholders and can facilitate referrals to appropriate services by developing consensus. Their reports filed with the court at every hearing make recommendations for the child's best interests. The court report is an excellent vehicle to bring the child's or parent's "red flag" behaviors to the attention of the court with a recommendation to require a mental health or substance abuse evaluation in the event consensus for referrals cannot be developed.