

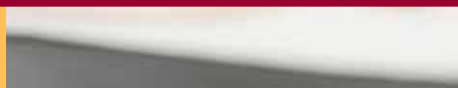
Center for Advanced Studies
in Child Welfare

School of Social Work
UNIVERSITY OF MINNESOTA



CW360°

a comprehensive look at a prevalent child welfare issue



Safety



Permanency



Well-Being

*The Intersection of Child Welfare and Disability: Focus on Children
Spring 2013*

From the Editors

We have the good fortune of living and working in a time in which progress is being made in communities as they learn to understand, define, integrate, accept, and embrace 'disabilities.' In spite of this progress, children and adults with disabilities, as well as their families, friends, advocates, and the professionals with whom they work, know that there is considerably more to do in order to achieve the highest quality of life possible for each individual person. An important indicator of quality of life is obviously that of safety, the primary concern of the child welfare system. The unfortunate reality is that both children with disabilities and children of parents with disabilities, for a variety of reasons, are overrepresented in the child welfare system in the United States. To thoroughly examine the complicated facets of this issue, we will be covering the topic of the intersection of child welfare and disabilities over two issues this year. This spring 2013 edition of *CW360°* is dedicated to exploring the issues of children with disabilities in the child welfare system. We will follow with a special edition of *CW360°* to be released this summer that will focus on the experiences of parents with disabilities in the child welfare system.

As in previous editions, the preparation for this issue of *CW360°* began with an extensive literature review and exploration of best practices in the field. Then, CASCW staff and editors engaged with individuals who emerged as leaders in or who had a unique contribution to the issue's topic. One challenge to framing the topic of disabilities is the variety of ways in which disability is defined throughout the literature and practice

organizations in the disability field. As a result, this issue of *CW360°* encompasses a wide range of conditions or diagnoses that are considered to be 'disabilities.' Articles touch on intellectual and developmental disabilities; social, emotional, and behavioral disabilities; and physical, sensory, and communication disabilities.

Because of the numerous definitions and approaches to studying disability and maltreatment, the reporting of prevalence can be a challenging but critical component for child welfare entities as they examine their practices and policies in working with children with disabilities. There is not a child welfare worker, supervisor, or administrator practicing in the field today that has not or will not come into contact with children with disabilities. Indeed, it is likely that many of the children on any given child welfare worker's caseload have some form of disability.

CW360° is divided into three sections: overview, practice, and perspectives. In the overview section, articles focus on the current state of research and policy concerning children with disabilities in child welfare. The practice section highlights evidence-informed and promising practices in the field. Lastly, the perspectives section presents articles from a variety of child welfare stakeholders highlighting innovative examples of cross-system collaborations and offering practical suggestions and strategies for system and practice improvements.

We have provided you with information and tools throughout this publication that will help you apply the research, practice, and perspectives to your own work settings

and identify opportunities to apply this new learning. **Please refer to the discussion guide at the end of the publication to help start discussions with workers and administrators at your agency.**

Another way to join the conversation on this topic, as well as other challenging questions facing the child welfare system today, is through our newly launched Child Welfare Video Wall (<http://z.umn.edu/videowall>). Several of the authors throughout this publication have recorded their thoughts about how we can improve child welfare services for people with disabilities. Just look for the Video Spotlight in selected articles and click on the URL on that page to take you to a 90-second video from the author. Then take 90 seconds to record your own reflections and ideas!



We invite readers to join CASCW staff and *CW360°* contributors Dick Sobsey, Traci LaLiberte, Elizabeth Lightfoot, Guadalupe Ortiz-Tovar, and Clayton Finck for our full-day conference on **May 7, 2013 at 9:00 am** dedicated to discussing the intersection of child welfare and disabilities in both children and parents. Two panels including local and national experts on children and parents with disabilities in child welfare will react and interact with our keynote speakers on localized impact and application of their work. The conference can be viewed via web stream from any location. The conference will also be archived and available for viewing after its conclusion. To access registration information or the web stream archive of the event, visit our website at <http://z.umn.edu/cwdisability>.

Traci LaLiberte, PhD
Executive Director, Center for Advanced Studies in Child Welfare
Executive Editor, *CW360°*

Tracy Crudo, MSW
Director of Outreach, Center for Advanced Studies in Child Welfare
Managing Editor, *CW360°*

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Registration is now open for the Center for Advanced Studies in Child Welfare's 14th annual child welfare conference

The Intersection of Child Welfare and Disability

May 7, 2013: 9:00 a.m. - 4:00 p.m.

Johnson Room, McNamara Alumni Center,
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Individuals may view the program either in person, by individual web stream from their own computers, or at a remote off-site location at a group web stream setting. Off-site participants are encouraged to email, Tweet, or Facebook questions throughout the program.



For more information and to register to attend in person or via Web stream, please follow this link:

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Table of Contents

Overview

Defining Disability and Understanding Prevalence among Children in Child Welfare, <i>Elizabeth Lightfoot, PhD & Traci LaLiberte, PhD</i>	4
Understanding Maltreatment of Children with Disabilities: An Ecological Systems Perspective, <i>Carl L. Algood, MSW, LICSW, Jun Sung Hong, MSW, MA, & Ruby M. Gourdine, DSW, LICSW, LCSW</i>	6
Stigma Matters: Maternal and Child Welfare in Families of Children with Disabilities, <i>Sara E. Green, PhD</i>	7
An Overview of Adoption for Children with Disabilities, <i>JaeRan Kim, MSW</i>	8
African American Children with Disabilities in the Child Welfare System, <i>Ruby M. Gourdine, DSW, LICSW, LCSW</i>	9
The Elementary-School Functioning of Children with Maltreatment Histories and Mild Cognitive or Behavioral Disabilities: The Gamble-Skogmo Disabilities Study, <i>Wendy Haight, PhD</i>	10
Federal Policies Impacting Youth with Disabilities Transitioning out of Foster Care, <i>Katharine Hill, PhD, LISW</i>	11
Fostering Appropriate Psychotropic Medication Use among Youth in Foster Care: The Problem, Policy Response, and Resources, <i>Thomas I. Mackie, MPH, MA, Christopher Bellonci, MD, & Laurel K. Leslie, MD, MPH</i>	12

Practice

Managing Psychotropic Medications among Children and Youth in Foster Care through Systems Collaboration <i>A summary based on information from the national meeting Because Minds Matter: Collaborating to Strengthen Management of Psychotropic Medications for Children and Youth in Foster Care, by Heidi Skallet, MSW</i>	14
Developmental-Behavioral Screening Assessment in a Social Service Context, <i>Marisa Macy, PhD</i>	15
Early Intervention for Young Children with Disabilities in the Child Welfare System, <i>By Cindy Toppin, MA</i>	16
Using Data Tracking Systems to Improve Child Welfare Services for Children with Disabilities, <i>Patrick Shannon, PhD, MSW & Christine Tappan, MSW, CAGS</i>	17
Competencies for Child Welfare Caseworkers Serving Children with Disabilities, <i>Judith S. Rycus, PhD, MSW</i>	18
Interviewing Children with Intellectual and Developmental Disabilities as Witnesses, <i>Lucy Henry, BSc (Hons), DPhil, DClinPsych & Rachel Wilcock, BSc (Hons), PhD</i>	20
Breaking Through Barriers in Delivering Mental Health Services to Children in Child Protection, <i>Timothy Zuel, PhD, LICSW</i>	21
Children with Intellectual and Developmental Disabilities: Care in the Aftermath of Trauma, <i>Nancy J. Razza, PhD & Dick Sobsey, EdD</i>	22
Supporting Youth in Making Healthy Choices, <i>Guadalupe Ortiz-Tovar</i>	24
Shared Parenting: Untapped Potential, <i>Nancy Rosenau, PhD</i>	25

Perspectives

Challenges with Cross-Systems Service Coordination, <i>Susan E. Frame, MSW, LICSW</i>	26
Collaboration Across Systems: A School Social Worker's Perspective, <i>Stephanie Ochocki, MSSW, LICSW</i>	27
Gifts from the Creator: Disability in American Indian Communities, <i>Priscilla A. Day, MSW, EdD</i>	28
The Perception of Hidden Disabilities in the Somali Community, <i>Nasro Mohamed, MSW, LGSW, interviewed by Heidi Skallet, MSW</i>	29
The Importance of Emotional Support: A Former Foster Youth's Perspective, <i>Ollie Hernandez</i>	30
Being a Treatment Foster Parent of Children with Special Needs, <i>Aura Recuero</i>	31
Sick and Tired, <i>Carla Burks</i>	32

References

Integrated Bibliography	35
IDEA'S Thirteen Disability Categories and Definitions	41
Agency Discussion Guide and Resources	42

Defining Disability and Understanding Prevalence among Children in Child Welfare

Elizabeth Lightfoot, PhD & Traci LaLiberte, PhD

Child welfare professionals work with children and youth at the highest risk for maltreatment. Within this highly vulnerable group of children is an even more vulnerable group—children with disabilities. Although the majority of child welfare professionals would say that they often work with children who have disabilities, we argue that many

their definitions. For example, the definition of autism and other disabilities have been updated in the latest Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2012).

Prior to the 2010 reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA), the field of child welfare had not

[Child] protection agencies and their staffs must recognize and actively respond to the growing body of evidence which indicates that children with disabilities are present in their caseloads in increasing numbers.

professionals and the systems within which they work do not have a clear understanding of the extent to which they provide services to children with disabilities. In order to understand the prevalence of children with disabilities within child welfare, one must first understand how disability is defined.

Defining disability

While disability may seem like a straightforward concept to define, there are hundreds of different definitions of disability used in the United States at the federal, state, and local levels. Some federal and state laws, such as the Americans with Disabilities Act, define disability based on functional limitations while other laws define disability not based upon functioning but rather on a particular diagnosis or specific type of disability. A disability can be temporary or permanent, and a disability can be present at birth or acquired at any point during a person's life. Simply having a disability diagnosis by a physician or psychiatrist does not necessarily mean that a person is defined by a federal or state law as having a disability.

Child welfare professionals need to remain abreast of current disability definitions and disability terminology as both evolve over time based on changes to legislation as well as changes in public attitudes. For example, in the twentieth century 'mental retardation' was a term used widely for a cognitive impairment and was considered appropriate by both professionals and advocates. However, in the United States 'mental retardation' is now considered inappropriate, and 'intellectual disability' is the preferred term. Likewise, in other parts of the world a cognitive limitation is known as a 'learning difficulty' or a 'learning disability.' Similarly, other types of disabilities have undergone and will likely continue to undergo modification to

adopted a consistent definition of disability. For researchers attempting to study the prevalence of children with disabilities in child welfare, these inconsistent disability definitions made it difficult to compare across states (see Shannon and Tappan in this issue, p.17). The 2010 reauthorization of CAPTA required states to include child disability in their abuse and neglect incidence and prevalence reporting. Within the reauthorization, a child is considered to have a disability based on the definition used in the Individuals with Disabilities Education Act (IDEA) (see section 602, 2024 U.S.C. 1401; 202 U.S.C. 1432). IDEA defines disability based on whether a child is evaluated as having one of thirteen disability categories. See [page 41](#) for an overview of IDEA's 13 disability categories.

Prevalence

Child welfare professionals require an enormous set of knowledge, skills, and attitudes (KSAs), also known as competencies, which they must possess to provide excellent services to children and families. As children with disabilities are highly prevalent within child welfare, developing disability competency is also a critical element of practice (see Rycus in this issue, pp. 18-19 for an in-depth discussion). To improve one's disability competency, a basic understanding of the prevalence of children with disabilities involved in child welfare services, based upon the best data available, is essential.

As states' Statewide Automated Child Welfare Information Systems (SACWIS) solidify their processes for collecting and reporting disability data as required by the 2010 CAPTA reauthorization, researchers and practitioners will be better informed about the prevalence of disability among children in child welfare systems and,



therefore, positioned to justify acquisition of adequate supports and services for this highly vulnerable group of children and youth. However, there have been a number of studies that have measured the prevalence of maltreatment of children with disabilities prior to the more uniform collection of disability data.

All studies examining demographic patterns of child maltreatment among children with disabilities have found that children with disabilities experience higher rates of maltreatment than children without disabilities. The largest study of children with disabilities in the child welfare system found that children with disabilities were 1.7 times more likely to have substantiated maltreatment than children without disabilities (Crosse, Kaye, & Ratnofsky, 1992). The largest epidemiological study of children with disabilities was conducted by Sullivan and Knutson (2000) in Omaha, Nebraska. Through merging records from hospitals, foster care settings, law enforcement agencies, and schools, they found that children with disabilities were 3.4 times more likely to experience child maltreatment than children without disabilities. The most comprehensive study in the United States using administrative data used data from Minnesota child welfare records. This study found that 22 percent of all children with substantiated maltreatment in Minnesota had a disability and that 28 percent of children over the age of five had a disability (Lightfoot, Hill, & LaLiberte, 2011).

While children with all types of disabilities experience maltreatment at greater rates than children without disabilities, studies have found that children with emotional or behavioral disorders and children with intellectual or developmental disabilities are particularly more likely to experience maltreatment (Jonson-Reid, Drake, Kim, Porterfield, & Han, 2004; Lightfoot et al., 2011; Spencer et al., 2005). In addition, children who have multiple disabilities and those receiving special education are also more likely to experience maltreatment (Jonson-Reid et al., 2004; Sullivan & Knutson, 2000). Some studies have found that children with disabilities are particularly more likely to experience neglect as a form of maltreatment than children without disabilities (Crosse et al., 1992; Sullivan & Knutson, 2000; Slayter & Springer, 2011). There are also some unique forms of maltreatment that children with disabilities can experience that are related to their disability. Some examples of disability-related maltreatment include: withholding medication or needed equipment, such as a wheelchair or a walker; not providing needed personal care, such as not helping a child get dressed or

assisting in feeding; and limiting access to communication, such as not providing sign language interpretation or removing assistive communication technology that a child uses to communicate.

Severe child maltreatment can also cause a wide range of permanent disabilities in children and youth; however, most of the research has focused on the relationship between child maltreatment and mental health disabilities as opposed to other types of disabilities. For example, there is a clear link between child maltreatment and both depression and post-traumatic stress disorder manifestation in children and youth (Gilbert et al., 2009; Springer, Sheridan, Kuo, & Carnes, 2003). There are many instances of severe child maltreatment leading to other types of disabilities, such as blunt force trauma leading to developmental disabilities, but there has not been much research into the overall incidence of these types of childhood disabilities caused by maltreatment.

Conclusion

Despite historical challenges in defining 'disability' within the field of child welfare, child protection agencies and their staffs

must recognize and actively respond to the growing body of evidence which indicates that children with disabilities are present in their caseloads in increasing numbers. Data found within this body of evidence serve as a call to action to child welfare professionals to be prepared to recognize disabilities, appropriately assess safety based upon individual needs associated with disabilities, and provide appropriate services to maltreated children with disabilities and their families.

Elizabeth Lightfoot, PhD is Associate Professor and PhD Program Director at the School of Social Work, University of Minnesota. She can be reached at elightfo@umn.edu.

Traci LaLiberte, PhD is Executive Director at the Center for Advanced Studies in Child Welfare, School of Social Work, University of Minnesota. She can be reached at lali0017@umn.edu.



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Understanding Maltreatment of Children with Disabilities: An Ecological Systems Perspective

Carl L. Algood, MSW, LICSW, Jun Sung Hong, MSW, MA, & Ruby M. Gourdine, DSW, LICSW, LCSW

Barriers to child abuse prevention and intervention are attributed to a major dearth of adequate information on the prevalence rates due to inadequate reporting by caseworkers, a lack of specific definition of disability, absence of training to properly assess maltreatment in social service agencies, and negligence of caseworkers to document and identify disabilities (Hibbard & Desch, 2007; Sullivan, 2009).

The ecological systems theory facilitates an understanding of the intricacies related to maltreatment of children with disabilities by conceptualizing the environment as an interactive set of systems. An examination of the complexities of abuse of children with disabilities through use of this framework is important in examining current policies and in developing new ones that lead to effective prevention and treatment. The individual child is an inseparable part of a large social network, which consists of micro-, meso-, exo-, and macrosystems (Bronfenbrenner, 1976, 1977). The microsystem consists of the immediate environment; the mesosystem comprises connections between immediate environments; the exosystem consists of external environmental factors which indirectly affect development; and the macrosystem consists of the larger cultural context (Bronfenbrenner, 1979, 1994).

Microsystem

The increased need for care and oversight and behavioral challenges children with disabilities may present can have a negative impact on



Social workers need to understand how developmental disabilities can impact the parent-child dyad and family functioning (Algood, Hong, Gourdine, & Williams, 2011). Social service agencies also need to train child welfare workers to effectively recognize signs of maltreatment and domestic violence and to systematically document both substantiated and unsubstantiated cases of abuse (Romney, Litrownik, Newton, & Lau, 2006).

At the microsystem level, social workers and other professionals could enhance the protective capacities of children with disabilities by providing ongoing and developmentally appropriate training to

in violent and unsafe neighborhoods may experience disruptions in parent/child bonding, which can subsequently lead to abuse (Park, Turnbull, & Turnbull, 2002). Moreover, children who reside in poor areas are especially exposed to risk factors associated with low birth weight and chronic illnesses, which are subsequently linked to disabilities (Fujira & Yamaki, 2000).

A thorough assessment of the factors contributing to parental stress is important (DiLauro, 2004). With regards to community level factors, social workers should consider community-based programs, such as the Positive Parenting Program and Community Outreach through Parent Empowerment (COPE), which have been proven effective in reducing parental stress (Fantuzzo, Stevenson, Abdul Kabir, & Perry, 2007). These programs can also reduce the impact of stress associated with living in impoverished neighborhoods by linking families to important resources.

The Individualized Family Service Plan (IFSP), a mandated component of the Individual with Disabilities Education Act, is another recommended tool to help leverage services and support for families of children with disabilities. Social workers and child welfare professionals might also consider utilizing the IFSP as a child abuse prevention strategy for families residing in high-risk neighborhoods (Child Welfare Information Gateway, 2001).

Macrosystem

Culturally defined parenting practices as well as beliefs regarding parental discipline

The ecological systems theory facilitates an understanding of the intricacies related to maltreatment of children with disabilities by conceptualizing the environment as an interactive set of systems.

their relationships with their parents, which can increase the likelihood of maltreatment (Ammerman, 1991). Further, due to the often demanding level of care required by children with disabilities parents may struggle to find appropriate child care providers leaving them vulnerable to abuse when left with inadequate supervision. In some instances, parents who are subjected to domestic violence may utilize harsh discipline measures which can also lead to maltreatment (Hartley, 2002; Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe, 2003).

It is imperative that social work practitioners assess how the parent and child relate to one other and form bonds.

these children and their families to help them recognize signs of abuse so that they can take preventive actions and seek help (Child Welfare Information Gateway, 2001).

Exosystem

Parents are susceptible to a number of physical, emotional, and economic stressors, which can increase the likelihood of maltreatment (Algood et al., 2011). Lack of social support can contribute to heightened levels of child abuse due to stress (Hibbard & Desch, 2007; Socolar, Winsor, Hunter, Catellier, & Kotch, 1999). Families residing

are relevant factors that can foster or inhibit maltreatment of children with disabilities (Algood et al., 2011). Social workers and child welfare professionals need to consider culture as a potential risk or protective factor with regards to maltreatment of children with disabilities. Project Ecosystem (Lutzker & Campbell, 1994), a parent training program, recognizes cultural factors in educating parents on prosocial parenting behaviors.

Social workers and child welfare professionals must also consistently advocate for child abuse prevention policies that take cultural relevance into consideration. In addition, intervention strategies need to be team-based and systematically coordinated among various professionals.

Conclusion

To effectively address the problem of maltreatment of children with disabilities, social workers and child welfare professionals need to thoroughly assess factors occurring at multiple settings (e.g., home, school, and neighborhood). Social workers and child welfare professionals also need to assist families in having access to needed resources and services in the community. Culturally-defined stigma associated with disabilities must also be addressed when implementing policies to prevent or intervene in maltreatment situations. Social services need to advocate for the rights of children with disabilities to receive needed services (Algood et al., 2011).

Carl L. Algood, MSW, LICSW is Doctoral Candidate at Howard University School of Social Work. He can be reached at clalgood@yahoo.com.

 <http://z.umn.edu/cpq>

Jun Sung Hong, MSW, MA is Doctoral Candidate at School of Social Work, University of Illinois at Urbana-Champaign. He can be reached at jhsong23@illinois.edu.

Ruby M. Gourdine, DSW, LICSW, LCSW is Professor at Howard University School of Social Work. She can be reached at rgourdine@howard.edu.

 <http://z.umn.edu/cpv>

Stigma Matters: Maternal and Child Welfare in Families of Children with Disabilities

Sara E. Green, PhD

Stigma is a complex interactional phenomenon that can be described as an adverse reaction to a negatively evaluated difference (Goffman, 1963; Susman, 1994). Stigma is most likely to be enacted in the context of interactions among individuals with unequal power, such as among professionals, mothers, and children within the child welfare system (Link & Phelan, 2001; Schambler, 2004). This article examines stigma and the disability experience as it pertains to child welfare using three sources of data: 1) a survey of 81 mothers of children with disabilities and follow-up interviews with 7 participants (Green, 2007b, 2004, 2003, 2001); 2) a survey of university students with and without disabilities (Green, 2007a); and 3) interviews with 8 adults with disabilities in which childhood memories were explored (Green, Davis, Karshmer, Marsh, & Straight, 2005). The combined findings of these studies suggest that, for both individuals with disabilities and their mothers, perceived stigma can be associated with emotional distress, social isolation, and vulnerability to mistreatment.

The adults with disabilities interviewed had developed skills for managing common aspects of stigmatizing encounters (such as awkwardness, staring, and expressions of sadness) and fighting overt discrimination. Far more upsetting were childhood memories of shunning and abuse. As one interviewee put it, "nobody ever talked to me unless they had to... So I was completely ignored and that's painful."

Similarly, among university students with disabilities those who believed that others equate disability with personal failure and shun/devalue people with disabilities reported more symptoms of depression.

Perceived stigma is also associated with emotional distress among mothers. As one mom put it, "I remember...when people would say things, I used to just want to... cry..." Serious maternal distress could be a potential source of child neglect or mistreatment. Recognizing the role of stigma in this distress could help child welfare workers prevent negative consequences for mothers and children. In addition, while most moms described benefits of parenting a child with disabilities, those who perceived high levels of stigma reported fewer benefits.

Maternal concerns about stigma may also increase social isolation for both mothers and children. Children whose mothers perceived high levels of stigma played less frequently with age peers. In addition, mothers of young children who perceived high levels of stigma were more likely to consider placing their children in residential facilities which could lead to early entry into the formal welfare system. Mothers who perceived high levels of stigma also tended to prefer to interact with individuals who are "wise" to the world of disability. This preference may reduce the pool of potential friends for mothers and children. More importantly, mothers who preferred interactions with "wise" individuals were less critical of health service providers – perhaps for fear of losing the support of those with whom they felt most comfortable. Ironically, it seems that in seeking to avoid stigma-related distress mothers may increase



isolation and vulnerability for themselves and their children.

Because maternal distress, social isolation, and hesitance to criticize service providers could potentially lead to child maltreatment, stigma is a topic that should matter to those interested in child welfare. Child welfare workers need to be cognizant of the damage stigma can do. Helping children and families develop strategies to resist and counter the stigmatizing reactions they encounter in their everyday lives could be a very valuable role for child welfare workers to play in the lives of children with disabilities and their families.

Sara E. Green, PhD is an associate professor in the Department of Sociology at the University of South Florida. She can be reached at sagreen@usf.edu.

An Overview of Adoption for Children with Disabilities

JaeRan Kim, MSW

Achieving permanency for children with disabilities continues to be a challenge in child welfare work. Children with disabilities have a higher rate of maltreatment and are more at risk for being victims of violence (American Academy of Pediatrics, 2001; Crosse, Kaye, & Ratnofsky, 1992; Jones et al., 2012; Sullivan & Knutson, 2000). School-aged children in Minnesota are more than twice as likely to be placed out of home and once in care, older youth with disabilities in particular experience a higher number of placements, longer periods of time in care, and are less likely to have a concurrent permanency plan (Hill, 2012a; Lightfoot, Hill, & LaLiberte, 2011). In addition, an increasing number of children adopted internationally have one or more disability (Kreider & Cohen, 2009).

Historical context

Historically, children without parental care were institutionalized. In the late 1890s the orphan train movement, the first large-scale

adoption. As parents and relatives of people with disabilities began to advocate for de-institutionalization, social work professionals agreed that children with disabilities were safer and healthier in families rather than institutions. Many children with disabilities were placed in foster care but not considered for adoption due to parental resistance to severing parental rights and the difficulty of finding adoptive parents willing and able to meet the child's needs (Cole, 1990).

Current challenges

Current permanency and adoption policies support the recruitment of adoptive parents for children with disabilities for whom reunification is not possible, including the creation of adoption subsidies, training, and post-adoption supports; however, many challenges still exist (Cole, 1990). Barriers to achieving permanency for children with disabilities include agency practices and court biases, not merely a lack of prospective parents



the child's school regarding accommodations and Individualized Education Plans. In addition, many children with disabilities exhibit challenging behaviors that require specific parenting strategies. Adoptive parents are more likely to understand how to address medical and physical disabilities while struggling to manage behaviors related to disability (Gaviday-Payne & Hudson, 2002).

While adoption subsidies help, adoptive parents identify resources such as respite care, parent education on specialized topics related to their child's specific needs, social peer support for both parents and children, and access to adoption-competent mental health providers as resources that help prevent adoption dissolutions (Barth & Berry, 1988). These supports are important given that not all children with disabilities are eligible for adoption subsidies, for example, children adopted through private or independent adoptions and intercountry programs.

Conclusion

More and more adoptive parents are opening their homes to children with one or more disability. Longitudinal studies find that these children with disabilities often thrive in their adoptive homes (Glidden, 2000). When adoptive parents receive full disclosure and information about the child's disability, as well as pre-placement training and affordable and accessible post-placement supports, they are better prepared to meet the needs of their children.

JaeRan Kim, MSW is Stability, Permanency and Adoption Coordinator at the Center for Advanced Studies in Child Welfare, School of Social Work, University of Minnesota. JaeRan can be reached at blev0001@umn.edu.



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Preparation and full disclosure about a child's disability is an important factor in permanency stability for children with disabilities.

fostering program, placed urban children with rural families. At the time, children were valued for their economic worth and prospective parents would assess children's height, weight and physical appearance before selection. Children with disabilities were not chosen (Holt, 1992).

Eventually children became valued for their emotional, rather than economic, contributions to the family. Yet children with disabilities largely remained in institutional care. In the first half of the twentieth century, adoption social workers promised professional services that minimized the risk of "mismatching" children with prospective parents (Cole, 1990). Children were subjected to IQ tests and developmental assessments to "be sure that the child was without physical, emotional or mental defect;" this promoted the belief that "adopting a child was a far less risky procedure than having one normally" (Reid, 1963, p. 30). Children with disabilities were considered "unadoptable" (Cole, 1990).

Social changes during the mid-twentieth century impacted permanency and adoption. Public awareness about child abuse and neglect led to increased numbers of children in out of home care. At the same time, decreased stigma for having children outside of marriage and greater accessibility to reproductive alternatives meant fewer healthy infants were available for

willing to adopt. Youth with disabilities in the U.S. may be less likely to have reunification or placement with relatives as a priority in their permanency plans. They are also more likely to be placed in group homes or residential treatment facilities than family foster care, decreasing their opportunities for permanency or adoption (Hill, 2012a; National Council on Disability, 2008).

In terms of recruitment, child-specific recruitment strategies are a promising practice. One study found that agencies successful in recruiting adoptive parents for children with disabilities were those who sought prospective parents for their ability, rather than "willingness," to adopt a child with a disability and who viewed adoptive parents as "resources" (Coyne, 1990).

Preparation and full disclosure about a child's disability is an important factor in permanency stability for children with disabilities. Adoptive parents who received full information and disclosure about a child's disability reported higher satisfaction and stability in parenting a child with a disability (Barth, 1991; Glidden, 1991).

Children with disabilities often require a great deal of professional post-permanency support. Adoptive families may need to schedule and transport the child to many appointments and therapies and work with

African American Children with Disabilities in the Child Welfare System

Ruby M. Gourdine, DSW, LICSW, LCSW

African American children are disproportionality represented in both child welfare and in special education systems. Approximately eight percent of children in the U.S. have disabilities, and these children are more likely to be abused than their non-disabled peers (US Census Bureau, 2002 as cited in Kendall-Tackett, Lyon, Taliaferro, & Little, 2005). Oftentimes the

14 percent of the general child population in the United States but represent 31 percent of the children placed in out of home placements (Child Welfare Information Gateway, 2011a). The statistics indicating disproportionality in both systems are eerily similar.

Much of the child welfare literature has posed several reasons why these disparities exist. Some state that the reason is rooted

and McCrae (2010) indicate that poverty is a predictor of both special educational placement and out-of-home placements.

Although most research indicates that there is no difference in prevalence rates of child maltreatment and disability among races, African American children are still overrepresented in the child welfare and disability services (special education) systems (Sedlak, McPherson, & Das, 2010). What remains as a salient issue in this overrepresentation is the enlarged gap between Black and White children in economic well-being (Sedlak et al., 2010). There is a risk of children with disabilities entering child welfare at higher rates than their non-disabled peers. This can be addressed through support and education of parents and families of children who have a disability and by focusing on eliminating poverty.

Ruby M. Gourdine, DSW, LICSW, LCSW is Professor at Howard University School of Social Work. She can be reached at rgourdine@howard.edu.

The issue of African American children being overrepresented in both child welfare and special education has existed for a while, but solutions to these disparities have yet to come.

rate of children with disabilities within the child welfare system is difficult to determine because the child welfare worker may assess a person as having a disability without the training to do so (Kendall-Tackett et al., 2005). Additionally, according to Hibbard & Desch, (2007, p.1019), "The prevalence of maltreatment of children with disabilities is difficult to calculate, because states do not use comparable definitions of child abuse and neglect."

In a review of the literature seldom do studies combine the incidences of child placement with incidences of disabilities. One would wonder if these two very important factors could have some relevance to each other. Kendall-Tackett et al. (2005) make the compelling argument that the rate of out-of-home placement entry for children without disabilities is 21.3 per 1000 while the rate for children with disabilities is 35.5 per 1000. Due to a lack of comparative data on race, it is difficult to cite the statistics of disability and child welfare placements in the African American communities.

African Americans identified as having special needs are most often identified as having high incidence of disabilities. These disabilities typically fall into the following categories: learning disabilities, emotionally disturbed, developmental disabilities, and speech and language disorders (Cartledge & Dukes, 2009). Developmental disabilities are most overrepresented in African American children: African American children make up 17 percent of the general student population but are 32 percent of all the children assigned to programs for the developmentally disabled (Aud, Fox, & KewalRamani, 2010).

In addition, African Americans are disproportionately represented in child welfare. African American children represent

in disparate needs of African American children; others suggest that it is a lack of culturally competent workers coupled with the existence of institutionalized poverty and place of residence (Chibnall et al., 2003). The issue of African American children being overrepresented in both child welfare and special education has existed for a while, but solutions to these disparities have yet to come. In fact, Coutinho and Oswald (1999, 2000) state that economic and community factors differentially affect identification of an educational disability. Likewise, Scarborough



<http://z.umn.edu/cpv>



The Elementary-School Functioning of Children with Maltreatment Histories and Mild Cognitive or Behavioral Disabilities: The Gamble-Skogmo Disabilities Study¹

Wendy Haight, PhD

As a group, children involved with child protection struggle in school. They have relatively high rates of placement in special education programs, more suspensions and expulsions, and poorer performance on standardized achievement tests compared to other students (Piescher, Hong, & LaLiberte, 2012). Children who have been maltreated also are more likely to have disabilities than their non-maltreated peers. These children may experience an escalation of risk to their school functioning due to the complex, bidirectional relationship of disability and maltreatment. Supporting the school functioning of children involved in child protection is critical not only to their immediate well-being but to their employment, self-sufficiency and self-esteem as adults. (See Haight, Kayama, Kincaid, Evans, & Kim, 2013).

In some cases, children with relatively mild cognitive and behavioral disabilities, such as specific learning disabilities and ADHD, can be at increased risk relative to children with more apparent disabilities. Unlike challenges faced by children with disabilities involving vision, hearing, mobility, and global cognitive deficits, for instance, those experienced by children with relatively “hidden” disabilities can be difficult for the children and others to interpret. Misinterpretations of the source of children’s difficulties can delay their access to the support necessary for their development, including special education services. These misinterpretations also may leave children with hidden disabilities vulnerable to maltreatment. (See Haight et al., 2013).

The Gamble-Skogmo Disabilities Study

We linked Minnesota child protection administrative data with data from the Minnesota Department of Education to identify and describe children with maltreatment histories and disabilities. We included 10,394 children enrolled in Minnesota public schools in third through sixth grades in 2009–2010 who had substantiated allegations of abuse or neglect. We also conducted in-depth, individual, audiotaped interviews with 37 experienced professionals: 22 child welfare professionals and 15 educators practicing in a northern,



rural, working class county or a more urban, middle class, southern county.

The administrative data analysis showed that of the children with maltreatment histories, 32% were eligible for special education services. Of those children, 73% had identified mild cognitive or behavioral disabilities; the most frequent primary

unmet mental health needs may be distracted from learning academic content and have fewer emotional resources and less motivation for tackling their learning challenges. Children’s mental health issues also may manifest as difficulties in developing and maintaining relationships with peers and educators.

Supporting the school functioning of children involved in child protection is critical not only to their immediate well-being but to their employment, self-sufficiency and self-esteem as adults.

disabilities categories were specific learning disabilities (33%) and emotional/behavioral disorders (27%). Children with maltreatment histories and disabilities scored significantly below children with maltreatment histories and no disabilities on standardized assessments of math and reading, and this gap increased with grade level for math.

Challenges and supports for children’s school functioning

Professionals described the school functioning of children with maltreatment histories and mild cognitive or behavioral disabilities as hampered by multiple, complex, unmet mental health and behavioral needs, especially trauma and loss. Children struggling with

Professionals also recognized that the multiple, complex, unmet needs of families can overshadow children’s disability needs. When families are in crisis, other basic needs for income, shelter, safety, etc. are prioritized over children’s school struggles. These priorities can result in delays in children’s receipt of services and in their development of social, emotional and behavioral difficulties due to experiences of frustration and failure.

Professionals also described children’s challenges due to disabilities as masked by their own and their families’ unmet needs. For example, children’s challenges resulting primarily from their cognitive disabilities can be misattributed to mental health issues

Continued on page 33

¹This article is based on: Haight, W., Kayama, M., Kincaid, T., Evans, K., & Kim, N. (2013). The elementary-school functioning of children with maltreatment histories and mild cognitive or behavioral disabilities: A mixed methods inquiry. *Children and Youth Services Review*

Federal Policies Impacting Youth with Disabilities Transitioning out of Foster Care

Katharine Hill, PhD, LISW

Research has indicated that youth with disabilities are disproportionately represented in the child welfare system and out-of-home placement (Crosse, Kaye, & Ratnofsky, 1992; Hill, 2012b; Lightfoot, Hill, & LaLiberte, 2011; Sullivan & Knutson, 2000). Although there are many federal policies and programs that address the needs of older youth and at-risk youth, few take a collaborative or integrative approach. Instead, policies that address transition are fragmented in their approach, addressing the needs of a specific population (for example, youth with disabilities, youth in foster care, youth in the justice system) rather than approaching the needs of youth holistically. Thus, it is incumbent upon individuals who work with

Additionally, FCIA funds can be used for education, vocational, and employment training and to help with room and board for youth. In 2001, the FCIA was amended to include educational and training vouchers for youth participating in postsecondary education and vocational programs.

Fostering Connections to Success and Increasing Adoption Act

The Fostering Connections to Success Act (P.L. 110-351) of 2008 requires child welfare caseworkers to develop a personalized transition plan as directed by the youth during the 90-day period prior to the youth's emancipation from foster care. The transition plan must include options regarding housing,



Opportunities for youth with disabilities transitioning from foster care

All of these federal policies place an emphasis on preparing youth who are considered to be at-risk for successful adulthood, particularly in the areas of education, employment, and independent living. As well, all three identify careful planning as a key component of transition planning whether through an Individualized Education Plan (special education) or through an Independent Living Plan (ILP; child welfare). Youth and their advocates who are able to leverage transition planning to help them achieve stated goals across service areas may be able to access a broader range of services and supports than if they limit themselves to a single service area.

Additionally, all three of these policies specifically acknowledge the likelihood that youth may be involved in multiple systems of care and that best practice approaches call for a collaborative approach among the multiple stakeholders that might be involved in the young person's life. This acknowledgement may serve as an opening for cross-agency resource- and information-sharing which may, in turn, lead to more efficient and complete services for youth with disabilities who are aging out of both the child welfare and special education systems.

Katharine Hill, PhD, LISW is an Assistant Professor at St. Catherine University/University of St. Thomas School of Social Work. She can be reached at katharine.hill@stthomas.edu.



<http://z.umn.edu/cpo>

It is incumbent upon individuals who work with foster youth with disabilities to educate themselves about the range of services and supports mandated by federal policies so that they are able to leverage available supports and ensure that systems work collaboratively.

foster youth with disabilities to educate themselves about the range of services and supports mandated by federal policies so that they are able to leverage available supports and ensure that systems work collaboratively.

The three federal policies discussed in this article are the John H. Chafee Foster Care Independence Act, the Individuals with Disabilities Education Act (IDEA), and the Fostering Connections Act. These three policies mandate programs and services specific to youth aging out of foster care or transitioning from special education. However, advocates for youth with disabilities aging out of foster care would be advised to look into other areas that may impact youth, including policies impacting youth in the corrections systems, youth employment supports, and programs for homeless and runaway youth (see Fernandes-Alcantara, 2012, for a more complete discussion of the range of federally funded programs available).

John H. Chafee Foster Care Independence Act (FCIA)

The FCIA (P.L. 106-169), passed in 1999, provides states with funding for the provision of independent living services for youth transitioning out of foster care as well as foster care alumni between the ages of 18 and 21. Independent living services may include emotional and personal supports; financial, housing, or employment training and services; and training in daily living skills (Hill, 2009).

health insurance and health care proxies, education, connections with caring adults, and workforce and employment services. The Fostering Connections Act also permits states to extend assistance programs for older youth who are in foster care through the age of 21, as long as the young person is employed, in school, engaged in vocational training, or has a documented medical condition.

Individuals with Disabilities Education Act of 2004 (IDEA)

IDEA (P.L. 108-446) is the federal law that mandates special education services for children with disabilities ages birth to 21. Transition services for youth with disabilities are mandated to begin at age 16 and continue until the young person leaves the educational system. These services are intended to improve the academic and functional realization of the young person's movement from secondary school to adult living. Transition plans are developed and monitored through young people's Individual Education Plans (IEPs). The IEP will describe a set of activities and goals specific to the young person that will lead to attaining postsecondary or vocational education, employment, independent living, and community integration. IEPs should be developed through a collaborative process that involves the young person's teacher, family, and other concerned individuals, including case workers, social workers, or vocational counselors.

Fostering Appropriate Psychotropic Medication Use among Youth in Foster Care: The Problem, Policy Response, and Resources

Thomas I. Mackie, MPH, MA, Christopher Bellonci, MD, & Laurel K. Leslie, MD, MPH

Psychotropic medication use among youth in foster care

The United States child welfare and child protective services system (hereafter, “child welfare”) is confronted with the pressing concern of appropriate psychotropic medication¹ use among children and adolescents (hereafter “youth”) in foster care (Government Accountability Office, 2011). While rates of psychotropic medication use among youth in the general population have risen significantly in the last ten years, national trends are even more significant for youth in foster care. Rates of psychotropic medication use in analyses of Medicaid administrative claims data range from 37 to 52% among youth in foster care (Ferguson, Glesener, & Raschick, 2006; Kansas Health Policy Authority, 2008; Office of Texas Comptroller, 2006) compared to a rate of approximately 4% in the general population, an estimate derived from the Medical Expenditure Panel Survey (Olson, Marcus, Weissman, & Jensen, 2002).² The high rates of psychotropic medication use may reflect:

- the increased use of psychotropic medications and decreased use of evidence-based psychotherapies in outpatient settings in general (Olson, Blanco, Liu, Moreno, & Laje, 2006);
- challenges in access to and quality of Medicaid services, the primary funder of health and mental health services for youth in foster care (Iglehart, 2003);
- the higher rate of emotional and behavioral problems and trauma of youth in foster care as compared to the general population (Costello et al., 1988; Landsverk, Garland, & Leslie, 2002);
- variation in the state- and county-level approaches to psychotropic medication oversight employed by child welfare agencies and youth-serving partners (Naylor et al., 2007; Leslie et al., 2010; Mackie et al., 2011); and
- the lack of clarity regarding who serves as parent in providing consent and oversight of medical and mental health care for youth in foster care, which can be exacerbated by placement changes (Battistelli, 1996).

The majority of published research (e.g., Zito et al., 2008), government publications (Government Accountability Office, 2011; Office of Texas Comptroller, 2006), and class action lawsuits (Cohen, Lapsley, Meltzer, Shookhoff, & Vincent, 2007) suggest that psychotropic medications are overused to manage emotional and behavioral health problems of youth in foster care. Of particular concern has been the increased use of antipsychotics, use of medications in preschool age children, and polypharmacy. In a study examining Medicaid claims data for 45 states, Rubin and colleagues (2012) found that, among the 48 states, 11.8% of children in foster care were prescribed an antipsychotic in 2007 (range at state-level from 2.8% to 21.7% of children in foster care) while 5.3% of children in foster care were prescribed three or more psychotropic medications over a 30 day period (range at state-level from .5% to 13.6% of children in foster care; Rubin et al., 2012). Between 2002 and 2007, rates of antipsychotic medication use among youth in foster care significantly increased in all 45 states included in the sample. During



the Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351) charged child welfare agencies to partner with clinical practitioners and Medicaid to provide ongoing oversight of health

The majority of published research, government publications, and class action lawsuits suggest that psychotropic medications are overused to manage emotional and behavioral health problems of youth in foster care.

this same study period (2002-2007), rates of psychotropic polypharmacy significantly increased among youth in foster care within 18 of the 45 states (Rubin et al., 2012).

Policy response

Longstanding concerns pertaining to appropriate physical and mental health care for youth in foster care, including medication use, have sparked a policy shift in child welfare practice. Rather than concentrating solely on safety and permanency, the Adoption and Safe Families Act of 1997 mandated for the first time the inclusion of child well-being (i.e., mental, physical, developmental, and dental health; Wulczyn, Barth, Yuan, Harden, & Landsverk, 2005) as part of the mission of child welfare. In 2008,

and behavioral health services, including psychotropic medications, for youth in foster care (Geen, 2009).

Recent Federal legislation, the Child and Family Services Improvement and Innovation Act, pushed P.L. 110-351 one step further by requiring states to develop specific protocols related to psychotropic medication oversight for youth in foster care. States were also required to outline how they intend to respond to the emotional trauma experienced by these youth. Congruent with this call, a partnership between the Administration for Children and Families (ACF), the Centers for Medicare and Medicaid Services (CMS), and the Substance Abuse and Mental Health Services Administration (SAMHSA) has focused efforts on delineating the role and

¹ For a brief description of psychotropic medications and other mental health terms in this article, refer to Table 1, Terms and Working Definitions.

² The selected pharmacoepidemiologic studies use varied data sources, specifically Medicaid Prescription Claims Data (Office of Texas Comptroller, 2006; Kansas Health Policy Authority, 2008; Ferguson et al., 2006); and the Medical Expenditure Panel Survey (Olson et al., 2002). The different data sources vary with respect to likelihood of under- or over-estimating rates of psychotropic medication use. For additional information, see “Storm, B. (2005) Pharmacoepidemiology. New Jersey: John Wiley & Sons.”

responsibilities of state and county child welfare agencies and partnering with other youth-serving systems to provide mental health care oversight, including psychotropic medication use and trauma-informed care.

Simultaneously, the Government Accountability Office (GAO) has examined mental health oversight for youth in foster care. In its December 2011 report, entitled “HHS³ Guidance Could Help States Improve Oversight of Psychotropic Prescriptions,” the GAO presented agency-derived research evidence from five states (i.e., Florida, Massachusetts, Michigan, Oregon, and Texas) demonstrating higher rates of psychotropic medication use in youth in foster care compared to the general population. It also called attention to a number of concerning prescribing practices, such as prescribing five or more psychotropic medications for a single child and the prescription of psychotropic medications for infants and toddlers. Monitoring programs in the five states were evaluated and fell short of meeting the best principle guidelines published by the American Academy of Child and Adolescent Psychiatry ([AACAP]; AACAP, 2011); consequently, the GAO recommended that U.S. Department of Health and Human Services (HHS) endorse guidance regarding psychotropic medication oversight for state child welfare agencies and their partners (GAO, 2011).

As a result of this research and legislative activity, a major focus in 2012 for the Administration of Children and Families (ACF) was the development and implementation of state oversight plans in response to P.L. 112-34 (2011). A series of ongoing Federal initiatives offers research evidence and technical assistance, including conference presentations, webinars, technical reports, and a Web-based information clearinghouse (Child Welfare Information Gateway; U.S. Department of Health and Human Services, n.d.). These initiatives have, to date, aimed to assist state child welfare agencies and partnering child-serving systems in both understanding the scope of the problem and developing mandated plans for psychotropic medication oversight in the State Child and Family Service Plans (submitted June 2012). In addition, the Casey Family Foundation and the Annie E. Casey Foundation, two intermediary organizations with a commitment to youth in foster care, have supported four meetings of relevant federal stakeholders and experts to share research evidence and promote cross-agency collaboration in addressing this legislation.

Continued on page 34

Table 1: Mental Health Terms and Working Definitions

Terms	Definitions
Antipsychotics	A class of medication that can assist in controlling psychotic symptoms (delusions, hallucinations) or disorganized thinking. These medications may also help muscle twitches or verbal outbursts as seen in Tourette's Syndrome. They are occasionally used to treat severe anxiety and may help in reducing very aggressive behavior (American Academy of Child and Adolescent Psychiatry [AACAP], 2012).
Medicaid	State-administered health insurance programs for which youth in foster care receive categorical eligibility (Schneider, Elias, Garfield, Rousseau, & Wachino, 2002).
Mental Health Problems	An emotional and/or behavioral condition generally associated with distress or a disability and not considered a part of normal development.
Mental Health Services	Services such as evaluation, psychosocial, and psychopharmacology targeting improvement of mental health outcomes.
Psychotropic Medications	Broad category of medications that can alter the effect of perception, emotion, and/or behavior. In this chapter, psychotropic medications are used interchangeably with psychopharmacology.
Polypharmacy	The simultaneous use of two or more medications to manage mental health problems.

Table 2: Examples of Resources to Inform Systems Improvements

Sponsor / Authors	Resource
AACAP	Position Statement on Oversight of Psychotropic Medication Use for Children in State Custody: A Best Principles Guideline (AACAP, 2011)
AACAP	Policy Statement on Psychiatric Care of Children in the Foster Care System (AACAP, 2001)
AAP/ Szilagyi	Fostering Health: Health Care for Children and Adolescents in Foster Care (Szilagyi, 2005)
Jensen, Hunter Romanelli, Pecora, Ortiz	Mental Health Practice Guidelines for Child Welfare (Jensen, Hunter Romanelli, Pecora, & Ortiz, 2009)

Note. AACAP = American Academy of Child and Adolescent Psychiatry; AAP = American Academy of Pediatrics.

Table 3: Example of Psychotropic Medication Guidelines, Handbooks, and Resources

Sponsor / Author	Publication
AACAP	Psychiatric Medications for Children and Adolescents: Part I—How Medications are Used (AACAP, 2012b)
Children's Bureau	Making Healthy Choices: A Guide on Psychotropic Medications for Youth in Foster Care (Children's Bureau et al, 2011)
California Evidence-Based Clearinghouse	California Evidence-Based Clearinghouse website (The California Evidence-Based Clearinghouse for Child Welfare, n.d.)
NAMI	NAMI Policy Research Institute Task Force Report: Children and Psychotropic Medications (Gruttadaro & Miller, 2004)
NIMH	Mental Health Medications (NIMH, 2012)
NIMH	Treatment of Children with Mental Illness (NIMH, 2009)

Note. AACAP = American Academy of Child and Adolescent Psychiatry; NAMI = National Alliance on Mental Illness; NIMH = National Institute of Mental Health.

³ Department of Health and Human Services (HHS)

Managing Psychotropic Medications among Children and Youth in Foster Care through Systems Collaboration

A summary based on information from the national meeting Because Minds Matter: Collaborating to Strengthen Management of Psychotropic Medications for Children and Youth in Foster Care by Heidi Skallet, MSW

The rate of psychotropic medication use among children and youth, particularly those in foster care, has been a topic of concern among policymakers and child advocates over the last few years. In the Overview section of this issue, Mackie, Bellonci, & Leslie (2012) highlighted prevalence and policy issues related to this topic. This article's intent is to expand upon Mackie et al.'s discussion of the efforts put forth by federal agencies, namely the Administration for Children and Families (ACF), the Centers for Medicare and Medicaid Services (CMS), and the Substance Abuse and Mental Health Services Administration (SAMHSA), to develop system-level practice strategies for monitoring and implementing psychotropic medication management for children and youth in foster care.

Current state-level monitoring & oversight strategies¹

States are now required to have protocols in place for oversight and monitoring of psychotropic medication use among children and youth in foster care (Mackie et al., 2013). See Table 1 for the five components required in states' protocols.

A review of state plans showed that few states actually included all five components and that states infrequently "addressed both client- and agency-level protocols." Many states use the Drug Utilization Review (DUR) Program through CMS to facilitate monitoring, which initially screens prescription drug claims for issues like incorrect dosage and clinical misuse, and then regularly reviews claims data in order to find patterns of issues such as medically unnecessary care (CMS, 2012). In many states, oversight systems contain certain triggers to automatically flag a case for review; such triggers include antipsychotic prescriptions for children under six years of age.

Most states also did not have in place clear strategies to increase the availability of non-pharmaceutical interventions though they did tend to recognize this issue as potentially contributing to the high rates of psychotropic drug prescriptions among children in foster care (Allen, 2012).

The increased focus on trauma-informed child welfare practice (see the Winter 2013 CW360°² on this topic), as well as recent federal legislation mandating that states

Table 1: Required components for state protocols for oversight and monitoring of psychotropic medication use

1. Comprehensive and coordinated screening, assessment, and treatment planning mechanisms to identify children's mental health and trauma-treatment needs (including a psychiatric evaluation, as necessary, to identify needs for psychotropic medication);
2. Informed and shared decision-making (consent and assent) and methods for ongoing communication between the prescriber, the child, his/her caregivers, other healthcare providers, the child welfare worker, and other key stakeholders;
3. Effective medication monitoring at both the client and agency levels;
4. Availability of mental health expertise and consultation regarding both consent and monitoring issues by a board-certified or board-eligible Child and Adolescent Psychiatrist (at both the agency and individual case level); and
5. Mechanisms for sharing accurate and up-to-date information related to psychotropics to clinicians, child welfare staff, and consumers. This should include both data-sharing mechanisms (e.g. integrated information systems) and methods for sharing educational materials.

Children's Bureau, 2012

screen children for emotional trauma related to maltreatment and removal (Child and Family Services Improvement and Innovation Act, 2011), prompted many states to utilize trauma-informed assessments throughout the initial placement stages. Such assessments were often conducted as part of Early and Periodic Screening Diagnosis and Treatment (EPSDT). Several states also incorporated trauma consultation in complex cases; for example, a trauma specialist may be called in when multiple medication changes do not improve symptoms, or trauma-informed technical assistance hotlines may be available for providers.

Some states utilized other innovative practices, such as screening via telemedicine using validated screening tools, mental health consultation lines to address provider shortages in rural areas, guides and tools for youth in order to ensure informed consent/assent, and "medical passports" for youth that incorporate behavioral health.

Recommendations

During an August 2012 meeting organized by ACF, CMS, & SAMHSA, state child welfare, mental health, and Medicaid leaders worked together to formulate collaborative strategies for oversight and monitoring (Samuels,

2012). Some of their recommendations included the following:

- Child welfare agencies should create a consent policy, to include a youth assent policy, and partner with other agencies, particularly Medicaid and behavioral health agencies, to provide better access to services and data (Allen, 2012).
- Youth and family engagement is essential in order to effectively monitor psychotropic medication use (Allen, 2012; Pfennig & Stepleton, 2012).
- States should work on developing clear strategies to increase the number of non-pharmaceutical interventions, including evidence-based (psychosocial) interventions, in order to decrease psychotropic medication as a "first-line treatment strategy;" such strategies should take into consideration the possibility of financing through Medicaid and behavioral health and the provision of trauma-informed assessments and consultation (Allen, 2012; Pfennig & Stepleton, 2012; Hyde, 2012).
- Data on psychotropic medication prescriptions must be reviewed regularly (Allen, 2012).

Continued on page 34

¹All information in this section is derived from Pfennig and Stepleton (2012) unless otherwise noted.

²<http://z.umn.edu/cw360>

Developmental-Behavioral Screening Assessment in a Social Service Context

Marisa Macy, PhD

Early detection efforts should be included as a standard practice in the social service system so children at risk for developing a delay/disability are identified at the earliest point in time (King et al., 2010; Romanelli et al. 2009; Urquiza, Wirtz, Peterson & Singer, 1994). Young children whose families interact with social services are likely to have or to be at risk for developmental problems (Horwitz, Simms, & Farrington, 1994; Jee et al. 2006; Leslie, Gordon, Ganger, & Gist, 2002; Villagrana, 2010). Harmful environmental factors such as exposure to violence and abuse and neglect place infants, toddlers, and preschoolers at increased risk (Stahmer et al., 2005). For example, a young child who experiences domestic violence may develop difficulties with communication and/or social emotional competency. Long-term negative effects in children's development are possible if left undiagnosed and untreated.

Early intervention can serve as a preventative public health priority for improving child and family outcomes (Cohen, Cole, & Szrom, 2011; Zimmerman & Mercy, 2010). The Child Welfare Information Gateway (2011b) report shows the most common sources of referrals for children are professionals working in education (16.5%), legal and law enforcement (16.4%), and social services (11.4%). For that reason, conducting developmental-behavioral screening assessments in a social service context would promote the early identification of children with delays/disabilities.

Developmental-behavioral screening is a formal assessment of young children that is brief and often takes about 10-15 minutes to complete. It can be administered by a professional, or a parent can complete the

screening assessment in the form of a survey or questionnaire. The assessment gives a snapshot of a child's performance and can be used to compare her/him to others of the same age. Results of the screening assessment are the basis for making appropriate referrals when needed.

A screening tool can be selected that fits the purpose and need of the children and families as well as agency and overall system. There are a variety of research-based screening tools on the market to choose from (Macy, 2012). Global developmental screening tools can help identify concerns with a child's growth and development in areas like fine and gross motor, adaptive skills, communication, and cognition. In addition to global developmental screening, children in social service settings would benefit from screening tools focused on social and emotional competencies (Horwitz, Owens, & Simms, 2000). At least half of the children who interface with child welfare services demonstrate serious developmental and/or behavioral issues, and less than 25% of children receive any intervention over the course of one year (American Academy of Pediatrics, 2000; Stahmer et al., 2005). Table 1 shows age range, developmental coverage, and administration time for selected developmental screening tools.

Bricker, Macy, Squires, and Marks (2013) suggest the following factors to consider when choosing a tool: flexibility of use, compatibility with existing services and personnel, developmental coverage, cost, scoring options, parental involvement, and rigor of the assessment/psychometric properties. Special attention will need to be paid to understanding the training needs of staff

(Cole, Pearl, & Welsch, 1989; Lotze, Bellin, & Oswald, 2010; Russo-Gleicher, 2008). Some screening tools may require initial training and ongoing technical assistance, whereas others may not. Some tools offer video or online professional development. Publishers of screening tools may be able to provide on-location training and support.

Last, child welfare workers need to coordinate developmental-behavioral screening services with other related activities in the system. Service coordination is needed where social, health, and educational services collaborate to implement an effective early detection system (Bai, Wells, & Hillemeier, 2009; McCrae, 2009; Mercy & Saul, 2009). To coordinate screening, avoid a fragmented approach to service delivery where there is no overlap or redundancy in services. Cross-sector collaboration will involve communication across agencies and disciplines to share screening resources, responsibilities, and outcomes. Program evaluation activities will assist in the development and implementation of a continuous improvement plan.

Children who experience abuse/neglect, poverty, homelessness, and multiple foster placements are at increased risk for developing health and learning problems. Early detection systems implemented in a social service context will serve children by addressing the needs of the family and implementing social emotional and universal developmental screening practices. Children will have a brighter future when an effective early detection system is in place in social service settings.

Marisa Macy, PhD is Assistant Professor at Lycoming College. She can be reached at macy@lycoming.edu.

Table 1: Select Developmental Screening Tools for Infants, Toddlers, and Preschoolers

Title of Screening Tool	Authors & Year of Publication	Age Range	Administration Time	Developmental Coverage
Ages & Stages Questionnaires, 3rd ed.	Squires, Bricker, Twombly, & Potter, 2009	2 months to 5 years	10-20 minutes	Communication, gross motor, fine motor, problem solving, and personal social
Ages & Stages Questionnaires, Social Emotional	Squires, Bricker, & Twombly, 2002	6-60 months	10-20 minutes	Social emotional
Battelle Developmental Inventory Screening Test	Newborg, 2005	12-96 months	10-30 minutes	Adaptive, personal-social, communication, motor, and cognitive
Brigance II Screens	Brigance & Glascoe, 2002, 2005a, 2005b	Birth to Preschool	10-20 minutes	Language, motor, self-help, academic/school readiness, and social-emotional
Denver II	Frankenburg et al., 1996	Birth to 6 years	10-20 minutes	Adaptive, motor, language, and personal-social
Parents; Evaluation of Developmental Status (PEDS)	Glascoe, 1997	Birth to 9 years	2 minutes	Cognitive, language, motor, behavior, social-emotional, self-help, and pre-academic skills

Early Intervention for Young Children with Disabilities in the Child Welfare System

By Cindy Toppin, MA

According to Zero to Three's 2011 publication *A Call to Action on Behalf of Maltreated Infants and Toddlers*, "data from the National Survey of Child and Adolescent Well-Being indicate that 35% of children from birth to 3 years old involved in child welfare investigations were in need of early intervention services" (Cohen, Cole, & Szrom, 2011, p. 3), but only 12.7% had Individualized Family Service Plans.

In Minnesota, thirty percent of all accepted child maltreatment reports involve children ages birth to three (Minnesota Department of Human Services, 2012). We don't know how many have disabilities and receive Early Childhood Special Education services because we do not track that data.

Under the Keeping Children And Families Safe Act of 2003 (P. L. 108-36), states were required to develop procedures to assure that all children from birth to 3 years old who were involved in a substantiated incident of abuse or neglect be referred to Early Intervention services under Part C of the Individuals with Disabilities Education Act (IDEA). During a twelve-month period ending in June 2011, Ramsey County (MN) child protection workers made 134 referrals to the county's Early Childhood Information and Referral; only 1 child received Early Childhood Special Education services (Help Me Grow, Ramsey County, personal communication, June 2012).

Why did so few of these children receive Part C services? One explanation is that referrals are mandatory, but parents do not have to agree to screening or evaluation services. Many parents declined service, others had moved and could no longer be found, and some agreed to a Follow Along¹ survey sent in the mail (but only 15 percent sent it in).

Early Head Start & Head Start are great options for children in the child protection system because children in these programs are screened for disabilities and access is provided to therapies and mental health services. While foster children are categorically eligible for Head Start and may be prioritized in terms of getting into the program, only 1.5% of enrolled children in the Head Start program in Ramsey County, MN in 2011 were children in foster care (24/1,534) (Community Action Partnership of Ramsey and Washington Counties, personal communication, June 2012).

A program that does address the developmental needs of children in the child welfare system is Lifetrack Resource's Families Together Therapeutic Preschool, a research-based program that strives to build

of behavior" (Shonkoff & Phillips, 2000). When children are in "flight or fight" mode, they cannot listen to a story or do well in school. Through our preschool and therapy services, children learn to manage their stress

Through our preschool and therapy services, children learn to manage their stress and learn to explore and play. Parents learn about basic child development, how to meet their children's needs, and how to promote a positive parent/child relationship.

social, emotional and life skill competence through a relationship-based and child-focused early intervention program. To participate, children must be 2-9 months or older and ineligible for kindergarten or special education. Children must be experiencing difficulty in at least one developmental area. Families must be low-income, live in certain neighborhoods, and have at least one risk factor (homelessness, child abuse or neglect, domestic violence, parenting ability challenged by mental, physical or chemical health of the caregiver, prenatal exposure to alcohol or drugs). The average number of risk factors was eight per family for those enrolled for the 2011-12 school year.

Most referrals come from child protection or public health nurses; however, participation is voluntary. Program services include door-to-door transportation, a 4-star Parent Aware² rated preschool, therapy services, home visiting and connection to community resources.

While children do not come to Lifetrack eligible for special education, they come with delays in development that include limited vocabulary; delayed speech and language; issues with self-regulation, motor skills, and visual perception; and trauma related mental health issues that lead to toxic stress. On average 45% of the children receive speech-language therapy, 50% receive occupational therapy, and 75% receive mental health services.

We know these developmental therapy services make a difference. Eighty to ninety percent of our children enter kindergarten proficient in Work Sampling skills or in progress (Work Sampling is an assessment tool used by the public schools to measure progress). A core result is that children have improved self-regulation so they enter school ready to learn. "The growth of self-regulation is a cornerstone of early childhood development that cuts across all domains

and learn to explore and play. Parents learn about basic child development, how to meet their children's needs, and how to promote a positive parent/child relationship.

Not every child has access to a therapeutic preschool. **What else could we do to address the needs of these young children?**

1. There is a need for **cross training** of early childhood professionals and child protection workers on how to "sell" early childhood intervention services to parents.
2. Courts could use the "**power of the courts**" to mandate that developmental screenings take place, that children are referred to ECSE, and that parents follow through. Innovative projects around the country include Safe Baby Courts (*Zero to Three*) or Arizona's *Best for Babies*.
3. Help parents take the next step, fill out the Head Start application or ensure that each child gets a developmental screening and provide families with the resources and support they need.
4. DHS and MDE need to implement plans to **track these children across programs**.
5. Child protection workers need to focus on child well-being not just safety and permanency.
6. Schools need to try a different approach to engaging these families.

These children deserve the services that can put them on the path to future success.

Cindy Toppin, MA is the Vice President of Programs at Lifetrack Resources and a long-time advocate for young children in the Child Welfare system. She can be reached at cindy@lifetrackresources.org.



<http://z.umn.edu/cpp>

¹The Follow Along Program is a program through the Minnesota Department of Health (MDH) that allows parents to monitor their child's developmental progress up to age 36 months through questionnaires sent out via mail.

²Parent Aware is Minnesota's Quality Rating and Improvement System, or QRIS.

Using Data Tracking Systems to Improve Child Welfare Services for Children with Disabilities

Patrick Shannon, PhD, MSW & Christine Tappan, MSW, CAGS

Children with developmental disabilities are present in the nation's child welfare systems in significant numbers (Romney, Litrownik, Newton, & Lau, 2006; Sullivan & Knutson, 2000). However, identification and tracking of children with disabilities continues to be less than adequate (Shannon & Agorastou, 2006). There are many reasons for poor documentation, including inadequate data systems, absence of routine developmental screening and assessment, and lack of training of child welfare staff related to understanding and working with children with developmental disabilities (Shannon & Tappan, 2011a; Shannon & Tappan, 2011b). Improving outcomes for children with disabilities can be accomplished by (a) improving the understanding and implementation of disability identification procedures and (b) using data systems to improve practices. This article will focus on the latter.

Using data systems to improve practices with children with disabilities

Data systems can play an essential role in improving child welfare outcomes for children with disabilities. At the practice level, data systems can assist caseworkers in determining what the response should be. Designing data systems that drive continuous quality improvement (CQI) at the practice level is critical and should be built upon the following:

- Clear definitions of developmental disabilities
- Requirements for standardized developmental screening and assessment data
- Integrated triggers that prompt an individualized service response.

Child-specific responses may include various therapies (i.e., occupational, physical, speech language, special education). Responses regarding supports for families could include respite, parent-to-parent support, functional behavioral support, child care, and help negotiating with school systems to support their children's education.

On the system-wide level, administrative data sets tend to focus on global categories, such as physical or intellectual disability or chronic health. There often are overlapping categories that relate to developmental disabilities, such as one category for mental health problems and another for disabilities. Relying on quantitative data alone does not provide a complete picture of the complex needs of children with disabilities. Over the

last decade, through the Child and Family Services Review (CFSR) process, child welfare has been moving towards CQI that includes collecting and analyzing both qualitative and quantitative data to drive ongoing practice improvement. The Children's Bureau (U.S. Department of Health and Human Services, 2012) specifically highlighted the importance of qualitative case reviews to "assess what is behind the safety, permanency, and well-being numbers in terms of day-to-day practice and how that practice is impacting child and family functional outcomes" (p.6). Case reviews on children with disabilities can inform practice by uncovering met and unmet developmental and family support needs, day-to-day practice, and how they impact outcomes. Flagging cases that involve a child with a disability and conducting a quality assessment (QA), which involves (1) an examination of completed assessments, (2) reassessment, and (3) service assessments, can help identify specific needs and gaps in the service process. They also impact system responses by assessing the service array to meet specific needs, relationships with community partners, and internal processes. Finally, developing comprehensive CQI systems can prove to be an important step in improving the effectiveness of the child welfare response to children with disabilities and their families.

Case example: New Hampshire Division for Children, Youth and Families

We have been unable to identify a state data system that currently follows the complete structure just described. However, the New Hampshire Division for Children, Youth and Families (DCYF) is thoughtfully moving in this direction. First, DCYF in collaboration with the Center for Professional Excellence (CPE) in Child Welfare at the University of New Hampshire's Department of Social Work has developed and implemented training for Child Protective Service Workers (CPSWs) that focuses on defining and identifying disabilities, engaging families, developing individualized service plans, supporting foster care families, and working with community partners to meet complex needs. Second, through the Watch Me Grow initiative, a plan was developed with community partners around the state to develop a comprehensive system for conducting developmental screening and assessments with every child under the age of five with a substantiated

case of abuse and/or neglect. Developmental screening for children older than five is unfortunately not universally conducted yet. However, as mentioned above CPSWs will be receiving training on how to conduct developmental screenings and assessments.

An especially encouraging development is the inclusion of categories in DCYF's children information system (BRIDGES database) for identifying children with disabilities that may trigger individualized service responses. When a comprehensive assessment of the family's and child's needs is conducted during the course of an assessment, at the conclusion of the protective assessment (e.g., investigation) the worker completes a mandatory field named Apparent Disabilities/Special Needs (which is a yes/no choice and with a list of disabilities to choose from). If a case is opened for services from the agency, this information is populated into the electronic case record, which prompts the assigned Family Services CPSW to develop a case plan that would include the services needed to address the child's and/or family's specialized needs. This data can be queried but is not currently included in reports. DCYF administrative and quality improvement staff are currently assessing whether to include this information in reports. Finally, cases involving children with developmental disabilities will be included as part of the CFSR case review process to examine in detail what is working for these children and their families and what can be improved.

Patrick Shannon, PhD, MSW is Associate Professor in the Department of Social Work at the University of New Hampshire. He can be reached at Patrick.Shannon@unh.edu.

Christine Tappan, MSW, CAGS is Project Manager at ICF International in Virginia. Christine can be reached at ctappan@icfi.com.

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Competencies for Child Welfare Caseworkers Serving Children with Disabilities

Judith S. Rycus, PhD, MSW

Children who have developmental disabilities, emotional disturbance, mental illness, or severe behavior problems are increasingly being served by child welfare agencies. While early identification and timely intervention can greatly improve the likelihood of positive developmental outcomes, accessing appropriate services can be a significant challenge for families and agencies.

system enables training developers to address high priority needs in a timely manner.

Sequentially organizing competencies by their levels of learning (Rycus & Hughes, 2001) also promotes development of the most suitable training strategies. Classroom training and self-directed learning can help workers acquire the necessary knowledge base. However, to develop and master new skills,

of universal child welfare skills: family engagement and empowerment, safety and risk assessment, comprehensive family assessment, case planning and service provision, placement prevention, family reunification, case management, and interviewing. With that caveat, there are key specialized competencies identified for child welfare caseworkers serving children with developmental, behavioral, and emotional disabilities and their families.

The first skill set, with twelve competencies, is the “ability to identify indicators of specific developmental disorders in children and adolescents” (IHS, 2011, p. 43). The first nine competencies encompass the caseworker’s ability to recognize the characteristics and indicators of specific developmental disorders, such as cerebral palsy, autism spectrum disorder, and learning disorders, and how they might impact children’s functioning. The last three competencies emphasize caseworkers’ understanding of early identification, referral, and intervention for children exhibiting such characteristics and indicators. See Table 1 for select competencies from this skill set.

The second skill set, with fourteen competencies, is the “ability to provide case management and supportive services to families of children with developmental disorders” (IHS, 2011, p. 43). The first four competencies highlight the importance of knowing not just the caseworker’s role as advocate and case manager but also the types of services, early intervention, and medications available for children with developmental disorders. The remaining ten competencies focus on safety and risks and

One essential strategy for improving child welfare services to children with disabling conditions is to provide specialized training to the caseworkers and supervisors who serve them, namely a comprehensive, competency-based training model.

Identifying and coordinating specialized medical care, developmental assessment, special education, respite care, psychological or psychiatric services, financial assistance, recreational programs, and supportive family counseling is a complex and often daunting undertaking (Children and Family Research Center, 2004). Many child welfare agencies depend on community providers and other service systems to meet the specialized needs of these children and their families. Unfortunately, in many communities, specialized services may be unavailable, underdeveloped, poorly coordinated, or inconsistently applied (Rycus & Hughes, 1998). This creates additional challenges for workers who have case management responsibility for these families.

learners must apply their knowledge in the real world. Appropriate training strategies include educational supervision, coaching, peer supervision, interactive distance learning, and shadowing professionals who have mastered the skills.

Competencies for child welfare caseworkers

In 1985, the Institute for Human Services (IHS) began development of competencies that delineate the array of knowledge and skills essential to provide effective child welfare services to children with special needs. The competencies were used to develop standardized training for child welfare caseworkers and supervisors in identifying and serving children with a variety of disabilities. These competencies were last revised in 2003.

Effective work with these children and their families first requires mastery

The importance of competency-based training

One essential strategy for improving child welfare services to children with disabling conditions is to provide specialized training to the caseworkers and supervisors who serve them, namely a comprehensive, competency-based training model.

Competencies are statements that incorporate the knowledge and skills necessary for the performance of job tasks consistent with standards of “best practice” (Rycus & Hughes, 2000). They support the assessment and priority ranking of each worker’s individual training needs, with the highest priority needs occurring when considerable development is needed in competencies that are highly relevant to a worker’s job. Supervisors use needs assessment data to devise individualized training and development plans with their staff; compiled data for an entire unit, agency, or service



prevention of child maltreatment. See Table 2 for select competencies from this skill set.

Additionally, there are specialized competencies within two skill sets for child welfare caseworkers serving children with mental health needs. The first skill set of eleven specialized competencies addresses the identification and assessment of mental health problems in children and adolescents. Two competencies state the need for caseworkers to have a broad understanding of the mental health and behavioral disorders most often seen in children and the impact of such disorders on the development and functioning of children. Seven competencies are devoted to knowledge on specific mental health and behavioral disorders. The final two competencies relate to referrals and preparation of children for developmental assessments. See Table 3 for select competencies from this skill set.

The second skill set of ten competencies focuses on the provision and monitoring of treatment for children with mental illness and emotional/behavioral disorders. The first competency stresses the importance of being able to understand how mental illness and behavioral problems can increase children's risk of maltreatment. Four competencies focus on supportive services for families and caregivers and strategies to reduce stress levels resulting from caring for children with mental illness or behavioral problems. Five of the competencies are specific to treatment and services for children with mental illness and behavioral problems. See Table 4 for select competencies from this skill set.

These competencies form the foundation of standardized training for child welfare workers. As a permanent part of IHS' Universe of Child Welfare Competencies they help ensure that child welfare workers have the knowledge and skills necessary to providing effective child welfare services to children with special needs and their families.

To view all competencies, please visit the IHS Ohio Child Welfare Training Program's website at <http://www.ocwtp.net>.

Judith S. Rycus, PhD, MSW is Program Director with the Institute for Human Services, North American Resource Center for Child Welfare, Columbus, Ohio. She may be reached at jrycus@ihs-TRAINet.com.

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Table 1. Select competencies from 326-01: Ability to identify indicators of specific developmental disorders in children and adolescents

326-01-002	Knows the characteristics and indicators of autism spectrum disorder, pervasive developmental disorder and Asperger's syndrome, in children and youth
326-01-008	Knows the early indicators of developmental disorders or delays in infants and very young children
326-01-009	Understands how developmental disorders affect children's physical, cognitive, social, and emotional development and functioning
326-01-011	Knows how to use observation, interviewing, and developmental assessments to identify children who are developmentally delayed and to refer them for comprehensive assessment

Table 2. Select competencies from 326-02: Ability to provide case management and supportive services to families of children with developmental disorders

326-02-003	Knows the types of services necessary to enable families to care for children with developmental disorders in their own homes
326-02-006	Understands the cause and effect relationship between children's developmental disorders and child maltreatment and the increased vulnerability of children with disabilities to maltreatment
326-02-010	Understands the importance of respite care, support networks, and other supportive family services in sustaining families' ability to care for their children at home
326-02-014	Can monitor family situations to ensure the ongoing safety of children with developmental disorders at home or in out-of-home care

Table 3. Select competencies from 304-01: Ability to identify and assess mental health problems in children and adolescents

304-01-002	Knows the characteristics, behavioral indicators, and preferred treatments for mood disorders such as depression, bipolar disorder, and anxiety in children and adolescents
304-01-007	Knows the characteristics, behavioral indicators, and preferred treatments for trauma and post-traumatic stress disorder (PTSD) in children and adolescents, and how children's responses to trauma may be misdiagnosed as indicators of mental illness or behavioral disorders
304-01-009	Understands how mental health and behavioral disorders can affect the social, emotional, and cognitive development and functioning of children and adolescents
304-01-011	Can prepare children and adolescents for psychological, psychiatric, and developmental assessments and, where appropriate, help them understand the findings

Table 4. Select competencies from 304-02: Ability to provide and monitor treatment for children and youth with mental illness, emotional, or behavioral disorders

304-02-001	Knows how mental illness or behavior problems in children and adolescents can increase their risk of maltreatment
304-02-003	Knows the types of medications used to treat mental health problems in children and adolescents, their effectiveness, their side effects, and the risks of misuse or discontinuation
304-02-006	Knows strategies to help parents and caregivers cope with the stresses of caring for children or adolescents with mental health and behavioral disorders
304-02-008	Can mobilize and help access supportive community-based services, specialized out-of-home placements, financial resources, and respite care for families whose children or adolescents have mental illness or behavior problems

Interviewing Children with Intellectual and Developmental Disabilities as Witnesses

Lucy Henry, BSc (Hons), DPhil, DClinPsych & Rachel Wilcock, BSc (Hons), PhD

It is an unfortunate fact that children with intellectual and developmental disabilities are more likely to be maltreated and abused than children with typical development. This presents a challenge for criminal justice professionals (police, barristers/lawyers, judges) to ensure that access to the criminal justice system is fair and equitable for these

purpose of the interview to put the child at ease followed by clearly and unambiguously expressed questions to reveal the child's understanding of truth and lies. Following this, the interview turns to the event in question and the most important general advice is to begin with a very open ended request for information to elicit the child's

a guide; however, such information is not always available or up-to-date, and individual assessments are strongly recommended. For example, a particular child may have superficially good language skills yet not understand key concepts relating to time and frequency, which are critical in forensic contexts. In some jurisdictions (England and Wales) there is a provision for an 'intermediary,' often a highly qualified speech and language pathologist, to carry out an assessment of the child's language, development, and communication skills, and to assist with communication between the child and any relevant criminal justice professionals during police interviews and questioning in court.

Other practical guidance useful for children with intellectual and developmental disabilities includes:

- conduct the interview as soon as possible after the event
- explain to the child that the interviewer does not know what happened to them
- structure interview questions so that they are simple, short, and contain only the simplest possible vocabulary
- pace the interview carefully and allow plenty of time for breaks
- ensure that the interviewer demonstrates supportive verbal and non-verbal behaviour throughout the interview
- allow the child plenty of time to respond
- avoid the urge to interrupt the child
- ensure that the interviewer does not use abstract ideas
- conduct interviews in environments that do not contain distractions and feel "safe" for the child

With careful attention to best practice guidelines for interviewing children, and suitable additional adjustments for the particular profile of strengths and needs relevant to individual children with developmental and/or intellectual disabilities, forensically useful information can be elicited.

Lucy Henry, BSc (Hons), DPhil, DClinPsych is a Professor of Psychology at London South Bank University. She can be reached at henrylc@lsbu.ac.uk.

Rachel Wilcock, BSc (Hons), PhD is a Reader in Psychology at London South Bank University. She can be reached at wilcockr@lsbu.ac.uk.

Criminal justice professionals need to take into account relevant guidance for interviewing children but also adapt their interviewing styles and techniques as necessary to suit the particular needs of children who have intellectual and developmental disabilities.

vulnerable individuals. In order to achieve sensitive and effective interviews, criminal justice professionals need to take into account relevant guidance for interviewing children but also adapt their interviewing styles and techniques as necessary to suit the particular needs of children who have intellectual and developmental disabilities.

Our understanding of witness skills in children with intellectual and developmental disabilities has been growing in recent years. For example, Henry, Bettenay, and Carney (2011) suggest that children with mild to moderate intellectual disabilities (IQ levels between 40 and 70) can recall forensically useful information about a witnessed event, and that a reasonable guide of their ability to recall details and to resist suggestive questioning is mental age (the approximate current level of cognitive development the child has reached, based on comparisons with large samples of typically developing children). The research in relation to children with specific developmental disorders is limited, but indicates that higher functioning individuals with autism spectrum disorders can recall forensically useful information but may have difficulties in recalling the overall "gist" of an event and/or its personal dimensions; and that higher functioning teenagers with Down syndrome recall relevant details at a level commensurate with their mental age (Henry et al., 2011).

Interviews

Best practice guidelines for interviewing children are a good place to start when interviewing children who have intellectual and developmental disabilities. These generally advise building a good level of rapport with the child and explaining the

account in his/her own words; for example, "tell me what happened." Many research studies have demonstrated that this free recall account is likely to contain the most reliable and accurate information (Lamb, Orbach, Hershkowitz, Horowitz, & Abbott, 2007). Nevertheless, many free recall accounts of children, particularly those with developmental and intellectual disabilities, are short of detail, so prompts to "tell me more" are useful followed up with a small number of very general questions that request extra information without focusing on details.

After this point, the interview can move to more specific questions about details. Any form of leading question whereby the answer is implied in the question itself is strongly discouraged as children show heightened propensity to agree with an interviewer's suggestions. Similarly, repeating questions can be problematic, particularly for children with intellectual disabilities, who may assume their original answer was incorrect and change it. Many jurisdictions have specific guidelines or recommendations with respect to interview formats for children and vulnerable witnesses; see Achieving Best Evidence in Criminal Proceedings (Ministry of Justice, 2011) for vulnerable witnesses and victims in England and Wales and the National Institute of Child Health and Human Development (NICHD) Investigative Interview Protocol (Lamb, Hershkowitz, Orbach, & Esplin, 2008).

Forward planning prior to interviews with children is essential and even more so for children with intellectual and developmental disabilities. This needs to be done at an individual level based on the profile of a particular child's strengths and weaknesses. Information about developmental or intellectual disabilities is extremely useful as

Breaking Through Barriers in Delivering Mental Health Services to Children in Child Protection

Timothy Zuel, PhD, LICSW

In recent years there has been an increasing awareness of the mental health needs of the child welfare population. According to the National Survey of Child and Adolescent Well-being (U.S. Department of Health and Human Services [US DHHS], 2005), of the population of two- to five-year-olds investigated for maltreatment, one-third had indicated behavior problems, but only seven percent received any mental health intervention within the preceding twelve months (Burns et al., 2004). Further, when viewed by cohort, two groups stand out as having little access to mental health services: children who remain in the home following a maltreatment investigation (compared to those who are in out-of-home placement) and children who are subjects of neglect investigations (Burns et al., 2004; Garland, Landsverk, Hough, & Ellis-MacLeod, 1996; McCrae, Cahalane, & Fusco, 2011; Rosenberg, Zhang, & Robinson, 2008).

Because of the accumulated research on the early intervention needs of the child welfare population, both the Individuals with Disabilities Education Act (IDEA; U.S.

assessment. Researchers have identified disparities in screening outcomes depending on who is doing the assessment. In the child welfare population the screening is usually done by child welfare social workers. In their 2011 study of mental health screening in the child welfare population in Pennsylvania, McCrae et al. found that of the children screened by early childhood staff, 32 percent showed social/emotional concerns compared with 16 percent of children screened by child welfare social workers. This further reflects the possibility of underreporting of the mental health needs of this population.

Case example: Mental health/child welfare navigators

Due to an increased focus on trauma and mental health issues in the child welfare population, Hennepin County, Minnesota began focusing on integrating their mental health services into the child welfare population in 2011. The first step was to increase the number of required mental health screenings conducted in the child protection



could not maintain stability in foster care or within their environment (family, school, community). The mental health navigator model has allowed for the tracking of the required mental health screening of children involved in child welfare. It has eased the access of mental health resources for kids. Finally, the model has helped integrate the mental health needs of child welfare-involved children into the practice process of child protection.

The model has helped integrate the mental health needs of child welfare-involved children into the practice process of child protection.

Department of Education [US ED], 2004) and the Child Abuse Prevention and Treatment Act (US DHHS, 2010) were amended to require child welfare agencies to assess and refer qualified children for early intervention services and provide funding under Part C of IDEA (US ED, 2004). Further, states were allowed to expand their mental health assessments of the child welfare cohort. Minnesota passed legislation in 2003 that mandated Children's Mental Health Screening for specific target populations within the juvenile justice and child welfare systems commencing in 2004 (Minnesota Department of Human Services [MN DHS], 2009, p. 2). However, the 2010 Children and Community Services Act Annual Performance Report for Minnesota (MN DHS, 2010) revealed that statewide in the year 2009 only 55 percent of those child welfare-involved children eligible for screening were actually screened.

Screening for both mental health and developmental delays in the child welfare population has been shown to be a cost-effective approach to early identification (Bergman, 2004). Identification is a necessary element in order to proceed with thorough

division. Along with this increased attention to the screening process, several mental health social workers were also employed as "navigators" for the child welfare staff. The social work navigators were available for consultation and assistance to child welfare staff as the children on their caseload came into the system through child protection. The social work navigators were able to guide those children in need of deeper end children's mental health services, in effect lowering the threshold for access to mental health.

The addition of these social work navigator positions also resulted in the easing of child protection workloads. Previously, child protection workers were responsible for providing children's mental health services for those children who were involved in the system but remained in their homes. With the new navigator position, child protection workers were able to refer the children on their caseloads who needed services to the children's mental health division.

The child welfare work force has historically been trained to concentrate on risk and safety. Children who received mental health intervention typically were those who

Recommendations

Research has clearly shown the high need of mental health screening, assessment, and services to the child welfare population. Given the increasing complexity and requirements placed on child welfare staff, it may be reasonable to create mental health workers who would take over the function of screening child protection-involved children as well as continue to assist children who need more focused mental health. This is essentially broadening the navigator model at Hennepin County.

Another possible model is to incorporate mental health screening into children's medical checkups. This could be done by expanding the Child & Teen Checkup Program (Minnesota's Early Periodic Screening, Diagnosis, and Treatment program) to include mental health and trauma screening.

Child welfare agencies do not operate in a vacuum. The courts, guardians ad litem, and numerous attorneys involved in the child welfare system should all be vanguards of appropriate screening and assessment of these children.

Timothy B. Zuel, PhD, LICSW is Supervisor at Hennepin County Public Health and Human Services. Tim can be reached at tzuel@umn.edu.

Children with Intellectual and Developmental Disabilities: Care in the Aftermath of Trauma

Nancy J. Razza, PhD & Dick Sobsey, EdD

Many children in the child welfare system, or in need of protection, have disabilities. Overall, research suggests that children with a wide variety of disabilities are three to four times as likely as other children to be abused or neglected (Jones et al., 2012). In some cases a child's disability may increase vulnerability and increase risk for maltreatment; in other cases, the child's disability may have been caused by the abuse. In still other cases, third factors such as parental substance abuse may increase the risk for both childhood disability and child maltreatment.

Trauma, intellectual disability, and mental health

A number of recent studies have found the presence of an intellectual disability, for so long ignored in mental health research, to be the strongest predictor of mental health problems; stronger, in fact, than many established adverse circumstances known to lead to poor mental health (Chen, Lawlor, Duggan, Hardy, & Eaton, 2006; Sternberg, Grigorenko, & Bundy, 2001). In fact, research suggests that the rate of psychopathology in people with intellectual disabilities is 3 to 4 times that found in the general population (Fletcher, Loschen, Stavrakaki, & First, 2007).



for example, Wallin, 2007). Children with secure parenting are most likely to develop into secure, emotionally stable adults who, in turn, tend to be capable of raising secure children of their own. In the absence of

which provides consistent reinforcement for increasingly adaptive behavior (Dosen, 2001; Sterenburg, Janssen, & Schuengel, 2008).

Psychotherapy outcome research with children dually diagnosed with an IDD and serious psychopathology now reflects a move toward incorporating attachment-based strategies along with heretofore standard behavioral treatments.

Moreover, the presence of an intellectual disability in addition to other adverse circumstances, such as exposure to physical and/or sexual abuse, caregiver instability and/or psychopathology, or parental loss, further increases the risk of psychopathology (Chen et al., 2006). Thus, children with intellectual/developmental disabilities (IDD) in the child welfare system are among the most vulnerable clients we serve.

At the same time, research also suggests that children in alternative placements (foster care, group homes, institutions, and so on) show much higher than average rates of behavioral and emotional disorders (Heflinger, Simpkins, & Combs-Orme, 2000; Tarren-Sweeney, 2008). That out-of-home placement would increase the risk of psychopathology is understandable in light of mounting research on the critical relationship between attachment and mental health (see,

secure parenting, a variety of problematic patterns can develop which lead to emotional instability and poor mental health outcomes.

Children on our caseload who have an IDD, along with a history of abuse and with attachment trauma related to out-of-home placement, run a very high risk of developing emotional and behavioral disorders/psychopathology. In fact, psychotherapy outcome research with children dually diagnosed with an IDD and serious psychopathology now reflects a move toward incorporating attachment-based strategies along with heretofore standard behavioral treatments. Promising new research efforts support the idea that such dually diagnosed children show greater improvement when attachment-sensitive treatment, i.e., treatment which promotes sensitive, consistent support from the primary attachment figure, is used in conjunction with a behavioral strategy

Recommendations

For those working in child welfare, we offer the following recommendations. Note that these recommendations constitute good treatment for all children not only for those children with IDD. We stress the importance of these recommendations, however, because of the heightened vulnerability of children with IDD.

First and foremost, strive to maximize the child's security. Remember that children with IDD have the same needs for secure attachment that non-disabled children have. In addition, children with IDD seem to be more vulnerable to adverse mental health outcomes related to attachment disruption and abuse.

Specifically, teach foster parents and anyone involved with the child never to threaten the child with displacement. Comments such as "If you keep that up, you'll be out of here!" and the like are anxiety-provoking and only increase the chance of symptomatic (and problematic) behavior. Teach foster families to respond to problem behavior by stating clearly what the preferred behavior is, then reinforcing that with verbal affirmation. For example, the foster parent might say, "What you need

to do in this house is to come and tell me as soon as someone teases you; do not hit them. Come and tell me." Have the child repeat this back to ensure that she understands. Then, whenever the child does the behavior, that is, she reports the teasing, the caregiver should immediately praise her: "Good for you! You told me just as I asked!"

Again, with the goal of fostering a sense of security, the earlier the entry into permanent placement, the better the outcome is for the child. Make every effort to move quickly when the need for placement into care is determined and to plan for the move to be permanent. Putting a child into a placement that is known to be temporary from the outset will contribute to the child's anxiety and symptomatic behavior.

It is important to avoid multiple moves. Moving children from one care home to another is re-traumatizing. Rather than move children due to disruptive behavior, seek the support of a qualified psychotherapist who is informed with respect to attachment needs and behavioral treatment. Provide therapeutic support to the child and the foster family.

Consider that the support of a qualified psychotherapist for such children should probably be the rule rather than the exception. Given the many known risk

factors in these cases (IDD, attachment trauma, out-of-home placement, and abuse), seeking an evaluation for treatment might catch problems at earlier and, perhaps, more treatable stages. In addition, the involvement of a mental health professional on the team increases the opportunity for all members of the child's team to be operating in ways that support the child's mental health and sense of security.

With respect to finding a psychotherapist or psychologist to provide treatment for the child and foster family, one resource is NADD, the National Association for the Dually Diagnosed. NADD is pioneering the development of standards for clinicians treating adults and children with IDD and co-morbid mental health disorders.

Educate and guide caregivers on the following key features associated with secure attachment:

- sensitive responsiveness to the child's behavior; remember that all behavior is a form of communication of the child's needs.
- acceptance rather than rejection; every opportunity to demonstrate to the child that he is accepted is a step toward healing.
- cooperation rather than control; foster parents need to think of their

communications to the child as efforts to encourage the child to cooperate with them. If they simply exert force and pressure the child to behave in certain ways, it is more likely that the child will become distressed and even oppositional. Forceful control tends to backfire.

- emotional availability rather than aloofness or absences. Being emotionally responsive to the child's feelings, rather than cut off, adds to the child's sense of security and helps in her recovery from traumatic disruptions in her life.

Nancy J. Razza, PhD is a NJ Licensed Psychologist and Adjunct Assistant Professor of Pediatrics at the Elizabeth M. Boggs Center on Developmental Disabilities at Robert Wood Johnson Medical School/University of Medicine and Dentistry, New Jersey. Dr. Razza can be reached at njrazza@yahoo.com.

Dick Sobsey, EdD is a Professor Emeritus of Educational Psychology at the University of Alberta. He can be reached at dsobsey@ualberta.ca.

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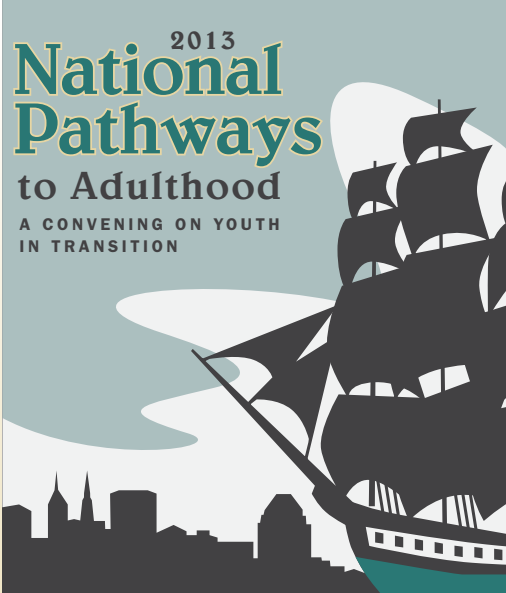
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Supporting Youth in Making Healthy Choices

Guadalupe Ortiz-Tovar

Considering the high rates of young people from foster care being prescribed psychotropic medications, recent laws being passed in support of better regulation, and the federal Summit on Psychotropic Medications held in 2012, the topic of psychotropic medication management became one in which youth voiced they wanted some guidance. The guide *Making Healthy Choices: A Guide on Psychotropic Medications for Youth in Foster Care*¹ is one tool to assist young people and their supportive adults in starting the conversation about possible mental health needs.

This new guide looks at ways youth can handle powerful feelings and behaviors and make healthy choices. Understanding how medications can help and what other options are available can be challenging.

With the help of their supportive adults, young people follow the steps within each section to determine what their needs may be. Whether these needs require help from a positive outlet, such as a doctor, counselor, or teacher, there are many examples of ways youth can seek support.

Some of the checklists included have to do with navigating certain behaviors and symptoms and understanding if such behaviors and symptoms are part of an experience that needs medical intervention. What we've heard from young people in and from foster care is that in some cases they don't have direct knowledge as to why they are on medications or why they are seeing a psychiatrist, therapist, or counselor. Our hope with *Making Healthy Choices* is that the guide can be used as a tool to promote discussion

What we've heard from young people in and from foster care is that in some cases they don't have direct knowledge as to why they are on medications or why they are seeing a psychiatrist, therapist, or counselor.

Written specifically for youth in foster care with input from youth and professionals, this guide can help youth decide what's best for them. *Making Healthy Choices* includes useful information, questions to ask, worksheets, and tips on:

- recognizing when you need help,
- knowing your rights and who can help,
- considering your options, including helpful approaches other than medication,
- making decisions about how best to stay healthy, and
- maintaining treatment (taking medication safely and continuing or stopping treatment after leaving foster care).

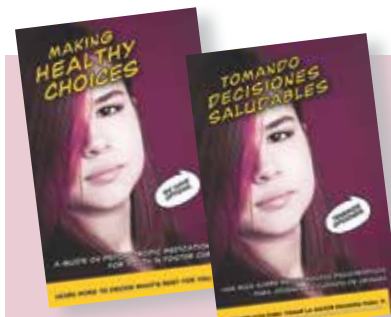
Making Healthy Choices is designed as an exploratory tool with checklists and worksheets that help youth organize their thoughts in regards to powerful feelings and behaviors in relation to mental health needs. Throughout the guide there are comic book style inserts of personal stories to further reiterate the varying experiences that youth in child welfare face and to show how differing placements and circumstances can help young people gain some awareness of situations in their own lives that impact their own feelings and behaviors.

between youth and the supportive adults in their lives about the youth's mental health needs.

Making Healthy Choices also encourages youth to determine who in their lives can assist them in advocating for their needs. Youth identify supportive adults in their lives, who then make up the youth's team of supportive adults (p. 9); there is specification on roles differentiating personal relationships from professional ones.

A unique note in this guide is the forward planning section found on page 20, which is for young people taking medications who are approaching their exit times from foster care, as there are insurance issues that need to be considered before they age out of the foster care system. An adult supporter is key in supporting youth through this transition as it takes pre-planning and documentation before they reach their emancipation age, which varies from state to state.

Using *Making Healthy Choices* is one strategy for involving youth in their mental health needs process. It is youth-friendly and encourages the development of a youth-driven plan. The guide also encourages assistance from supportive adults and covers a variety of domains necessary for young people to transition to adulthood.



How to get to the guide:

The guide is free online and in print. You can find the guide in English at <http://www.nrcyd.ou.edu/psych-med-youth-guide> and in Spanish at http://nrcyd.ou.edu/images/stories/publications/health/hhs_cb_psychomed_comic_esp_508b.3.pdf.

View fliers for youth here: <http://nrcyd.ou.edu/images/stories/stories/med-guide/youth-guide-psych-med-youth-flier.pdf> and for professionals here: <http://nrcyd.ou.edu/images/stories/stories/med-guide/youth-guide-psych-med-professionals-flier.pdf>.

A limited number of hard copies of the English version of *Making Healthy Choices* have been printed by the American Academy of Pediatrics for distribution through Child Welfare Information Gateway. Single copies can be ordered from Information Gateway, at no cost, at this link: <http://www.childwelfare.gov/catalog/index.cfm?event=catalog.viewIndex&letter=M> [scroll down to "Making Healthy Choices" and click on "Order"].

If your organization would like to order more copies (up to 50), please contact the Child Welfare Information Gateway at info@childwelfare.gov or 800.394.3366.

Guadalupe Ortiz-Tovar, BA is Program Development Specialist at National Resource Center for Youth Development/The University of Oklahoma OUTREACH, National Resource Center for Youth Services. Ms. Ortiz-Tovar can be reached at nrcyd@ou.edu

¹Making Healthy Choices, A Guide on Psychotropic Medications For Youth In Foster Care was a collaborative effort of young people and professionals from the Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services, American Academy of Child and Adolescent Psychiatry, American Academy of Pediatrics, Food and Drug Administration, Jim Casey Youth Opportunity Initiative, Maine Department of Health and Human Services, Maine Youth Leadership Advisory Team, National Resource Center for Youth Development, Substance Abuse and Mental Health Services Administration, Tufts Medical Center, and Youth MOVE Maine.

Shared Parenting: Untapped Potential

Nancy Rosenau, PhD

Over the past 10 years we have helped children with developmental disabilities move from residential facilities to family care. Most of these children had been placed voluntarily by parents seeking out-of-home placement from the disability service system when they felt they could no longer care for their children at home rather than through child protective services. When offered support to enable their children to return home, some families were still unable to resume care. An alternative that proved successful in achieving family life for their children was placement with a "Support Family." In this form of voluntary placement, the child's parents retain legal authority and delegate the child's care to the Support Family. A Support Family has a relationship not only with the child but with

Attributes of Support Family (shared parenting) arrangements currently in use

- An alternative to residential care for a child whose parents are unable to care for them at home due to their circumstances, capacity, or comfort in providing for their child's disability-related needs
- Support Families recruited with an expectation of a relationship with the child's parent(s)
- Careful matching and preparation of the Support Family
 - » Related to the child's disability needs and the relationship with the child's family
- Ongoing support after placement
 - » Related to the child's disability needs and the relationship between the two families

amenable to adaptation. A fitting adaptation begins with an understanding of the reasons the child is coming into care. Families of children with disabilities may become involved with the child welfare system due to the need for disability-related services and support. For example, they may have a lack of knowledge about a medical condition, lack of skills in managing challenging behavior, and/or lack of support resulting in high stress contributing to parental behavior. Additionally, they may be relinquishing care in order to obtain services.

Each of these situations is potentially amenable to change with better support. When removal is required, it is possible to envision a strong mentoring relationship with the right Support Family to teach and coach the parent and to model how to respond to the child's behavioral or health condition. Learning can be paced at the parent's ability to absorb the lessons until they can safely resume care.

Clearly, developing a shared parenting arrangement in child welfare cases will be challenging and will require carefully structured situations. It will also require changes in practice. Mentoring relationships require a different role for foster parents than substitute parenting does.

Nancy Rosenau, PhD is the Executive Director of EveryChild, Inc. She can be reached at nrosenau@everychildtexas.org.

The relationship between the two families is one of "shared parenting" where the families work together to jointly assure the well-being of the child who can remain an integral part of his or her family's life.

the child's family. The relationship between the two families is one of "shared parenting" where the families work together to jointly assure the well-being of the child who can remain an integral part of his or her family's life. In practice, Support Families have become like extended kin. In the words of one mother about her son's Support Family, "She's like my sister. She knows I'm his mother, but she provides him with that motherly love."

Support Families are recruited, paid, and certified to provide foster care through a provider organization that contracts with the state and assumes responsibility for the child's plan of care. Two important features of these arrangements are: (1) adequate disability-related services and supports through an individualized plan and (2) a collaborative relationship between the two families.

We believe this arrangement has potential for adaptation in some child welfare situations where a child has to be removed from his or her family until return home or another permanency goal can be safely achieved. Because our only involvement in CPS cases has come many years after parental rights were terminated, we have not had the chance to demonstrate an adapted version of shared parenting. But in looking back at the histories of these children, some of their families' situations may have been amenable to a variation of shared parenting that might have resulted in reunification if it had been available and offered early.

Potential of Support Family (shared parenting) arrangements adapted for child welfare situations

Of course, there are differences between child welfare situations and voluntary placements through disability services systems, but there are a number of aspects of the shared parenting arrangement that might be

Caseworker responsibilities	Child-placing agency responsibilities
<ul style="list-style-type: none"> • Clear reunification goal and potential • Assessment of family <ul style="list-style-type: none"> » Willingness and ability to cooperate » Openness to mentoring by a Support Family • Development of a shared parenting agreement with clear expectations • Monitoring of agreement with court oversight 	<ul style="list-style-type: none"> • Recruitment of families <ul style="list-style-type: none"> » Willing and able to provide care for a child with disabilities » Willing and able to have a mentoring relationship with the child's parent(s) • Training and preparation of the Support Family <ul style="list-style-type: none"> » Regarding the child's disability » Regarding mentoring the child's parent(s) • Monitoring and ongoing support <ul style="list-style-type: none"> » Related to the child's care and disability-related needs » Related to the relationship between the families

Challenges with Cross-Systems Service Coordination

Susan E. Frame, MSW, LICSW

Lori is a 13-year-old female who was diagnosed with cerebral palsy. Due to her physical limitations she requires total assistance with all of her activities of daily living. She has limited verbal communication. She receives special education services under the eligibility criteria for DCD (Developmental Cognitive Disability). Lori is eligible for voluntary case management services for children with Developmental Disabilities (DD) through the county she resides in and has an ongoing DD county social worker. One day at her school, her teacher noticed several bruises on her body. This bruising along with the information the teacher gathered from Lori necessitated a report to Child Protection intake. Child protection investigated the report and determined that it was not safe to return Lori to her home. She was placed on an emergency 72 hour hold. The shelter resource available to Lori was in a hospital setting due to limited shelter resources. Out of home placement was ordered at the hold hearing and the only available foster home resource was in a different county.

While this is a fictitious scenario I have had the opportunity to work with many children in similar situations. I currently hold a position as a senior social worker providing long term case management to children with developmental disabilities within a county setting. In the course of my 23 years of professional experience, I have also had the opportunity to work in child welfare as the social worker responsible for the placement and coordination of services for the child while in out of home placement. Having worked in both systems has provided me with a unique vantage point from which to view the challenges that arise in cross-system collaborations for children with developmental delays in the child protection system.

Emergency shelter

When a child with a developmental disability is removed from the home for safety, they, like any other child, need a safe place to stay in the least restrictive environment for emergency shelter. They also need special care to address their various disabilities. Unfortunately our system does not have sufficient placement options to provide this special care needed for children with developmental delays. The county in which I work has only one available emergency shelter bed that is held for child protection for children with developmental disabilities. Often that bed is full so the child is typically placed in a hospital setting until a more appropriate placement is found. Because the child is in a more clinical setting than a home environment, this throws the already

traumatized child into more uncertainty and into a situation that they may not understand.

Placement and service coordination for long term care

Given the child's special care needs or the behaviors of the child, I have often seen the difficulty of finding other family members who are willing or able to provide temporary or more permanent care for the child. If

always informed of or aware of the involvement of child protection with a child and family with whom we are working. If DD social workers were involved in the collaboration of a case, they might be able to assist in providing some of the necessary records needed to establish the services required for the continuum of care for the child.

In trying to access certain services for a client, the social workers involved will explore the various funding sources. For a

If DD social workers were involved in the collaboration of a case, they might be able to assist in providing some of the necessary records needed to establish the services required for the continuum of care for the child.

family or kin are not available to provide care, it is often equally difficult to find a foster home that can provide the specialized care.

Most often the placement is out of the child's school district making it more difficult to set up the necessary services in the new school district. In my experience I have also often seen the child's established medical, social service and educational services get put on hold and disrupted as the child protection worker gathers the child's records and establishes new services, often in a different geographic location.

Communication

There is often a lack of information sharing and collaboration among the child welfare system and the other systems that can serve and support children with disabilities. In the developmental disabilities (DD) service area, since our services are voluntary, we are not

child with developmental disabilities, a DD waiver is a potential funding source for home and community based services. Access to waivers is determined by specific eligibility standards and the availability of a waiver. There is an eligibility pool of over 2300 adults and children waiting for a DD waiver, and placement options for children with developmental disabilities are limited. There is not a lot of cross team understanding of what resources can be provided for a DD child.

With limited resources available to our clients, fragmented communication, and lack of funding, we must rethink how we can collaborate and find creative ways to share the resources we all bring in order to provide the best care for our clients.

Susan Frame, MSW, LICSW is a Senior Social Worker at Hennepin County. She can be reached at Susan.Frame@co.hennepin.mn.us.



Collaboration Across Systems: A School Social Worker's Perspective

Stephanie Ochocki, MSSW, LICSW

Data privacy can be a major barrier when working with child welfare to provide effective service coordination for students. Difficulties have included times when school staff has not been notified that a student is placed in foster care or has a change of placement regarding their foster care which, of course, makes coordination of needs between home and school a challenge.

Working with the county

I have had challenging experiences on both sides of the coin when simply trying to make sure a child in foster care is able to receive the Free & Reduced Lunch program, participation they are entitled to based on their foster care placement. There were times when I had the placement information and was able to link the case manager or foster parent to the program application; at other times I reached out to both the county case manager and the parent to educate them about the application form and obtain a completed form but never got a response.

I do recall a time when working with the county regarding school staff concerns about a student with autism who reported being physically abused and being left without supervision appropriate for their age. Due to the laws of mandated reporting, school staff were able to share with the county valuable background information regarding the student's disclosure, the student's history of involvement with county services, and how the student typically responds to new situations and people. The county child protection services (CPS) investigator not only listened to this information from school staff but also acted on the information in creating the investigation/assessment with the student. This included supporting efforts by school staff familiar to the student to follow-up with the student on a number of questions and points of concern prior to the county social worker meeting with and interviewing the student. The county social worker also took the time to address the student's perceptions that he was in trouble, the county was going to kick his family out of the country, etc.

Whether or not this effort impacted the outcome for the student or their perception about speaking with a county social worker, I cannot say. It did, however, reflect the coordination between school staff and the county to meet the needs of this child with a disability in a way that was different from other experiences I have had over time when working with the county on issues of abuse and neglect.



Collaboration across multiple systems

In the above situation, the county social worker also made a point to inform the student's county developmental disabilities (DD) case worker of the recent reports to child protection regarding the student, which prompted the case worker to contact me

that illustrated the fear and perception that the student and parent had regarding county involvement. I believe sharing this information allowed the DD case manager to shape the conversation with the student and parent in a way that highlighted the DD case manager's role as a county worker whose purpose was to support their family and,

I do believe it was coordination among the child protection, developmental disabilities, and school systems that made the difference.

and the student's Individualized Education Program (IEP) case manager. This initial contact allowed us to ensure the DD case worker would be included on invitations to the student's IEP meetings and also would receive updated information regarding school staff concerns regarding the student and his or her home situation.

Whether the DD case worker already had the consent to collaborate with school staff before the referrals to child protection or if this came as a result of the child protection involvement, it was the first contact the IEP case manager or I ever had with the DD case manager. We learned about the DD case manager's efforts to check in with the student and family and link them to resources they were entitled to. The DD case manager shared that the parent was hesitant about engaging further with "the system" for supports and was currently utilizing the DD case worker at what sounded like a minimalist level. The DD case manager was planning to follow up with the family to discuss supports in order to prevent further CPS involvement. The IEP case manager and I were able to share statements the student was making

thus, would approach them about additional services and supports rather than "take the student away" or "kick us out of the country."

I do believe it was coordination among the three systems that made the difference. The CPS worker was the one who shared with the IEP case manager and me the worker's plans to connect with the DD case manager regarding the student's CPS referral. The DD case worker sent in the needed release of information that allowed us to collaborate regarding what services/supports the family was utilizing in the community, the supports the student was receiving at school, and our shared goal of ensuring the student was safe and the parent knew about options for help. All three systems were joined in the effort to ensure the student was safe and was hearing a consistent message that safety was a priority, rather than getting the student in trouble.

Stephanie Ochocki, MSSW, LICSW is the Lead School Social Worker for the Anoka-Hennepin School District. She can be reached at [stephanie.ochocki@anoka.k12.mn.us](mailto:ochocki@anoka.k12.mn.us).

Gifts from the Creator: Disability in American Indian Communities

Priscilla A. Day, MSW, EdD

American Indian/Alaska Native populations number about 6.2 million and are diverse in culture and practice (Office of Minority Health, 2013, para 1). There are 566 federally recognized tribes in the United States and more than 100 additional tribes that are also recognized within their states (Office of Minority Health, 2013, para 1). Tribes are sovereign, meaning that they have retained legal rights and jurisdiction on tribal lands, which make tribes unique from other minority groups.

Because of their unique differences, tribes have different customs related to disability. Even within tribal groups, there is great variation in the way in which tribal people think about disability. When I was asked to write this article, I kept thinking that I didn't really know many American Indian people with disabilities. As I struggled to write something that would be meaningful, it occurred to me that actually I do know quite a few American Indian people with disabilities, but I don't think of them as having disabilities and they tend not to view themselves that way.

Data about the numbers of American Indians who have disabilities are hard to come by since researchers tend to find Native populations too small to differentiate so we



disability, this might be seen as that child having been given a unique gift that is theirs to understand and use to the best of their ability. A common indigenous belief is that there is a reason that things happen; people have a purpose to fulfill in this world and need to find out what that purpose is in order to live their life in the way that the Creator intended. If one has this cultural lens, then disability might be seen as an opportunity to have a unique role in one's family and community.

Many American Indians live in rural areas, on or close to reservations, which can make getting services for disabilities a challenge.

who had rather severe developmental and physical disabilities was able to be successful with the support of her family. She was able to graduate from high school and go to the community tribal college. There, she continued to be successful because other students, faculty, and staff, mostly American Indian, accepted her but also provided her with assistance when she appeared to need it. She graduated from the tribal college and was eagerly looking forward to matriculating to the local four-year college. After one semester there, she failed out of her classes. She went from being in a supportive environment that valued her and saw her as having gifts to offer the community to being invisible or someone with a disability. She was not used to having to fend for herself or to have to ask for assistance from others. In her family and community, she was assisted as part of daily life. These kinds of stories are heartbreaking not just for the individual and her family but for the lost potential contributions to all of society. By viewing people in terms of their disability rather than in terms of their gifts and abilities, we miss the opportunity to learn from them and we miss the contributions they can make to larger society.

The literature has surprisingly little information about American Indians and disability. There is a need for good data about American Indians and the impact disability places in child welfare cases. Because American Indians have high risk factors that often lead to child removal – poverty and cultural misunderstanding – adding disability to the mix only increases the risk of child removal.

Priscilla Day, MSW, EdD is Professor in the Department of Social Work, University of Minnesota Duluth and Director of the Center for Regional and Tribal Child Welfare Studies, University of Minnesota Duluth. She can be reached at pdlay@d.umn.edu.

By viewing people in terms of their disability rather than in terms of their gifts and abilities, we miss the opportunity to learn from them and we miss the contributions they can make to larger society.

often get put in the “other” category or not counted at all. Estimates of American Indian/Alaska Natives that have disabilities range from 22% to over 24%, or at least 550,000 American Indians/Alaska Natives (National Council on Disability, 2003; Scalpcane, 2005). American Indian children might be impacted by having a parent or guardian with a disability severe enough to be deemed unable to care for their child or the children themselves might have a disability. One study found that “there was a 26.5% rate of disability among Native American caregivers from whom the child welfare system removed children” (National Council on Disability, 2013, para 4). This kind of over representation in the child welfare system is alarming.

As mentioned earlier many American Indians don't think about disability in the same way that others might, as a liability or a deficit. In general, American Indians see health or lack of health as a symptom of being out of balance. Or if a child is born with a

When services are available, they often are not culturally appropriate. There may be a lack of childcare, specifically childcare appropriate for children with disabilities. Because of the sovereignty of tribes, there may be jurisdictional issues about the application of the Americans with Disabilities Act on tribal lands or just an overall lack of understanding about the unique needs of people with disabilities. Even when tribes want to provide services, they have limited tribal resources (National Council on Disability, 2003). “American Indians and Alaska Natives have the most disproportionate rate of disabilities of all population groups, compounded by factors such as high poverty and school dropout rates, geographic isolation from state or local district rehabilitation and health care, and limited employment options” (National Council on Disability, 2003, p. 3).

An example of how a young person in a tribal setting may be treated differently comes from my own community. A young woman

The Perception of Hidden Disabilities in the Somali Community

Nasro Mohamed, MSW, LGSW, interviewed by Heidi Skallet, MSW

Autism & Minnesota's Somali community

The Somali community in Minnesota has become increasingly more aware of the higher than average rate of autism spectrum disorder (ASD) diagnosis among its preschool-age children. A 2009 Minnesota Department of Health study found that these children were two to seven times as likely as other children to receive such a diagnosis (McNeil, 2009).

Currently there are two studies underway at the University in Minnesota that attempt to address this issue. The first study, funded by the Centers for Disease Control, the National Institute on Health, and Autism Speaks, seeks to determine autism prevalence among Somali children (Minnesota Department of Health, 2013; Parrott, 2012). The second study's focus is on the impact of culture on Somali parents understanding of the signs and symptoms of ASD and how they choose treatment options for their children (MDH, 2013). This study is funded through legislative appropriation from Minnesota's 87th legislative session.

The heightened awareness of hidden disabilities (including autism) in the Somali community has begun to cause changes in the way Somali families view physical versus intellectual/cognitive disabilities. However, despite this awareness, there is still stigma attached to having such disabilities.

Responsibility & acceptance

In the Somali community, oral communication is very important as information among the Somali people is generally conveyed verbally rather than in writing. Traditionally, history, culture, and values have been passed down from generation to generation through storytelling, poetry and singing. Participation in the community is contingent upon self-expression. Since individuals with physical disabilities are still able to express themselves, there is more of a stigma attached to intellectual/cognitive disabilities. The stigma derives from a lack of understanding of intellectual/cognitive disabilities, particularly as children with these disabilities grow into adults—though they are physically grown, they may still exhibit child-like behaviors.

This stigma not only affects the individual with the disability, it also impacts the family of the individual. Future partnering between families may be affected once one family discovers that the other family has a relative



with a disability. A family with a child diagnosed with autism may isolate themselves to avoid pity from their neighbors. If that child is male, his father may feel that his lineage has ended as it is not common for individuals with disabilities to head their own families.

become involved in the child welfare system may have difficulty sharing information with child welfare workers.

It is important to establish rapport with Somali families and build relationships and trust. In a child protection investigation,

Understanding the refugee experience as well as the Somali perception of disability is essential to being able to work effectively with Somali children with disabilities and their families.

However, Somali families also have a strong sense of responsibility for their family members with disabilities. For example, if a family has a child with disabilities who needs 24-hour supervision due to their behaviors, the family¹ will work to ensure the child can remain in the home and avoid out-of-home placement.

Though Somali families have always been protective of each other, they may be more accepting of individuals with disabilities here in the United States where there is greater access to services for individuals with disabilities and their families. Individuals with disabilities tend to encounter more abusive and disrespectful behavior in East Africa, especially if they have no family and end up living on the street.

Of special relevance to child welfare professionals

Due to political and systemic issues in their homeland, Somali families tend to have a general distrust of government agencies and officials. In particular, they have more fear of and anxiety toward child protection workers than other service providers. Thus, Somali families with children with disabilities who

the investigator will not be able to get the whole story by simply asking the family direct questions from a checklist at the initial meeting. The family may have other needs that will not be revealed, and there may be issues below the surface that might be impacting the current situation. If possible, child welfare workers might find it helpful to confer with the family's other service providers who have already established relationships with the family.

In general, child welfare workers should be aware of the worldview of Somali families. Understanding the refugee experience as well as the Somali perception of disability is essential to being able to work effectively with Somali children with disabilities and their families.

Nasro Mohamed, MSW, LGSW is Disability Services Social Worker at a county agency and Community Facilitator for the University of Minnesota Somali Autism Surveillance research study. She can be reached at moham355@umn.edu.

¹Family" refers to extended kin networks in addition to immediate family members.

The Importance of Emotional Support: A Former Foster Youth's Perspective¹

Ollie Hernandez

From the time that children are born, they have a need to be nurtured. From infancy, children depend on their parents to take care of them and nurture them. As children grow up and start to develop mentally, they begin to understand how they connect with the people around them whether it is their mom or dad or siblings. However, without emotional connections, they are at risk of not being able to make emotional

hesitant to learn to fly again. In order for them to gain their confidence, the nurturer has to encourage them to trust that they'll be okay and that they will be able to thrive in the environment they are going to eventually surround themselves with.

In a way, foster children who have experienced emotional ordeals are like baby birds with broken wings; they have to heal and then trust that the people around them

I have learned in order to grow as a person emotionally you have to be willing to trust people and let them become your "family" because, though some people may deny it, we all need to sustain emotional attachments to others to be able to move forward.

connections later in their adult lives. When children are subjected to trauma, their sense of nurturance or emotional security is ripped away from them; and because of the trauma that they've experienced, they are hesitant to form connections with people who play a significant role in their lives.

In order to thrive in an environment that foster youth are not necessarily used to, they have to learn how to heal from their emotional traumas and need help to do so. An analogy that can be used to understand this is the "broken wing analogy." When a baby bird breaks its wing, someone usually takes care of the bird until his or her wing heals. Once their wing heals, they are often

will help them heal and learn how to thrive in an environment they aren't familiar with. In order for foster children to heal, they have to be treated as normal children and have supportive foster parents and social workers. It is important that these youth who have been emotionally damaged in the past know their self-worth and are constantly reminded of their worth. While these youth may have memories of their past, if someone can help them overcome their traumatic experiences, it is extremely possible that they will mature into healthy adults and go on to lead successful lives and sustain strong relationships.

Though I have never been diagnosed with a mental health or behavioral disorder,

throughout my experience in foster care I found that I was not able to sustain emotional relationships with the people whom I was closest to: my sisters, my foster mom, and my friends. It wasn't because I did not want to; the lack of stability had caused me to not trust people easily and to put up "emotional walls."

Before I entered the foster care system and became a ward of the state, I was emotionally and physically abused as a young child, which was the primary reason why I became a foster youth. My ability to develop emotional attachments and express my feelings in a healthy way dwindled when my mother passed away when I was ten. At the time, it seemed like the only person in my family who had not damaged my emotional well being was my mother and when she died, there was the fear that any person who would have any emotional investment in me would either hurt me or leave.

For the next couple of years, I made myself become emotionally unavailable to anyone who wasn't my sisters. As a coping mechanism for the traumatizing effects of being a kid in foster care, I created emotional walls and developed an icy exterior so I wouldn't have to experience any emotions or feelings. This façade started to develop in the fifth grade and continued until my freshman year of high school. However, because of a remarkable foster parent, things quickly turned around.

For the two years that I lived with that particular foster mom, she encouraged me to express my emotions and that feeling wasn't such a bad thing. It took a lot of therapy and a lot of help from everyone around me, but eventually I became more of a "bright and shiny" person and less "dark and twisty." Though I have moved to several foster homes and experienced a lot of emotional obstacles, I have learned in order to grow as a person emotionally you have to be willing to trust people and let them become your "family" because, though some people may deny it, we all need to sustain emotional attachments to others to be able to move forward.

Ollie Hernandez is a former foster youth and a member of the Young Adult Training and Technical Assistance (YATTA) Network. She can be reached at olliehernandez@me.com.



<http://z.umn.edu/d0d>

¹While writing this article, in order to learn more about behavioral and mental health issues experienced by children in foster care, I spoke with Dr. Brent Wilson, a child psychiatrist, to examine this issue more closely.

Being a Treatment Foster Parent of Children with Special Needs

Aura Recuero

I have had the experience of being a foster parent for many years now, and I wouldn't change that role for the world! Currently I am a treatment foster parent with a therapeutic foster care agency in Connecticut, meaning that the children I foster tend to have some type of disability. To me, being a foster parent means having patience, dedication, commitment, trust, and respect. There are no words that can express the love that you need to have in your heart to open your home to the children.

On fostering

In my opinion, it is very important that every child who comes into your home, whether it is to stay forever or temporarily, be treated individually. Every case should be treated differently, as you never know what the child has endured. Each case is different. For me, one quality that I always exert in my life is respect. I respect the children, and they respect me. I try to have a give and take relationship with them instilling trust and respect in the relationship and letting them know that they can come to me for anything.

On caseworker support

It is important that caseworkers in my agency be available to me. I have had some negative past experiences related to lack of communication. In particular, I have had workers who would only talk to the kids at school and never interact at home with the family. Once, when I dropped off one of the



In my current agency, when I am experiencing challenges, all I have to do is make a phone call, and the caseworker will talk to me about the child and how I can help the child. That is probably the best form of support I could have from the caseworker: that I'm able to make a phone call to the worker and she or the manager returns it. I appreciate that my caseworker has a fast response time and has made herself easily

are not left solely up to the foster parent. The agency itself is very supportive. For example, I have two boys with severe asthma and about once a month, a nurse from the agency comes to check on them. Another time I had a child with a problem with his skin and a nurse from the agency came with us to the dermatologist appointment.

Of course, as the foster parent, I'm with the child 24 hours a day, 7 days a week, so I make sure to keep the caseworker aware of what is needed for the child as well. Caseworkers can't provide for foster parents and the children in their care if the parent doesn't tell them what the child needs.

That is probably the best form of support I could have from the caseworker: that I'm able to make a phone call to the worker and she or the manager returns it.

kids at school, he clung to my leg, and I had to remove him. He told DCF that I hit him, which was not true, but rather than talk to me about what he said, I was falsely accused of hitting the child.

It is important to me that caseworkers are aware of what's going on with the family as a whole and not just the children in my care. For example, I was hospitalized at one point, and the caseworkers at the therapeutic foster care agency got in touch with my husband to see if he needed help with caring for the children. I understand that DCF has large caseloads, but it's still important to see how things are going on with everyone actually together, not just how the child is outside the home.

accessible. For example, I once received a letter on a Saturday saying that the children in my care were going to be removed due to what amounted to a misunderstanding of statements made by the children to DCF. I was really worried and devastated because my kids mean everything to me. I called my kids' caseworker at my agency and she came over right away. She and the agency director helped me draft a response letter and also went with me to a couple of hearings regarding the matter. I eventually won the appeal.

Having caseworkers like the one through the therapeutic foster care agency is very beneficial because they know which referrals to make and what the child needs. Things

Conclusion

It takes a lot of hard work and dedication to be a foster parent, but the reward of making a child happy is all worth it. I enjoy being able to provide these children with a safe, stable, happy home where they can feel at home and enjoy themselves. These children are like angels to me, and I will continue to be a foster parent for as long as I can.

Aura Recuero is a Treatment Foster Parent providing therapeutic foster care at Community Residences, Inc. in Connecticut. She can be reached at jessaura77@hotmail.com.

Sick and Tired

Carla Burks

Six years ago I lost my son to foster care because I got too exhausted and overwhelmed to care for him. My son, who is now 16, has been diagnosed with bipolar disorder and ADHD and was in and out of the hospital more than a dozen times in five years. I was a single parent with little support from my family. The pressure of caring for my son took a toll on me.

Destructive behaviors

My son was in preschool when he began showing very strong negative behaviors. If I told him “no,” he would throw things, break things, scream at me, and get so mad he would run out of the house. It became difficult to take my son anywhere or find childcare for him. He was kicked out of

medical staff felt it was necessary to call child protective services (CPS). Soon after, my son was placed in foster care.

I gave up custody

For reasons I don’t really understand, though, CPS did not place my son in therapeutic foster care as we’d discussed. Instead, CPS contacted my son’s father, who lived in Texas, and asked him to come to Virginia to care for our son.

Even though my son’s father had not been in his life, he told CPS that he wanted to take full custody. Within days we had an emergency hearing. I felt like I had no choice but to sign my son over to his father. But only a short time later, my son was removed from his father’s home. His

I believe my son would be home with me today if I was given respite or was able to place my son in temporary therapeutic foster care when we needed it.

several daycare centers. He was hospitalized for the first time at five years old.

I used all of the resources I could find to stabilize my son. Through the Virginia Department of Social Services, we had case management, mentoring and in-home counseling. Those services helped, but they were not enough.

I felt that no one could relate to my struggle. People would criticize me when they saw my son’s behavior, saying, “He needs a spanking,” or “Let him come home with me for a while. Then he wouldn’t act like that.” I felt so depressed and cried often. At times I was unable to work due to exhaustion. Even going to church was a struggle.

Considering foster care

When my son was 8, I began talking with our caseworker about options for my son’s care that would give me a break and help him do better. We discussed placing my son temporarily in therapeutic foster care with a family trained to respond to his needs. I thought it was a good idea for both of us.

But before we could make a plan, I got very sick and ended up in the hospital. I had pneumonia, a fever of 103 and extremely high blood pressure. The nurses asked me, “What is going on in your life?” I was physically and mentally exhausted when I said, “I have a special needs son who is causing me a lot of stress. I feel like I’m going to choke him or seriously harm him if I go back home!” The

father had gotten frustrated and hit him, the school reported bruises, and our son was placed in residential care.

It’s a long story what happened after that, but in the end, his father gave up his rights. Then, because I didn’t attend court hearings in Texas, I lost my rights and all contact with my son.

Fighting for my son

Now God has given me the strength to fight once again. Last year, I moved to Texas to try to reconnect with my son. I have met my son’s caseworker and gone before the judge to petition for contact. I am also in counseling now, and it’s helped me to better understand my emotional state and my son.

ometimes I feel so angry at what happened to my son and me. Although I made a verbal threat, I never caused my son bodily harm. I also wish I had had more support before I reached a crisis point. I believe my son would be home with me today if I was given respite or was able to place my son in temporary therapeutic foster care when we needed it.

Mostly, though, I feel sad. My son does not know the whole story. I’m afraid that he believes that I don’t want him in my life. I hope that I will have the chance to see my son and explain that I did not have control over the situation and I did not expect our separation to last forever.



Carla Burks is a writer for Rise magazine. She can be reached via Rise director Nora McCarthy at noral@risemagazine.org.

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Editors’ note:

In order to serve our clients most effectively it is essential that we understand our clients’ perception of our practice and be able to communicate to them what is happening in their case and why. Ms. Burks clearly felt there was an issue with communication among the various entities involved in her case. She expresses her frustration with being a client in a system that appeared to provide limited options and support for parents.

As we read Ms. Burks’ narrative we should ask ourselves, “How could this have turned out differently?” From your perspective as a child welfare professional or advocate, think about different points in the narrative where you would have intervened. For example, Ms. Burks expresses her opinion that support from the beginning, i.e. respite care/therapeutic foster care, could have changed her family’s outcome. How would a different approach or practice model have impacted the outcome?

The Elementary-School Functioning of Children with Maltreatment Histories and Mild Cognitive or Behavioral Disabilities: The Gamble-Skogmo Disabilities Study

Continued from page 10

stemming from stress, upheaval and lack of support in the home. Children's general lack of school readiness also may mask mild cognitive or behavioral disabilities. Regardless of the particular configuration of children's multiple challenges, the result is the same: children may remain undiagnosed longer and miss out on timely intervention.

Professionals also described child and family strengths that may account for some individual variation in the school functioning of children with mild cognitive or behavioral disabilities. The primary protective factor identified by professionals for children was positive engagement in school. One child welfare professional observed: "many of them [children with maltreatment histories] do think of school as a kind of refuge ... a good place, a happy place." Another protective factor described by professionals was parents' willingness to engage and work collaboratively with educators and child welfare professionals. As one child welfare worker explained, "...

[most] families really do want more and better for their kids than what they have."

Cross-system collaborations

Educators and child welfare professionals generally recognized that their collaboration provides opportunities to better understand and intervene in problems children and their families are facing. Yet most professionals also spoke of inadequate communication and collaboration across multiple systems involved with the child, for example, the school, child mental health and child protection. Professionals also noted that systems are not always parent-friendly. For example, multidisciplinary team meetings may be intimidating or uninviting for parents and multiple, large systems difficult to navigate. In a time of tight budgets, many professionals also described inadequate funding for services, especially mental health services.

Implications

Elementary school-aged children with maltreatment histories and mild cognitive and behavioral disabilities are especially vulnerable to academic problems. Our findings

underscore the need for timely assessment and effective intervention for children with maltreatment histories who may have mild cognitive and behavioral disabilities to prevent disengagement from school and academic failure. Attending to children's mental and behavioral health also is critical as these unmet needs can mask children's mild cognitive and behavioral disabilities and undermine school functioning. Similarly, attending to families' unmet basic needs and parents' mental and behavioral health needs also is necessary as these can overshadow children's mild cognitive and behavioral disabilities. Finally, to design and implement comprehensive, holistic intervention, collaboration between education, child welfare, mental health and other social service systems is essential.

Wendy Haight, PhD is Professor and Gamble-Skogmo Chair in Child Welfare and Youth Policy at the University of Minnesota. She can be reached at whaight@umn.edu.



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MN LEND Program

Leadership Education in Neurodevelopmental and Related Disabilities



The MN LEND is an interdisciplinary leadership training program engaging in activities related to neurodevelopmental disabilities and autism spectrum disorders. These include —

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The MN LEND is funded by the Maternal Child Health Bureau (MCHB) of the US Department of Health and Human Services to provide training to student and community trainees.

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Driven to DiscoverSM

Continued

Fostering Appropriate Psychotropic Medication Use among Youth in Foster Care: The Problem, Policy Response, and Resources

Continued from page 13

Resources

A number of resources are available to stakeholders, such as child welfare workers, caregivers, biological parents, youth, etc., as they seek to partner with child welfare to improve well-being for youth in foster care. Professional practice parameters and consensus statements are available to inform the **development of a systematic response** to psychotropic oversight, monitoring, and management (see Table 2). Handbooks, guidelines, and resources also exist to support stakeholders in being **engaged and informed consumers** of mental health services (see Table 3). Considerable opportunity exists in the sharing of state and county models and resources for psychotropic oversight and monitoring mechanisms (for a listing of state tools, see http://160.109.101.132/icrhps/prodserv/docs/Study%20Appendix_FINAL.pdf; Naylor et al., 2007; Leslie et al., 2010; Mackie et al., 2011).

Tom Mackie, MPH, MA is a Joint-Doctoral Candidate in Social Policy and Sociology at Brandeis University; his dissertation research on psychotropic medication oversight for children in foster care is supported by a Health Services Research Dissertation Award (R-36), from the Agency for Healthcare Research and Quality. He can be reached at tmackie@brandeis.edu.

Christopher Bellonci, MD is a Child and Adolescent Psychiatrist and Assistant Professor at Tufts University School of Medicine. He can be reached at cbellonci@tuftsmedicalcenter.org.

Laurel K Leslie, MD, MPH is an Associate Professor of Medicine and Pediatrics at Tufts Medical Center Floating Hospital for Children and Director, Program for Aligning Researchers and Communities for Health, at the Tufts Clinical and Translational Science Institute. She can be reached at lleslie@tuftsmedicalcenter.org.

Managing Psychotropic Medications among Children and Youth in Foster Care through Systems Collaboration

Continued from page 14

- Existing infrastructure should be utilized more effectively and collaboratively, including data systems (e.g. SACWIS and MMIS), financial resources, community-based organizations, and Memoranda of Understanding among agencies (Allen, 2012; Pfennig & Stepleton, 2012).
- States should engage providers and provide opportunities for education and training (Allen, 2012).

To learn more about how to develop and implement oversight and monitoring systems see <http://pal-tech.com/web/psychotropic> for materials from the national meeting *Because Minds Matter: Collaborating to Strengthen Management of Psychotropic Medications for Children and Youth in Foster Care*.

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DCWC

Disability Child Welfare Collaborative

The DCWC brings together practitioners and researchers from the fields of child welfare, disability, and education in an effort to improve outcomes for parents and children with disabilities in the child welfare system.

On our website you will find more information about child welfare, disability, and special education, as well as how those systems interact. This website is a clearinghouse of information, including materials that we have developed, as well as links to other organizations and resources that you may find helpful. There is also information about us and the organizations that are collaborating with us in our work.

<http://z.umn.edu/dcwc>



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IDEA's Thirteen Disability Categories and Definitions

Disability Category	Definition
Autism	means a developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before age three, that adversely affects a child's educational performance. Other characteristics often associated with autism are engaging in repetitive activities and stereotyped movements, resistance to environmental change or change in daily routines, and unusual responses to sensory experiences. The term autism does not apply if the child's educational performance is adversely affected primarily because the child has an emotional disturbance, as defined in #4 below. A child who shows the characteristics of autism after age 3 could be diagnosed as having autism if the criteria above are satisfied.
Deaf-Blindness	means concomitant [simultaneous] hearing and visual impairments, the combination of which causes such severe communication and other developmental and educational needs that they cannot be accommodated in special education programs solely for children with deafness or children with blindness.
Deafness	means a hearing impairment so severe that a child is impaired in processing linguistic information through hearing, with or without amplification, that adversely affects a child's educational performance.
Developmental Delay	for children from birth to age three (under IDEA Part C) and children from ages three through nine (under IDEA Part B), the term developmental delay, as defined by each State, means a delay in one or more of the following areas: physical development; cognitive development; communication; social or emotional development; or adaptive [behavioral] development.
Emotional Disturbance	means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance: (a) An inability to learn that cannot be explained by intellectual, sensory, or health factors. (b) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers. (c) Inappropriate types of behavior or feelings under normal circumstances. (d) A general pervasive mood of unhappiness or depression. (e) A tendency to develop physical symptoms or fears associated with personal or school problems. The term includes schizophrenia. The term does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance.
Hearing Impairment	means an impairment in hearing, whether permanent or fluctuating, that adversely affects a child's educational performance but is not included under the definition of "deafness."
Intellectual Disabilities	means significantly subaverage general intellectual functioning, existing concurrently [at the same time] with deficits in adaptive behavior and manifested during the developmental period, that adversely affects a child's educational performance.
Multiply Impaired	means concomitant [simultaneous] impairments (such as intellectual disability-blindness, intellectual disability-orthopedic impairment), the combination of which causes such severe educational needs that they cannot be accommodated in special education programs solely for one of the impairments. The term does not include deaf-blindness.
Orthopedic Impairment	means a severe orthopedic impairment that adversely affects a child's educational performance. The term includes impairments caused by a congenital anomaly, impairments caused by disease (e.g., poliomyelitis, bone tuberculosis), and impairments from other causes (e.g., cerebral palsy, amputations, and fractures or burns that cause contractures).
Other Health Disabilities	means having limited strength, vitality, or alertness, including a heightened alertness to environmental stimuli, that results in limited alertness with respect to the educational environment, that— (a) is due to chronic or acute health problems such as asthma, attention deficit disorder or attention deficit hyperactivity disorder, diabetes, epilepsy, a heart condition, hemophilia, lead poisoning, leukemia, nephritis, rheumatic fever, sickle cell anemia, and Tourette syndrome; and (b) adversely affects a child's educational performance.
Specific Learning Disabilities	means a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, that may manifest itself in the imperfect ability to listen, think, speak, read, write, spell, or to do mathematical calculations. The term includes such conditions as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. The term does not include learning problems that are primarily the result of visual, hearing, or motor disabilities; of intellectual disability; of emotional disturbance; or of environmental, cultural, or economic disadvantage.
Speech/Language Impairments	means a communication disorder such as stuttering, impaired articulation, a language impairment, or a voice impairment that adversely affects a child's educational performance.
Traumatic Brain Injury	means an acquired injury to the brain caused by an external physical force, resulting in total or partial functional disability or psychosocial impairment, or both, that adversely affects a child's educational performance. The term applies to open or closed head injuries resulting in impairments in one or more areas, such as cognition; language; memory; attention; reasoning; abstract thinking; judgment; problem-solving; sensory, perceptual, and motor abilities; psychosocial behavior; physical functions; information processing; and speech. The term does not apply to brain injuries that are congenital or degenerative, or to brain injuries induced by birth trauma.
Visual Impairment, including blindness	means impairment in vision that, even with correction, adversely affects a child's educational performance. The term includes both partial sight and blindness.

Agency Discussion Guide

In order to assist busy supervisors and managers in thinking through how they might engage others around the information presented in this issue, we offer several discussion questions to get the conversation started:

Between Supervisor/Workers

1. Knowing the importance of identifying disabilities as early as possible in children, what are some strategies we could implement in our daily practice to improve early identification? See Macy, Shannon & Tappan, and Zuel.
2. Several of the articles discussed the importance of cross-system collaboration, particularly among child welfare, education, children's mental health, and developmental disabilities. What are our current collaborative practices? Think of any challenges you may have encountered while working with outside systems. How can we maximize our partnerships among the various systems to improve outcomes for children with disabilities on our caseload? See Hill, Zuel, Haight, Frame, Ochocki, and Skallet.
3. Different communities may view disability in very different ways. It is essential that we keep this in mind as we work with children with disabilities and their families. How can we ensure that our practice is sensitive to the needs and values of other communities? See Mohamed, Day, and Rycus.
4. Take a look at the Making Healthy Choices guide (discussed in Ortiz-Tovar and featured in the Resources box). How can you utilize this handbook with older adolescents with disabilities on your caseload? How does this fit in with Dr. Katharine Hill's article on policies impacting older youth with disabilities aging out of care? See also Mackie et al., Skallet, and Hernandez.
5. Carla Burks wrote about her experiences as a biological parent in the child welfare system. After reading her narrative, think about how her perspective influenced your view of the case. What do you think other agencies' and professionals' (other than child welfare) perspectives might be? This article also highlights the importance of communication between worker and parent. What strategies would you have employed in order to ensure open and honest communication with the children and families whom you serve? See also Recuero and Hernandez.

Between Manager/Supervisor

6. One of the main issues discussed throughout this issue was the importance of early identification of disability in children involved in the child welfare system. How can we implement some of the practice strategies into our system and agency policies to improve screening and early identification? What are some ways we can increase staff buy-in as we work to make these changes? See Macy, Shannon & Tappan, and Zuel.
7. In her article, Dr. Ruby Gourdine highlights statistics indicating similarities in disproportionate placement rates for African American children in both the child welfare and special education systems. What are some ways our agency can address this disproportionality? How can we work with education systems to improve outcomes for African American children with disabilities who are involved in the child welfare system? See also Haight.
8. Tracking disability diagnoses among children in the child welfare system is not only pertinent for research purposes, but it also helps ensure that we are providing needed services to the children and families we serve. How does our SACWIS system help or hinder our efforts to track children with disabilities? Review current data practices to ensure that your SACWIS system is meeting agency needs and legal requirements. See Lightfoot & LaLiberte, Shannon & Tappan, Mackie et al., and Skallet.
9. Children with disabilities face additional challenges to finding permanency, compared with their non-disabled peers. In her article, JaeRan Kim mentions three promising practices: child-specific recruitment, preparation and full disclosure, and professional post-permanency support. Are these practices in place at our agency? If not, how can we work to implement these practices? See also Rosenau for another practice example.
10. Recent changes in the law regarding the monitoring of psychotropic medication use among children and youth in foster care mean that we must evaluate our current agency policies and practices related to this topic. What changes do we need to incorporate to meet the requirements of this new law? See Mackie et al. and Skallet.

Resources *Specific to Children with Disabilities in Child Welfare*

The Risk and Prevention of Maltreatment of Children with Disabilities (Child Welfare Information Gateway): <http://www.childwelfare.gov/pubs/prevenres/focus/>

Developmental Screening in your Community: An Integrated Approach for Connecting Children with Services (book co-authored by M. Macy)

Making Healthy Choices: A Guide on Psychotropic Medications for Youth in Foster Care (Children's Bureau et al.): <http://www.nrcyd.ou.edu/publication-db/documents/psychmedyouthguide.pdf>

Because Minds Matter: Collaborating to Strengthen Management of Psychotropic Medications for Children and Youth in Foster Care (ACF, CMMS, SAMHSA): <http://pal-tech.com/web/psychotropic/>

Select National Organizations

- National Council on Disability: <http://www.ncd.gov/>
- National Dissemination Center for Children with Disabilities: <http://nichcy.org/>
- Autism Speaks: <http://www.autismspeaks.org/>
- American Association on Intellectual and Developmental Disabilities: <http://www.aidd.org/>
- The Arc: <http://www.thearc.org/>

Select Minnesota Statewide Organizations

- Fraser: <http://www.fraser.org/>
- Minnesota Association for Children's Mental Health: <http://www.macmh.org/>
- NAMI-MN: <http://www.namihelps.org/>
- PACER Center: <http://www.pacer.org/>
- Institute on Community Integration: <http://www.ici.umn.edu/>

About CW360°

Child Welfare 360° [CW360°] is an annual publication that provides communities, child welfare professionals, and other human service professionals comprehensive information on the latest research, policies and practices in a key area affecting child well-being today. The publication uses a multidisciplinary approach for its robust examination of an important issue in child welfare practice and invites articles from key stakeholders, including families, caregivers, service providers, a broad array of child welfare professionals (including educators, legal professionals, medical professionals and others), and researchers. Social issues are not one dimensional and cannot be addressed from a single vantage point. We hope that reading CW360° enhances the delivery of child welfare services across the country while working towards safety, permanency and well-being for all children and families being served.

How can you improve child welfare services for children and/or parents with disabilities?

Do you have 90 seconds?

Contribute to the national dialogue on child welfare practice and policy by sharing your thoughts, ideas, questions and/or experiences about working with people with disabilities.



Look for the icon below in this issue to view video wall responses from some of our authors.



The Child Welfare Video Wall

Add your video. Add your voice. Transform the dialogue.

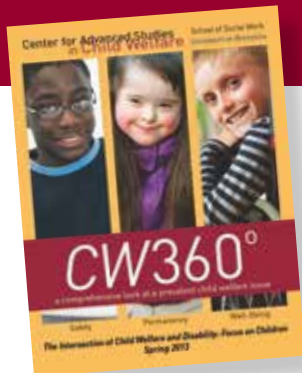


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Center for Advanced Studies
in Child Welfare

CASCW
School of Social Work
University of Minnesota
205 Peters Hall
1404 Gortner Avenue
Saint Paul, MN 55108

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In This Issue of CW360°

- An overview of the prevalence and population of children with disabilities and mental illness in the child welfare system, including a historical foundation
- How federal policies impact youth with disabilities and mental illness who are currently in foster care and those who are aging out of the system
- Cultural viewpoints of disability from Somali and Native American perspectives
- The importance of cross-systems collaboration to assist children and youth with disabilities and mental illness and practice strategies to encourage such collaboration
- Benefits of utilizing developmental assessments and early intervention for young children involved in the child welfare system
- How supportive adults, including foster parents and school social workers, can assist children and youth with disabilities in child welfare
- Ways in which child welfare professionals and the courts can communicate effectively with children with disabilities

CW360°

a comprehensive look at a
prevalent child welfare issue

Feature Issue: The Intersection of Child
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Managing Editor : Tracy Crudo
Editor : Heidi Skallet
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