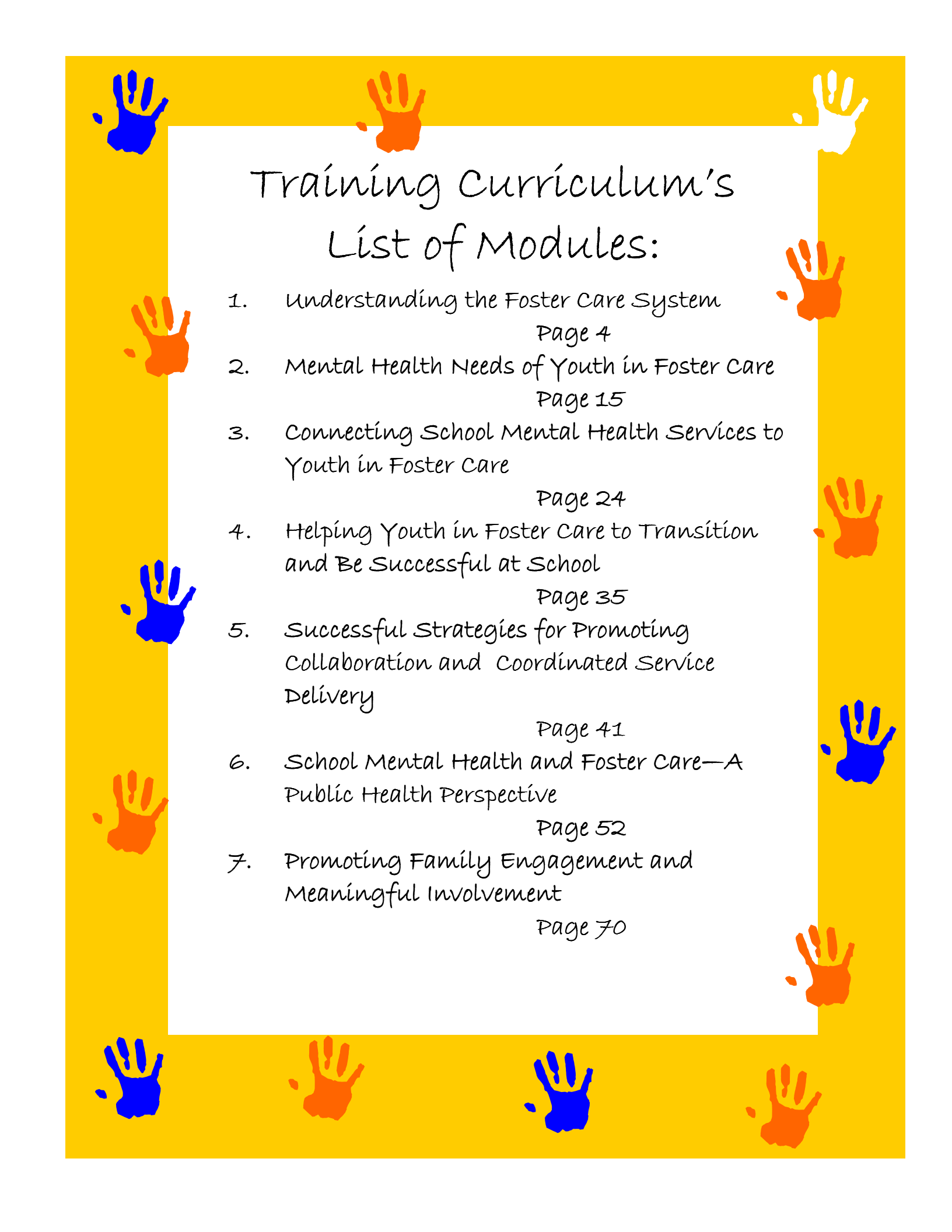Mental Health Needs of Youth in Foster Care

School Mental Health and Foster Care: A Training Curriculum for Parents, School-Based Clinicians, Educators, and Child Welfare Staff

Authors: Nancy lever, Maura Mulloy, Nicole Evangelista, Monique Vulin-Reynolds, Yaphet Bryant, Sylvia McCree-Huntley, Mark Weist, Michael Lindsey, & Pamela Jordan

Training Curriculum's List of Modules:

Introduction to School Mental Health and Foster Care: A Training Curriculum for Teachers, Child Welfare Staff, and School-Based Mental Health Providers

Through an initiative in the State of Maryland, the Center for School Mental Health with input from diverse stakeholders, including parents, youth, clinicians, educators, and child welfare staff has developed a modularized training curriculum entitled, School Mental Health and Foster Care: A Training Curriculum for Parents, Clinicians, Educators, and Child Welfare Staff. The training curriculum is designed to enhance the ability of schools, child welfare, and families to meet the mental health needs of youth in foster care. The curriculum consists of seven training modules entitled: 1) Understanding the Foster Care System, 2) Mental Health Needs of Children in Foster Care, 3) Connecting School Mental Health Services for Youth in Foster Care, 4) Helping Foster Care Youth to Transition and Be Successful at School, 5) Successful Strategies for Promoting Collaboration and Coordinated Service Delivery, 6) School Mental Health and Foster Care: A Public Health Perspective, and 7) Promoting Family Engagement and Meaningful Involvement.

The training curriculum is a user-friendly, cross-agency professional development resource for child welfare workers, school administration and staff, and mental health professionals. The curriculum was designed to help advance knowledge and skills related to understanding and addressing the unique mental health issues in youth in foster care. It also strives to advance effective strategies to improve collaboration and coordinated school mental health service delivery. This curriculum includes important strategies about when and how to connect youth to school mental health services, both in response to identified needs as well as in a proactive way to prevent the development of additional mental health problems. Effective strategies for achieving positive educational and mental health outcomes for foster care youth are highlighted.

Youth in foster care are at greater risk of mental health problems than other high risk populations (54% had one or more mental health problems in the past 12 months compared with 22% of the general population) (Pecora et al, 2005). Further, another study found that 25% of youth in foster care had Post-Traumatic Stress Disorder in the past 12 months. This rate is twice the rate of PTSD for returning United States war veterans. While youth in foster care represent a high need population that needs to be a priority in schools, there is little guidance and resources on how to effectively provide school mental health services for youth in foster care.

This training curriculum addresses a gap in necessary professional development and offers potential strategies for effective prevention, intervention, and ongoing individual and system level collaboration and partnership.

Understanding the Foster Care System

STEP ONE: Present the "Test Your Knowledge" questions below and have participants write down their answers. Tell the participants that you will provide the answers at the end of the session.
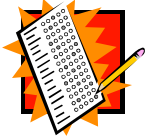
Test Your Knowledge: True or False

1) Involvement in the child welfare system typically begins through a report of suspected child neglect or abuse. (**T/F**)
2) The two most common types of foster care placements are court-appointed foster care with non-relatives and group home placements. (**T/F**)
3) The ultimate goal of foster care is family reunification when feasible. (**T/F**)
4) Permanency planning is initiated after a child has been in the foster care system for 12 months. (**T/F**)

STEP TWO: Provide the participants with the learning objectives for the session.
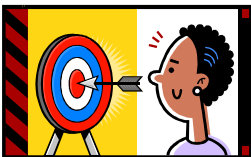
Lesson Objectives

Participants will be able to:
1) Identify at least three major types of foster care placement.
2) Understand the goals of foster care, including identifying three major discharge outcomes.
3) Understand the steps involved when a child or adolescent enters the foster care system.
4) Name at least 3 major players involved in the foster care systems and discuss the roles that they play.

Learning Points

STEP THREE: Present the content of the "Key Sections" using the Power Point provided or other presentation methods. It is highly recommended to utilize the activities in order to keep the participants engaged. The activities may be done in small groups or with the entire group.

➢ What is foster care?
  o Foster care is one aspect of the child welfare system whose objective is the provision of short-term out-of-home care for children removed from their family homes.   At the same time, the child's family also receives services that aim to help them reduce the risk of future neglect or abuse in preparation for the child's return home (Child Welfare Information Getaway, 2006).

➢ What is the main goal of foster care?
  o Foster care is intended to be a *temporary* living situation, with the goal of providing support and care for the child in order that either family reunification or another suitable permanent living situation (e.g., adoption) can be facilitated. Foster care is not meant to be a permanent solution!

➢ Basic Statistics: (See hand-out)
  o National Statistics:
    ▪ January 2008 data provided by the U.S. Department of Health and Human Services indicates that there are more than 500,000 children in the foster care systems throughout the United States.
    ▪ Currently the trend is showing more children entering the system than exiting.
    ▪ Amongst the children who are currently placed, there are approximately 20,000 children who will emancipate or age out of the system this year.
  o What is the situation in Maryland? (based on 2007 statistics)
    ▪ Total population in foster care: 11,063
    ▪ Age (Average: 7.0 Years)
      • 17% <1 year
      • 26% 1-5 years

- 25% 6-10 years
- 23% 11-15 years
- 7% 16-18 years
- 1% ≥ 19 years
  - Male: 51% Female: 49%
  - Please see the a handout 1.1 for a break-down in placement types (including foster homes, group homes, kinship care, etc) by race/ethnicity in Maryland.

- Additional Statistics in Maryland
  - Number of foster homes: In 2007, there were a total of 2801 foster homes in Maryland.
  - Length of stay: The average length of stay for children in care on September 30, 2003 was 48 months.
  - Reunification: Forty-one percent of the young people leaving the system in 2003 were reunified with their birth parents or primary caregivers.
  - Kinship care: On January 1, 2007, 28% of youth living in out-of-home care were residing with their relatives.
  - Adoption: Of children with state agency involvement adopted in 2003, 56% were adopted by their non-relative foster parents and 40% were adopted by relatives.

STEP FOUR: The following activity may be done in small groups or with the entire group. Provide participants with the prompt below for brainstorming. If possible, write their responses on a white board or chalkboard.

Activity: Discuss the different scenarios in which a child may be referred to foster care. Is foster care ever a voluntary option for caregivers? Why might this be?

Possible Answers: *Involuntary*: physical or sexual abuse, neglect or abandonment, domestic violence, drug abuse, long-term financial instability

Voluntary: parent/guardian cannot perform caregiver role due to absence (e.g., hospitalization, incarceration); child has needs that

➢ What are the different reasons that a child might be placed in foster care?
  o Physical or sexual abuse
  o Neglect or abandonment
  o Domestic violence
  o Drug abuse
  o Long-term financial instability
  o Caregivers' long-term illness or hospitalization
  o Caregivers' incarceration

➢ Is foster care ever a voluntary option?
  o Yes, occasionally. For example, when the regular caregivers must be absent on a short-term basis due to reasons beyond their control (e.g., hospitalization, incarceration, etc.), or when a child needs a level of services that the family cannot provide (e.g., behavioral problems requiring specialized treatment).

➢ Who are the key players in the foster care system, and what are their roles?
  o Foster parents, who can be:
    ▪ married couples or single or divorced individuals
    ▪ young or old
    ▪ work outside the home or not
    ▪ have young children, grown kids, or none at all (Foster Families, p. 1)
    The requirements to be a foster parent vary by jurisdiction, but in general foster parents must meet certain criteria to become licensed foster parents. Foster parents usually receive monetary reimbursement and/or other benefits to alleviate the costs of caring for the child.
  o Biological families receive services with the aim of improving their ability to care for child's physical and social-emotional needs, in order to achieve goal of family reunification.
  o Caseworker, typically a master's-level social worker. The case worker provides:
    ▪ Case management
    ▪ Clinical intervention
    ▪ Permanency planning
    ▪ Reunification support
  o A bachelor's-level caseworker may also provide support services that include:
    ▪ Mentoring
    ▪ Crisis intervention
    ▪ Therapeutic support

➢ What are the major types of foster care?
  o **Court-appointed foster care:** Caretaking of children displaced from biological parent(s), typically by a caring adult who has met the requirements to be a foster parent by their local jurisdiction. This situation is intended to be temporary.
  o **Kinship care:** Caretaking of children displaced from a biological parent(s), typically grandparents or other relatives. Child welfare agencies increasingly are turning to kinship care for children in need of out-of-home placements. This type of care is considered least detrimental because it improves stability and keeps displaced children closer to their extended families, neighborhoods and schools.
  o **Group homes/ Therapeutic group homes**: Group homes function more like dormitories than like a conventional family environment, and are usually a placement option for pre-teens and teenagers. Children and adolescents may be placed in group homes for the following reasons:
    ▪ a shortage of available foster families
    ▪ have difficulty in a foster family setting
    ▪ have emotional or behavioral problems that are better met in a group home environment, where they can receive professional assistance (this is especially relevant to a therapeutic group home placement).
  o **Emergency foster homes**: Available 24 hours a day to take in children until the social services system can determine a longer-term solution. These may be utilized when:
    ▪ Child is in danger of serious harm or injury.
    ▪ Child needs short-term placement until screenings are completed for kinship placement.
    ▪ Child has crisis in foster home and needs an immediate new placement.

➢ What is the process of a child being placed in care?
  o Involvement in the child welfare system typically begins through a report of suspected child neglect or abuse (Child Welfare Information Getaway, 2006).
  o Reports made are investigated, usually through a public agency such as a state's department of child and family services. If a report is substantiated, a course of action is determined.
  o Depending on the level of risk (no-low-moderate-high) to the child and if in-home services are deemed insufficient to alleviate the concern, the child is removed from the home and placed with other family members or in a foster home.

- o What happens once a child is placed in care? The foster care caseworker conducts an initial intake session and develops an **individual service plan** and a **permanency plan**. These plans include goals for both the child in foster care, and for the birth families to prepare for the child's eventual return.
- o An initial medical assessment will take place within five days of entry into foster care. Mental health is referred on a case-by-case basis, as deemed appropriate by the foster parent, department, and the attending physician.
- o Department of Human Resources (DHR) convenes a Family Team meeting (composed of family members, caregivers, relevant community members, even child/youth) to communicate and collaborate regarding: forming a plan for treatment and placement. These meetings occur at three major junctures: 1) after initial referral into the foster care system; 2) when a child/youth is transitioning from one placement to another; 3) when a child/youth is anticipating being reunified with his/her birth family.

- ➢ What are the possible mental health needs of children in foster care?
  - o In addition to whatever abuse or neglect they have suffered, children in foster care experience a great deal of emotional stress as a result of being removed from their homes.
  - o About 30% of children in foster care have severe emotional, behavioral, or developmental problems (American Academy of Child & Adolescent Psychiatry, 2008)
  - o It is important for caregivers and caseworkers to be aware of possible mental health issues, and to know how to seek help for these issues. Foster care caseworkers should collaborate with mental health providers within the school or community in order to address and treat children's mental health needs.

STEP FIVE: The following discussion questions may be used with small groups or with one large group. Provide participants with the possible prompts below to spark discussion.

Possible Group Discussion Questions:

Is family reunification always a good goal? What are the pros and cons of this approach? For example, what do you think about children who have been abused or neglected being returned to their biological parents? What kinds of challenges face a child who is aging out of foster care? How do you think that the foster care system could best prepare a child for this eventuality?

STEP SIX: Reconvene group and review the feedback from the discussion. Use the discussion to segue into the challenges inherent in the foster care system, as well as the issues involved in developing a permanency plan.

- ➢ **Permanency Planning**
  - o Permanency planning is initiated as part of the foster care process. Once a child has entered into care, the purpose of the plan is to ensure the shortest length of stay and to develop a plan for permanent home placement in concert with the family (Anderson, 1997; Pelton, 1991).
  - o In Maryland, the goal is to place all foster children into a permanent living arrangement within a maximum of 15 months from the date they entered foster care (Maryland Department of Human Resources).
  - o The main goal of the plan is always reunification of child and family. If reunification is not attainable, then other permanency options are explored. These include:
    - ▪ adoptive home (e.g., sometimes the bond between the foster care parents and child leads to them adopting child)
    - ▪ placement with a relative (i.e., 'kinship care')
    - ▪ discharge to independent living (i.e., if the adolescent is aging out of the foster care system). For older adolescents, the foster care plan may include education and resources to prepare them for a transition to independent living.

- ➢ What are the typical outcomes at the end of foster care?
  - o Reunification with caregivers
  - o Adoption (by foster parents or outside of foster system)
  - o Discharge to independent living
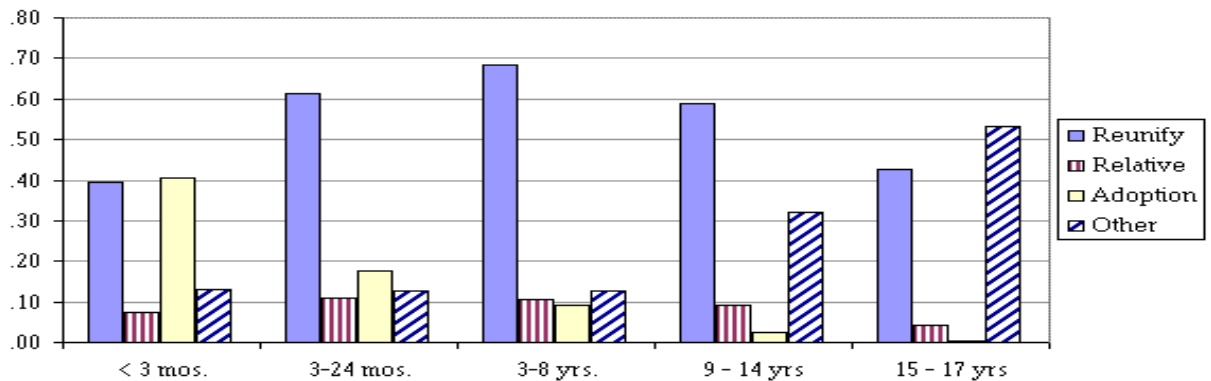
Department of Health and Human Services: Foster Care. Retrieved from http://aspe.hhs.gov/hsp/fostercare-reunif01/figB1.gif.
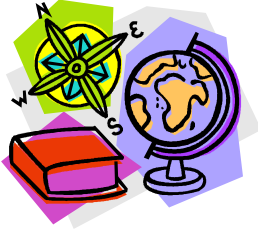
What You Need to Know

STEP SEVEN: Provide a summary of the key learning points as a take home message for participants. We suggest giving the answers to the "Test Your Knowledge" items from the beginning of the session and using those questions to review and discuss the key learning points.

Summary of the Learning Points

1. Involvement in the child welfare system typically begins through a report of suspected child neglect or abuse. (**True**)
   a. Explanation: Although some children enter the foster care system voluntarily (e.g., primary caregivers are absent on a short term basis, child needs intensive services), most children enter foster care system because they have been physically or sexually abused, neglected, or abandoned; have witnessed domestic violence; or their caregiver is incarcerated.
2. The most common type of foster care placement is court-appointed foster care with non-relatives. (**False**)
   a. Explanation: Most children in foster care are placed with either foster parents or relatives ("kinship care"). Some may be placed in group homes.
3. The ultimate goal of foster care is family reunification when feasible. (**True**)
4. Permanency planning is initiated after a child has been in the foster care system for 12 months. (**False**)
   a. Explanation: Federal law requires the court to hold a permanency planning meeting *within* 12 months of the child's placement, and every 12 months thereafter. Maryland's Department of Human Resources dictates that permanency planning begins "the moment you (the child) comes into care". Permanency planning meetings or hearings involves the child, the biological family, the caseworker, and sometimes the court. Moreover, in Maryland, permanency planning court hearings occur every *six* months.

Moving Towards Action

Ideas to Apply What You've Learned in your Mental Health or Child Welfare Practice:

- I can review the foster care process as a means to inform my work with children and youth in foster care.
- I can think about children/youth that I already work with who are in foster care and begin to learn more about their permanency plan.

Practical Resources

- o Factsheet about how the Child Welfare System Works: http://www.childwelfare.gov/pubs/factsheets/cpswork.cfm
- o Facts on Foster Care for Families, from the American Academy of Child and Adolescent Psychiatry: http://www.aacap.org/cs/root/facts_for_families/foster_care
- o Maryland Statistics on Children in Foster Care: http://www.fostercaremonth.org/AboutFosterCare/StatisticsAndData/Documents/MD-Facts-FCM07.pdf
- o National Statistics on Foster Care from the U.S. Department of Health and Human Services: http://www.acf.hhs.gov/programs/cb/stats_research/afcars/tar/report10.htm

Putting It All Together

This section includes a power point that can be used when presenting this module in a training session.

HANDOUT 1.1

Statistics in Maryland (Based on 2003 Statistics):

General Statistics

- ❖ Total population: 11,521

- ❖ Age (Average: 11.4 Years)
  - 4% <1 year
  - 19% 1-5 years
  - 19% 6-10 years
  - 33% 11-15 years
  - 20% 16-18 years
  - 6% ≥ 19 years

- ❖ Male: 53%   Female: 47%

Race/Ethnicity

Race/Ethnicity population	In out-of-home care	In state child
Black (non-Hispanic)	75%	32%
White (non-Hispanic)	20%	56%
Hispanic	2%	5%
Am. Indian/Alaska Native	0%	0%
Asian/Pacific Islander	0%	4%
Unknown	1%	N/A
2 or more races (non-Hispanic)	1%	3%

HANDOUT 1.1 CONTINUED

Additional Statistical Items

Length of stay
- ❖ The average length of stay for children in care on September 30, 2003 was 48 months.

Reunified
- ❖ Forty-one percent of the young people leaving the system in FY 2003 were reunified with their birth parents or primary caregivers.

Foster home
- ❖ In 2002, there were a total of 4,440 licensed kinship and non-relative foster homes in Maryland
- ❖ On September 30, 2003, 35% of youth living in out-of-home care were residing with their relatives.

Adoption
- ❖ Of children with state agency involvement adopted in FY 2003, 56% were adopted by their non-relative foster parents and 40% were adopted by relatives.

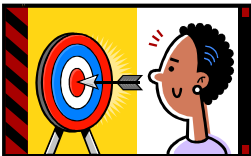# Mental Health Needs of Children in Foster Care

STEP ONE: Present the "Test Your Knowledge" questions below and have participants write down their answers. Tell the participants that you will provide the answers at the end of the session.
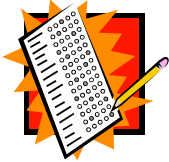
Test Your Knowledge: True or False

1) Trauma that a child in foster care experiences and may need help with stem from his or her life stressors prior to entering foster care. (**T/F**)
2) All children and adolescents in foster care should be referred for more intensive mental health services. (**T/F**)
3) Children in foster care are at the same risk of mental health problems as other children in high-risk family situations, such as those living in poverty. (**T/F**)
4) Before assessing and treating mental health concerns, it is important to give children in foster care time to adjust to their new home placement **(T/F).**

STEP TWO: Provide the participants with the learning objectives for the session.

Lesson Objectives

Participants will be able to:
1) Understand the effect of stress and trauma on children and adolescents in foster care.
2) Identify at least five signs and symptoms of mental health problems in children and adolescents.
3) Name three mental health disorders that are prevalent among children and adolescents in foster care.
4) Understand when and how to seek mental health services for children and adolescents in foster care.

STEP THREE: The following activity may be done in small groups or with the entire group. Provide participants with the prompt below for brainstorming. If possible, write their responses on a white board or chalkboard.

Activity: Brainstorm the different types of trauma and stresses that may be experienced by children and adolescents in foster care.

Possible Answers: domestic violence, drug abuse, physical or sexual abuse, neglect or abandonment, separation from one or both parents, unpredictable contact with biological families, multiple placements, lack of control over their own lives, adjustment issues, transitions

STEP FOUR: Present the content of the "Key Sections" using the Power Point provided or other presentation methods. It is highly recommended to utilize the activities in order to keep the participants engaged. The activities may be done in small groups or with the entire group.

Key Sections of Lesson & Activities

Types of Trauma Experienced by Children in Foster Care

- Children and adolescents in foster care have often experienced multiple traumatic life events that led to their foster care placement (e.g., domestic violence, drug abuse, physical or sexual abuse, neglect or abandonment).
- There is often trauma associated with being placed in the child welfare system (e.g., separation from one or both parents, unpredictable contact with biological families, multiple placements, lack of control over their own lives, adjustment issues).
- Youth in foster care often experience stress and trauma associated with transitions across families, schools, neighborhoods and communities.

The Affect of Trauma and Stress on Children and Adolescents

- Trauma and stress reduces one's sense of safety and trust, and/or leads children and adolescents to use survival strategies that may be maladaptive in school or home settings. For example, a survival strategy of self-reliance leads to a decrease in help-seeking tendencies, which further exacerbates difficulties in school and in well-being.
- Children and adolescents often have poor or nonexistent coping strategies when faced with trauma and stress. This lack of adaptive coping strategies may lead to further difficulty.
- For many children and adolescents, the accumulation of such difficult life experiences (combined with a lack of adaptive coping strategies) can contribute to the development of a mental health disorder.

Mental Health Needs of Children and Adolescents in Foster Care

- While not all youth who experience traumatic events and placement in the child welfare system need mental health treatment, many do.
- Children and adolescents in foster care are at a greater risk of mental health problems than the general population (even when compared to other youth in high risk family situations).
- If left untreated, mental health problems can escalate and lead to negative developmental outcomes.
- Thus, individuals who live or work with children and adolescents in foster care need to be aware of the important warning signs and symptoms of mental health problems.

STEP FIVE: The following activity may be done in small groups or with one large group. Provide participants with the prompt below for brainstorming.

Small or Large Group Activity: Take five minutes to make a list of ways in which mental health problems may manifest as symptoms among children and adolescents in foster care.

Possible Answers: Anger/irritability, Nightmares, Distressing memories, Sleep problems, Sadness, Hopelessness, Avoidance, Problems with attachment, Delinquency, Oppositional Behavior, Attention problems,

STEP SIX: As a large group discuss the brainstorming activity and use the results as a segue into presenting and discussing warning signs and symptoms of mental health difficulties for children and adolescents in foster care. Present the research on mental health disorders in children and adolescents in foster care. Lastly, review specific examples of warning signs and symptoms of mental health difficulties.

Warning Signs and Symptoms of Mental Health
- There are a variety of signs and symptoms that may indicate a child or adolescent is struggling with one of the mental health concerns noted above.
- Warning signs can include:
  - troubling thoughts and feelings
  - changes in behavior
  - loss of interest in activities he/she enjoyed
  - change in school functioning
  - engaging in problem behaviors
- These symptoms can point to the existence of a mental health disorder.

Research on Mental Health Disorders in Children and Adolescents in Foster Care
- 54% of children/adolescents in foster care had at least 1 mental health problem in the past year (compared to 22% of general population)
- 25% of children/adolescents in foster care exhibited Post-Traumatic Stress Disorder (PTSD) within the past year – twice the rate of U.S. war veterans!
- Other common mental health disorders include: Depression, Anxiety, Attention-Deficit/Hyperactivity Disorder (ADHD)

Let's Review Some Examples of Warning Signs:
1) Troubling Thoughts and Feelings:
   - Sad and hopeless for no reason, and these feelings do not go away
   - Very angry most of the time and crying a lot or overreacting to things
   - Frequent feelings of being worthless or guilty
   - Anxious or worried often
   - Unable to get over a loss or death of someone important
   - Extremely fearful or having unexplained fears
   - Constantly concerned about physical problems or physical appearance
   - Frightened that his/her mind either is controlled or is out of control

2) Changes in Behavior
- Showing declining performance in school
- Losing interest in things once enjoyed
- Experiencing unexplained changes in sleeping or eating patterns
- Avoiding friends or family and wanting to be alone all the time
- Daydreaming too much and not completing tasks
- Feeling life is too hard to handle
- Hearing voices that cannot be explained
- Experiencing suicidal thoughts
- Poor concentration and indecisiveness
- An inability to sit still or focus attention
- Worry about being harmed, hurting others, or doing something "bad"
- A need to wash, clean things, or perform certain routines hundreds of times a day, in order to avoid an unsubstantiated danger
- Racing thoughts that are almost too fast to follow
- Persistent nightmares

3) Problem Behaviors
- Alcohol consumption
- Substance use
- Dieting
- Excessive exercise
- Engaging in life threatening activities

STEP SEVEN: Each participant should pair up with a partner. Have each pair complete the following case study.

Case Study: Work with a partner to discuss the warning signs in the following case study. Does the child demonstrate symptoms of a mental health disorder? Note: Answers are below.

Marissa is a new 7th grade student at a local middle school and has been in the foster care system for approximately 1 year. She was placed in foster care because she was physically abused by her step-father and neglected by her mother who is addicted to drugs. Marissa can be even-tempered at times, but most of the time she is quick to anger and often has

outbursts where she will yell at other and then burst into tears. Marissa often gets into trouble at school for talking back to teachers and getting into arguments with other students in her class. She is also doing poorly in school because she reports being unable to sit still and concentrate on her work. Marissa has been labeled a "trouble-maker" and was suspended three times during the year. She responds angrily to any kind of correction or criticism from adults or peers and begins to cry when she gets angry. Marissa reports feeling like she needs to establish her reputation in her new school and often seeks out physical fights with girls who make any negative comments about her. During elementary school, Marissa was reportedly a good student who rarely got in trouble. Her irritability and aggression seems to have started when she was transitioned into foster care.

STEP EIGHT: As one large group, review the case study and Marissa's warning signs and/or symptoms. It is recommended to write these on a white board or chalkboard. Below are possible answers to the case study; however, you could come up with additional answers that are correct!

- Easily frustrated and angry
- Hyperactive
- Verbal abuse to teachers
- Peer relationship difficulties
- Academic difficulties
- Attention difficulties
- Fidgety
- Conduct problems at school – suspension
- Does not respond well to constructive criticism
- Cries easily/sad
- Irritability
- Symptoms started when she was first put in foster care

STEP NINE: Discuss with the participants what they can do once they've identified mental health needs in children and adolescents in foster care. You can discuss both prevention and treatment here!

- When a child or adolescent is displaying warning signs of a mental health disorder, it is important that they be connected to a mental health professional so that the problems do not continue to worsen.
- Even children and adolescents who are not in clinically significant distress (e.g., those that do not meet criteria for a "disorder") can benefit from prevention activities and mental health promotion.
- School mental health can provide treatment for those youth experiencing distress as well as prevention activities and mental health

promotion for those youth who are displaying resilience.

STEP TEN: Provide a summary of the key learning points as a take home message for participants. We suggest giving the answers to the "Test Your Knowledge" items from the beginning of the session and using those questions to review and discuss the key learning points.

Summary of the Learning Points

1. Trauma that a child in foster care experiences and may need help with stem from his or her life stressors prior to entering foster care. (**False**)
   Explanation: Children also experience trauma associated with their foster care placements and/or transitions (e.g., separation from one or both parents, unpredictable contact with biological families, multiple placements, lack of control over their own lives, adjustment issues).

2. All children and adolescents in foster care should be referred for more intensive mental health services. **(False)**.
   Explanation: many children and adolescents in foster care who do exhibit mental health problems, there are also many youth who are adjusting well and being successful in their lives. While most children can benefit from prevention and mental health promotion, more intensive services should be reserved for youth exhibiting more serious mental health problems.

3. Children in foster care are at the same risk of mental health problems as other children in high-risk family situations, such as living in poverty. (**False**)
   Explanation: Children in foster care are at a *greater* risk of mental health problems than the general population (even when compared to other youth in high-risk family situations).

4. Before assessing and treating mental health concerns, it is important to give children in foster care time to adjust to their new home placement **(False).**
   Explanation: If left untreated, mental health problems can escalate and lead to negative developmental outcomes. When a child or adolescent is displaying warning signs of a mental health disorder, it is important that they be connected to a mental health professional so that the problems do not continue to worsen.

STEP ELEVEN: Discuss how to move towards action and apply this module to the daily work of participants.

Moving Towards Action

Large or Small Group Activity: Brainstorm how you might be able to put this information into action.

- ◈ I can share the information I learned today, on warning signs of mental health problems, with three caregivers, teachers, or administrators.
- ◈ I can review the warning signs before I meet with a family so that I can better help the family determine if there is a need for a mental health referral.
- ◈ I can think about my current caseload and consider which warning signs of mental health problems may apply to the individuals that I am serving
- ◈ I can share this information with youth that I work with so that they can also be aware of the warning signs in themselves and in their peers.

Practical Resources

Child Welfare Trauma Training Toolkit
http://www.nctsn.org/nccts/nav.do?pid=ctr_cwtool
The *Child Welfare Trauma Training Toolkit* is designed to teach basic knowledge, skills, and values about working with children who are in the child welfare system and who have experienced traumatic stress.

Casey Family Programs:
http://www.casey.org/Resources/Publications/MentalHealthReview.htm
Published in 2006, this review surveys major findings gleaned from studies about the evidence base for mental health care and about related class action law suits. The review also outlines steps that will improve the mental health services delivered to children and youth in foster care.

http://www.casey.org/Resources/Publications/CFPYAS2006.htm
Published in 2006, the Casey Family Programs Young Adult Survey examines the quality of life reported by youth formerly in foster care. The survey covers several areas, including mental health, education, employment, life skills, living situation, physical health/substance abuse, relationships/social support, and criminal justice system involvement.

http://www.casey.org/Resources/Publications/EndlessDreams.htm
The *Endless Dreams* video showcases the great potential of schools to support and enrich the lives of youth in care. The video features a young woman in care and describes how life in foster care impacts her education. Casey Family Programs offers this 15 minute video upon request at no charge. For a copy of the video, please send e-mail to contactus@casey.org.


Putting It All Together

This section includes a power point that can be used when presenting this module in a training session.

# Connecting School Mental Health Services to Youth in Foster Care

STEP ONE: Present the "Test Your Knowledge" questions below and have participants write down their answers. Tell the participants that you will provide the answers at the end of the session.
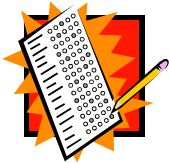
Test Your Knowledge: True or False

1) The only difference between school mental health and outpatient mental health is the location. **(T/F)**
2) School mental health services are only available to children with special education needs or mental health diagnoses. **(T/F)**
3) Most children experience some degree of mental health issues. **(T/F)**
4) School mental health services are primarily concerned with diagnosing and treating mental health issues. **(T/F)**
5) School mental health services can improve access to mental health services for children in foster care. **(T/F)**

STEP TWO: Provide the participants with the learning objectives for the session.
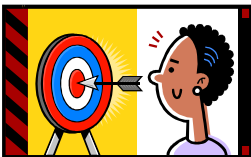
Lesson Objectives

Participants will be able to:
1) Define school mental health and understand the services provided by school mental health programs.
2) Identify children who could be served in school mental health programs.
3) Discuss three advantages of school mental health.
4) Understand how school mental health is relevant for children in foster care.

STEP THREE: The following activity may be done in small groups or with the entire group. Provide participants with the prompt below for a discussion. If possible, write their responses on a white board or chalkboard.

Activity: What is school mental health?

Answer: School mental health programs provide mental health services for children within a school setting. School mental health programs embrace the school culture and collaborate with the school system to help children succeed academically and promote healthy social-emotional well-being and positive behaviors. See

STEP FOUR: Present the content of the "Key Sections" using the Power Point provided or other presentation methods. It is highly recommended to utilize the activities in order to keep the participants engaged. The activities may be done in small groups or with the entire group.
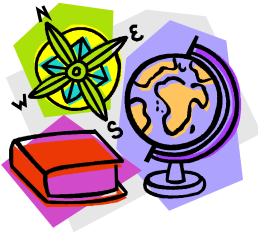
Key Sections of Lesson and Activities

What is school mental health?
- School mental health clinicians provide a full continuum of mental health services for children and adolescents, and are based within a school setting.
- The goal of school mental health is to reach all children, teachers, and administrators at the school by providing universal and prevention activities as well as more targeted intervention services, professional development for school staff, and staff consultation.

Why provide mental health services in schools?
- Most children experience some degree of mental health issues (e.g., anxiety about school performance, unhealthy peer pressure, grief and bereavement, depression, etc.). In fact, approximately 20% to 38% of youth in the United States have diagnosable mental health disorders.

- Unfortunately, only between one-sixth to one-third of youth with diagnosable mental health disorders actually receive treatment.
- Since children are already in schools for the majority of the day, schools provide the most natural and convenient setting for addressing mental health issues.
- Lastly, mental health issues affect students' school performance and engagement. Mental health is directly linked to educational outcomes.

Who provides school mental health services?

- School mental health services may be provided by school employees or providers who are employed by an outside agency (hospital, outpatient mental health center).
- Although some school mental health clinicians are employed by outside agencies (i.e., not school employees), they are located within the school, and more importantly, they embrace the school culture. For example, clinicians participate in committees, team meetings, parent-teacher organizations, etc., and work collaboratively with school staff to develop healthy learning environments that promote academic, social, emotional, and behavioral well-being.
- School mental health clinicians have various training and backgrounds. Most commonly, school mental health clinicians are social workers, psychologists, school counselors, and licensed clinical practicing counselors.
- Most often, several professionals at the school building provide school mental health services to students and ideally these individuals collaborate and work as a team.

STEP FIVE: Each participant should pair up with a partner. Have each pair complete the following case study.

Case Study: In a team meeting, you hear about a student named Jacob. Work with a partner to discuss how to proceed with this student. More specifically, discuss your thoughts about the appropriateness of referring Jacob for school mental health.

Answer: Although Jacob seems resilient and has many strengths, he has experienced a lot of loss and transitions in his life. Even though he performed well in 5th grade, he may be experiencing emotional distress in 6th grade. It's best to refer Jacob for an evaluation in order to determine if he would benefit from services.

Jacob is a 6th grade student at a middle school and has been in the foster care system for over one year. He was placed in foster care during 5th grade because his father is in prison for violating his probation by stealing a car. Unfortunately, Jacob's mother passed away when he was two years old. Although Jacob has experienced many difficult situations, his 5th grade teachers said that he is well-adjusted, intelligent, and a "star student." At the beginning of 6th grade, Jacob's teachers report that he is not completing class work or homework. Some of the teachers think he just needs to adjust to middle school and the larger workload; however, one of the teachers thinks that Jacob may need to "talk to someone."

What services are provided by school mental health?
- School mental health services are intended to address behavioral and emotional difficulties and promote students' academic success and emotional well-being.
- School mental health clinicians provide a full continuum of mental health services including:
  - After-school recreational and enrichment activities
  - School-wide mental health promotion
  - Classroom and small group prevention activities
  - Group therapy (for youth with similar emotional or behavioral concerns)
  - Individual therapy
  - Family therapy
  - Parent support sessions
  - Teacher consultation
  - Mental health evaluation
  - Assistance with outside mental health referrals for more severe cases
  - Consultation with outside providers (e.g., physicians, psychiatrists)

What types of children can participate in school mental health?
- Children of all ages and grades who are in regular or special education can participate.
- Mental health services are utilized by children with a range of concerns from typical developmental issues (e.g., peer relationships, healthy identity development) to severe behavioral disorders (e.g., Major Depressive Disorder, Conduct Disorder).

STEP SIX: The following activity may be done in small groups or with one large group. Provide participants with the prompt below for brainstorming.

Small or Large Group Activity: Take five minutes to brainstorm how school mental health relates to children in foster care?

Possible Answers: Children in foster care have difficulty accessing mental health services, so school mental health can provide easier access to care; children in foster care have higher rates of mental health difficulties than even other high-risk groups; etc.

How is school mental health related to children and adolescents in foster care?

- Children and adolescents in foster care experience more mental health issues than other high risk groups.
    - 54% of children and adolescents in foster care had one or more mental health problems in the last 12 months (compared with 22% of the general population).
    - 25% of children and adolescents in foster care have Post-Traumatic Stress Disorder (PTSD) within the past 12 months. This is twice the rate of U.S. war veterans (Pecora et al., 2005).
- Children and adolescents in foster care may not access the mental health services they need for a variety of reasons (e.g., childcare issues of the foster parent, transportation, distance, wait lists).
- Children and adolescents who must travel off-site to seek services (e.g., community mental health outpatient clinic) also disrupt their time in the classroom, which has negative effects on their academic performance.
- When children and adolescents in foster care do access services, they still experience interruptions and discontinuity in their mental health care (e.g., staff turnover, multiple providers involved in the intake process).
- School mental health services can help to address some of the access issues faced by children and adolescents in foster care.
    - In a study by Catron, Harris, and Weiss (1998), in which consecutive children were referred either to school-based programs or to a community mental health program, 96% of children referred to school-based mental health services

receive treatment; only 13% of children referred to a community agency receive treatment.

- By providing school mental health services, children in foster care will likely have improved continuity of care and access to services is easier. For example, school mental health can help:
    - communicate with teachers to identify and address mental health concerns that interfere with the learning process.
    - build a relationship of trust with the child and increasing children's sense of school connectedness.
    - reduce distance and travel barriers to receiving care.

NOTE: In Module 4, one of the key lessons is how to help promote mental health in youth in foster care in the schools. You may wish to present these modules together.

STEP SEVEN: The following activity may be done in small groups or with one large group. Provide participants with the prompt below for brainstorming.

Activity: Discuss the advantages and disadvantages of school mental health services. Brainstorm about ways that children in foster care might benefit from the available options. Think about the range of services that can be provided (e.g., assessment, prevention, or treatment).

What are some advantages of school mental health services?
1. Enhanced access (including the ability of the child/adolescent to be seen each school day)
2. Reduce stigma by providing a full continuum of services within the school setting. Since the school mental health clinician is involved in mental health promotion, prevention, and intervention activities, a foster child's connection with the provider would not necessarily indicate that they are being treated.
3. Ability of the clinician to help manage crises that may occur related to the child/adolescent in the moment.

4. Opportunities for observation and implementation of skills in a natural setting.
5. School mental health clinicians can communicate regularly with teachers and parents and/or guardians about child's successes and challenges in both academic and social-emotional/behavioral domains.
6. School mental health clinicians have the skills and knowledge to coordinate community and education services for children.

What are some disadvantages of school mental health services?
1. Most of the time, children are excited to meet with the clinician; however, some children may not enjoy being pulled out of class and other children may be embarrassed to meet with the provider. While clinician maximize pulling children and adolescents out of non-academic time, have shorter sessions times available (20-30 minutes), and rotate schedules so that the same class is not always interrupted, it still results in a child missing some school time.
2. Since sessions are during the school day, children are often seen without their foster care parent and/or legal guardian present. (Although regular contact with parents and guardians is necessary and strongly encouraged).
3. In the event that the child or adolescent transfers schools, he or she would need to transfer to a new school mental health clinician (if the services were available).

What are some common strategies to overcome barriers to engaging in school based prevention?

- School mental health programs encounter some challenges related to resources. For example, lack of financial resources, limited staff, inadequate space, inadequate capacity to meet the needs of students, time limitations related to school schedules (shortened day, holidays/vacations)
- The key to overcoming these barriers may be to foster collaboration across school-based staff and community programs and businesses. This requires outreach and networking with other professionals a school site, in the district, and other mental health programs. One extremely productive mechanism is a coordinating team consisting of mental health professionals and interested school staff and community members.
- Daily interaction and weekly meetings to facilitate essential sharing and collaboration among team members.
- To connect mental health professionals and other interested staff from schools located near each other, bimonthly meetings and periodic

workshops addressing foster care needs and mental health concerns are invaluable.

- Maintaining a good working relationship with all team members brings rewards that are immense. Such networking stimulates cooperation and coordination; it also generates support and ideas for improving both the quality and quantity of school based mental health interventions. Ironically, it often is the case that individuals who are too busy to take an hour to meet and plan spend countless hours trying to clean up.

STEP EIGHT: Provide a summary of the key learning points as a take home message for participants. We suggest giving the answers to the "Test Your Knowledge" items from the beginning of the session and using those questions to review and discuss the key learning points.

Summary of the Learning Points

1. The difference between school mental health and outpatient mental health is the location. **(False)**
   Explanation: The goal of school mental health is to become a vital part of the school culture, and to reach *all* children, teachers, and administrators at the school by providing universal and prevention activities as well as more targeted intervention services.
2. School mental health services are only available to children with special education needs or mental health diagnoses.   **(False)**
   Explanation: Children of all ages and grades who are in   regular or special education can participate.
3. Most children experience some degree of mental health issues. **(True)**
   Explanation: Most children experience some degree of mental health issues. About 20% to 38% of youth in the United States have diagnosable mental health disorders.
4. School mental health services are primarily concerned with diagnosing and treating mental health issues. **(False)**
   Explanation: School mental health services range from classroom and school-wide prevention activities and group counseling to more targeted diagnosis and treatment for individual mental health issues. Moreover, mental health services are utilized by children with a range of concerns from typical developmental issues (e.g., peer relationships, healthy identity development) to severe

behavioral disorders (e.g., Major Depressive Disorder, Conduct Disorder).

5. School mental health services can improve access to mental health services for children in foster care. **(True)**

STEP NINE: The following activity helps participants to think about how to begin to talk with schools around school mental health services for children in foster care. This activity can be done in pairs or small groups.

Moving Towards Action

Activity: Pair off and create a sheet of questions to use to inquire about what mental health services and other forms of student support (e.g. Student Support Teams) might be available in a school, as well as the steps required to link the child or adolescent with those services. **Answers will vary here depending on the school system.**

Additional Optional Activity: Discuss how you would help a child or adolescent get connected with a school mental health clinician.

Possible Answers: Inquire about the availability of school mental health services at your schools and provide this information to your child and his/her foster care parents; refer the child to the school mental health provider; schedule a team meeting with the teachers and counselors at your child's school to discuss mental health services; share the information below *Educational Advocacy Curriculum* or *Advocating in School for the Children in your Care* under Practical

Practical Resources
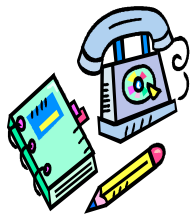
Advocating in School for the Children in Your Care
http://www.nfpainc.org/uploads/Advocating_in_School_for_the_Children_in_Your_Care.pdf
This brief article from the National Foster Parent Association and Casey Family Programs is aimed towards foster parents, and gives tips on how to become educational advocates for the foster children and youth in their care.

Educational Advocacy Curriculum
http://www.nfpainc.org/uploads/EDUCATIONAL_ADVOCACY.pdf
This training encourages and prepares foster parents to become educational advocates for the foster children and youth in their care. It is designed for foster parents and social workers.

Child Welfare Trauma Training Toolkit
http://www.nctsn.org/nccts/nav.do?pid=ctr_cwtool
The *Child Welfare Trauma Training Toolkit* is designed to teach basic knowledge, skills, and values about working with children who are in the child welfare system and who have experienced traumatic stress.

School Mental Health.org: *www.schoolmentalhealth.org*
This website provides information and fact sheets on children's mental health for providers, educators, families and youth. Specific information about mental health for youth in foster care is also available at this site.

Casey Family Programs:
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## Putting It All Together

This section includes a power point that can be used when presenting this module in a training session.

# Helping Youth in Foster Care to Transition to and Be Successful in School

STEP ONE: Present the "Test Your Knowledge" questions below and have participants write down their answers. Tell the participants that you will provide the answers at the end of the session.
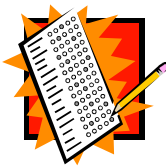
Test Your Knowledge: True or False

1) Most children in foster care are resilient and easily adapt to their changing home placements. **(T/F)**
2) Children in foster care do not need any special assistance with transitioning to a new school. They just need to have time to adjust. **(T/F)**
3) Teachers should always talk to children in foster care about their personal life and foster care experiences. **(T/F)**

STEP TWO: Provide the participants with the learning objectives for the session.
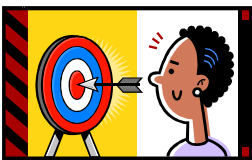
Lesson Objectives

Participants will be able to:
1) Discuss three challenges that children and adolescents in foster care face at school.
2) Identify three strategies to help children and adolescents in foster care transition to their new school.
3) Identify three classroom strategies to share with teachers who have students in foster care.

STEP THREE: Present the content of the "Key Sections" using the Power Point provided or other presentation methods. It is highly recommended to utilize the activities in order to keep the participants engaged. The activities may be done in small groups or with the entire group.

Key Sections of Lesson & Activities

What are some challenges at school for children and adolescents in foster care?
- Youth in foster care typically move placements or homes on average of three times during their time in care, which also mean they have changes in school placements. In addition to adjusting to a new family and community, frequent moves also require the youth to adjust to new peers, teachers, school culture, and curricula.
- Often, youth in foster care are enrolled in new schools prior to the school having adequate information about their academic needs.
- Due to the trauma they have experienced, many youth in foster care may have poor peer relationships and social skills. This can lead to peer rejection, which is often related to poor school achievement.
- This instability in schooling and lack of coordination and effective partnership between school, students, and families can lead to (a) declines in academic skills, (b) higher drop out rates, and (c) grade retention for youth in foster care.

STEP FOUR: The following activity may be done in small groups or with the entire group. Provide participants with the prompt below for a discussion. If possible, write their responses on a white board or chalkboard.

Activity: Discuss your organization's process to facilitate a smooth transition to a new school for youth in foster care. Groups can create a flow chart or visual representation of their organization's process for school transitions. What aspects of that process are effective? What aspects of that process need to be improved upon?

(If your organization does not have a school transition process, how would you implement a formal process at your organization and what steps need to be a part of the new enrollment/transition process? Brainstorm and construct a process (flow chart)

How can you help youth in foster care have a smooth transition to new schools?

- Make every effort to ensure that the student's school record is transferred to the new school before the student arrives.
- Obtain information from the student's current school prior to the student's transition. Ask about student strengths and successes as well as challenges. If possible find out what strategies have been successful with the student. Share this knowledge with the new teachers.
- Identify a support person (e.g., school mental health clinician, school counselor, school psychologist, teacher, assistant principal) upon entry into the new school so that the student has someone that he or she can talk to if problems arise.
- Identify a strong student who can serve as a "buddy" or "peer mentor" who can help the student find his/her way around the new school, answer questions, and provide peer support.
- Take the time to get input from and assistance in developing a support plan from the adult supports involved in the child's life.
- Establish policies that facilitate information sharing between the school and foster care workers/other agencies and programs working with the child.
- Consider development of specific guidelines that outline the roles and responsibilities that support staff and foster care parents should have when enrolling students in a new school and to ensure continued success in school.

How can you help youth in foster care succeed at school (even after the transition)?
- Foster parents and school mental health providers should have regular contact with the student's teachers.
- Encourage foster parents to advocate for student educational and social/emotional/behavioral needs. Ensure that relevant educational laws and resources are shared.
- Provide each student in foster care with an educational advocate who can continually work with the student, despite changes in placement, and effectively advocate for the student's educational needs.
- Identify students in foster care who may be in need of special education services. Work collaboratively to see if more intensive services are needed and develop action plans for implementing interventions/supports for the child.
- Refer the child to the Child Study Team for more intensive evaluation if needed.

- Start providing the adequate academic supports early (e.g. tutoring, enrichment programs, state achievement test preparation, ACT/SAT preparation, college tours, job fairs).
- Consider enhancing an existing school or organization newsletter to provide information to staff on typical experiences of youth in foster care, as well as ways in which school staff can support them. An example of a newsletter developed by the National Foster Care Month on what teachers/educators can do to support students in foster care can be found: http://www.fostercaremonth.org/GetInvolved/Toolkit/Support/Documents/What_Teachers_and_Educators_Can_Do.pdf

STEP FIVE: The following activity may be done in small groups or with one large group. Provide participants with the prompt below for brainstorming.

Activity: What can you do differently at your school(s) to help school staff improve understanding of how best to work with students in foster care? Think of a child you've worked with who was or is in foster care, how could their educational experience be improved? Use this activity as a segue for the next key lesson on classroom strategies for youth in foster care.

What classroom strategies can you suggest for teachers who work with youth in foster care?
- Maintain consistency and structure in the classroom. Youth in foster care have already experienced a significant amount of transition and unpredictability. School staff can assist these youth by remaining consistent and providing structure in the classroom. For example, notifying youth in advance of changes that will take place in their daily routine will help them as they learn to adjust in a new environment.
- Inform school staff of the need to respect the student's privacy. While it is helpful for school staff to know which children are in foster care, they should not assume the student wants to discuss aspects of their transition or family situation with them. A teacher should let his/her students know that he or she is available to talk if needed.
- Helping school staff understand signs of mental health issues and unique concerns for children in foster care is critical.

- School staff needs to remain sensitive to the student's living situation. As school staff creates assignments, they should communicate with the student and/or foster care parents. For example, giving an assignment that requires bringing in family photos or creating a family tree can be an overwhelming task for a student in foster care.
- School staff needs to be sensitive of the language used when communicating with the student. For example, saying that the student does not have any "real parents" or assuming that the student no longer desires to have a connection with his or her birth parents can result in negative feelings on behalf of the student.

STEP SEVEN: Provide a summary of the key learning points as a take home message for participants. We suggest giving the answers to the "Test Your Knowledge" items from the beginning of the session and using those questions to review and discuss the key learning points.

Summary of the Learning Points

1) Most children in foster care are resilient and easily adapt to their changing home placements. **(False)**
   Explanation: While some foster care youth may easily adapt to a changing placement, most foster care youth find it challenging to adapt to a new placement. At the same time that they are contending with the trauma behind a foster care placement, they are having to adjust to a new school, home environment, foster family, community, etc.
2) Children in foster care do not need any special assistance with transitioning to a new school. They just need to have time to adjust. **(False)**
   Explanation: Due to the trauma they have experienced (both prior to placement, and during placement due to transitions), children in foster care may benefit from additional supports within the school to ensure that they will have positive academic and social-emotional outcomes. Teachers should always talk to children in foster care about their personal life and foster care experiences. **(False)**
   Explanation: Teachers should be aware of the need to respect the student's privacy, and should not assume the student wants to discuss aspects of their transition or family situation with them. A teacher should let their student know

that he or she is available to talk if the student is interested. If the teacher notices signs of mental health issues, he/she should refer the student to a mental health professional.

Practical Resources

↓ **School Mental Health.org:** *www.schoolmentalhealth.org* This website provides information and fact sheets on children's mental health for clinicians, educators, families and youth. Specific information about mental health for youth in foster care is also available at this site.

↓ Additional tips for teachers and parents regarding classroom assignments and effective communication can be found in the PowerPoint presentation that was developed by the University of Massachusetts Center for Adoption Research and can be found here: http://www.umassmed.edu/uploadedFiles/Adoption%20in%20%20 the%20classroom.pdf

↓ The Vera Institute of Justice developed a toolkit, "Foster Children and Education: How you can create a positive educational experience for the foster child" that can be used by caseworkers and teachers. The toolkit can be downloaded at http://www.vera.org/publications

↓ *http://www.casey.org/Resources/Publications/EndlessDreams.htm* The *Endless Dreams* video showcases the great potential of schools to support and enrich the lives of youth in care. The video features a young woman in care and describes how life in foster care impacts her education. Casey Family Programs offers this 15 minute video upon request at no charge. For a copy of the video, please send e-mail to contactus@casey.org.

Putting It All Together

This section includes a power point that can be used when presenting this module in a training session.

# Successful Strategies for Promoting Collaboration and Coordinated Service Delivery

STEP ONE: Present the "Test Your Knowledge" questions below and have participants write down their answers. Tell the participants that you will provide the answers at the end of the session.
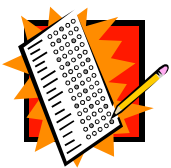
Test Your Knowledge: True or False

1) School staff members often have little knowledge of a child's foster care status. **(T/F)**

2) A lack of understanding of roles played by adults who live and work with foster care students (e.g., child welfare caseworkers, educators, mental health providers, families) serves as a major barrier to collaboration. **(T/F)**

3) Maryland has recently instituted Family Team Decision-Making meetings, which are meant to convene birth and foster families, caseworkers, and other service providers to collaborate in the decision-making and treatment planning processes. **(T/F)**

STEP TWO: Provide the participants with the learning objectives for the session.
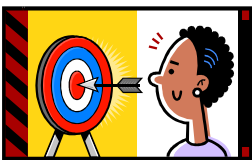
Lesson Objectives

Participants will be able to:
1) Describe common barriers that can impede collaboration among adults who live and work with children and youth in foster care, including confidentiality concerns, lack of clear understanding of

roles, and lack of collaborative meetings and/or coordinating liaison.

2) Discuss the advantages and disadvantages of having school mental health clinicians act in liaison roles to improve communication and collaboration across systems of care.

3) Describe the purpose and major components of Family Team Decision-Making (FTDM).

STEP THREE: The following brainstorming activity may be done in small groups or with the entire group. Provide participants with the prompt below for a discussion. If possible, write their responses on a white board or chalkboard.

Brainstorm: Brainstorm examples whereby children in foster care may be impacted by a lack of communication and collaboration among service providers – e.g., between the school and child welfare systems, between biological and foster families.

Some possible examples:

- Child welfare worker may be unaware of child's disruptive behaviors in school, and may not be sufficiently aware of child's academic issues.

- Teachers may not understand why a child is missing school time (e.g. for a scheduled custody hearing)

- Child welfare worker may not be contacted regarding a child's referral to special education, and so may miss taking part in the IEP process.

- Foster families may benefit from the birth families' expertise regarding the strengths and needs of their children

STEP FOUR: Present the content of the "Key Sections" using the Power Point provided or other presentation methods. It is highly recommended to utilize the activities in order to keep the participants engaged. The activities may be done in small groups or with the entire group.
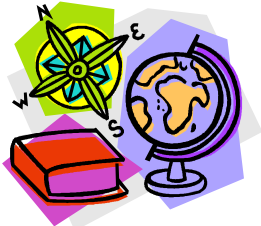
Key Sections of Lesson and Activities

> **Children in foster care are nested within several systems:**
>   o Child welfare services
>   o School system
>   o Parents (foster & biological)
>   o Mental health services (school or off-site)
>   o Juvenile services (more often for middle and high school age students)

*When these systems do not coordinate or communicate well, children's academic success and emotional well-being can be negatively impacted.

> ***"Good foster care comes out of respectful and creative collaboration"* (Annie E. Casey Foundation)**
>   o between birth and foster families
>   o between child welfare and educational systems

> **Barriers to Collaboration and Communication Across Systems of Care Can Include:**
>   o Confidentiality concerns lead to a lack of transparency across systems.
>   ▪ e.g., Schools are not often aware of child's foster care status and possible mental health needs.
>   ▪ e.g., Child welfare caseworkers are not sufficiently informed regarding children's academic issues.
>   o Unclear lines of responsibility and accountability for children's educational outcomes.
>   o Lack of a designated point person or joint meetings to facilitate collaboration or communication across systems.

> **Research Studies Illustrate the Problems Related to a Lack of Collaboration Across Systems**
>   o A study in the Journal of Social Work (Altshuler, 2003) uncovered the adversarial relationships that often exist between child welfare caseworkers and educators due to a perceived lack of communication and collaboration. Focus group interviews with both participant groups revealed the following problems:

- *Lack of understanding regarding confidentiality constraints*
  - Educators often felt that caseworkers withheld vital information.
  - Caseworkers were upset at being asked to disclose what they felt was confidential, "nonessential" information.
- *Lack of communication*
  - Educators were frustrated that they don't know who their foster kids are.
  - Case workers felt disincluded from educational processes, e.g. when child gets referred for special education and child welfare worker is not called to weigh in.
- *Perceived lack of caring or commitment to students*
  - Educators believed that child welfare workers were not truly involved in child's life and did not understand what was really going on.
  - Caseworkers felt that schools were not committed to working with children in foster care, especially those with behavior problems.
- *Lack of mutual trust*
  - Educators felt that caseworkers would make assumptions about child's progress in school without really knowing what was going on.
  - Caseworkers expressed frustration that schools had lower academic expectations for children in foster care.

o A research study that focused on the *children's* perspective in foster care indicated a number of problems related to coordination and communication among different systems of care (Finkelstein, Wamsley, & Miranda, 2002).
  - Many children reported that teachers and administrators did not understand the bureaucratic processes of foster care – like foster-care related appointments and/or the need to make up missed schoolwork.
  - Children also reported delays in registering for school because the school administration was not structured to accommodate the needs of children and adolescents in foster care.
o Another study (Finkelstein, Wamsley, & Miranda, 2002) concluded that schools, child welfare agencies and other

service providers typically do not coordinate or share information. This lack of coordination is due to confidentiality issues as well as stakeholders' assumption that each has a distinctly separate role within the child's life, as well as time constraints. The following examples illustrate the impacts of lack of information-sharing:

- *School Staff*
  School staff often have little knowledge of child's background (or even foster care status), and thus are not aware of how a child's previous experiences may influence classroom behavior or threaten academic achievement. They also are not sufficiently informed as to how the demands of the foster care system (e.g., medical appointments, court appearances, etc) can cause children to miss tests or class time.
- *Caseworkers*
  Caseworkers are primarily concerned with children's safety needs - and may attend to school situation only when there is a school crisis. Moreover, caseworkers do not have easy access to a child's educational records. Thus, caseworkers are often not sufficiently aware of a child's educational issues (including academic, behavioral, and emotional needs identified in the school setting).

***As a result, children in foster care often lack a consistent knowledgeable adult who can advocate for them across areas related to their academic success and social-emotional-behavioral well-being.

- ➢ **Impact of Confidentiality Requirements Upon Collaboration and Coordinated Service Delivery**
  - o Confidentiality requirements emerge from federal and state statutes, child welfare agency regulations, and professional mandates.
    - Ex. A child's foster care status is not included in the student record.
    - Ex. Information concerning the abuse or neglect of a child must NOT be part of the student record.
    - Ex. A caseworker must have official authorization from the local department of social services, or from the foster parents, in order to inspect and review a child's educational record.

- o These statutes are meant to protect the privacy of children in foster care, but can unintentionally strangle communication among different systems on important issues re: the child's academic progress and emotional well-being.
- o In Maryland, strategies are being implemented to simultaneously address the need to protect privacy and improve information-sharing (ex. Family Team Decision Making, described below)
- o *What is our challenge?* Learn how to collaborate effectively without breaking trust with clients.

STEP FIVE: The following activity may be done in small groups or with the entire group. Provide participants with the prompt below for brainstorming. If possible, write their responses on a white board or chalkboard.

Brainstorm: Brainstorm different ways that you might achieve a balance between respecting the privacy of children in foster care, while still attempting to ensure that they receive attention for possible mental health issues. Discuss how child might perceive the pros and cons of teachers knowing about their foster care status.

- ➢ **Ideas to Increase Collaboration Across Systems and Within the School Setting**
  - o *Improve Within-School and School-Community Collaboration*
    - ▪ Integration of mental health services, and community resources. This requires outreach and networking with other professionals at a school site, in the district, and other mental health programs. One extremely productive mechanism is a coordinating team consisting of mental health professionals and interested school staff and community members.
    - ▪ Daily interaction and weekly meetings facilitate essential sharing and collaboration. To connect mental health professionals and other interested staff from schools located near each other, bimonthly meetings and periodic workshops addressing foster care needs and mental health concerns are invaluable.

- *Strengthen School-Caseworker Collaboration*
    - Hold routine collaborative meetings to develop plans to address students' needs. These joint plans should specifically address what the caseworker and school staff will do.
    - Identify a supportive liaison that can advocate for the child across the different systems (e.g., school mental health provider, school social worker, etc.)
    - Hold periodic workshops addressing foster care needs and mental health concerns.

- *Improve School-Parent Collaboration*
    - Schools should provide a warm and welcoming climate, and should effectively communicate information re: available mental health services to both foster parents and caseworkers
    - Invite parents to participate in joint collaborative meetings including educators, caseworkers, mental health clinicians, and even the foster child if they are of an appropriate age.

- *Benefits of Collaboration*
    - Frequent interaction and meetings facilitate essential sharing and collaboration.
    - Maintaining a good working relationship with team members (e.g., children, parents, educators, mental health clinicians, community members) brings immense rewards. Such networking stimulates cooperation and coordination; it also generates support and ideas for improving both the quality and quantity of school-based mental health interventions.
    - Ironically, it often is the case that individuals who are too busy to take an hour to meet and plan spend countless hours trying to clean up.

> **Small Group Discussion:** Reflect on how your own service provision might benefit from greater collaboration. Identify and discuss both the specific benefits and the challenges of developing a more collaborative relationship across systems.

➢ **Proposed Solution: School Mental Health Providers can Act as Supportive Advocates and Liaisons Among Systems of Care**
  o School mental health service providers are well-placed to act as liaisons to improve communication and coordination among systems of care (school, child welfare agency, foster/biological parents, child), and to turn the spotlight on how to properly address children's emotional and academic needs across these systems.
  o School-based mental health providers are in a great position to increase collaboration among schools, caseworkers, and foster families! They can:
    ▪ Create better connections between school system and foster care system – bringing caseworkers' attention to emotional, academic and behavioral issues.
    ▪ Provide training for foster families in recognizing mental health issues and increasing school communication.
    ▪ Increase school staff's awareness of possible mental health and/or bureaucratic issues dealing with foster care.
    ▪ Cooperate with Student Support Services or Child Support Team to coordinate around issues and develop treatment plan for students who are identified as in need of services (i.e., special ed and/or mental health services). Can invite foster parents and caseworkers to participate in these meetings.
    ▪ Help to coordinate school transfers when necessary and make sure all available records transfer with the student.

➢ **Another Proposed Solution: Family Team Decision Making (FTDM)**

  o *What is it?* Multi-disciplinary meetings with families (birth and foster), extended families, community members, providers of services, and child welfare staff.

  o *Who developed the FTDM model?* The model was developed by the Casey Foundation's Family to Family, and is intended to institute a more family-centered approach to the foster care system, through engaging birth and foster families and relevant community members more fully in the decision-making and case-planning process.

o *Where is it being used?* FTDM is being increasingly implemented by child welfare agencies nationwide. It has recently been adapted by Maryland's DHR as part of a comprehensive effort to reform child welfare practices using a more family-centered model.

o *What is its purpose?* The goal of FTDM is to bring together all the important members of a child's life (e.g., birth and foster families, service providers, community members) to engage in case-planning and decision-making, in order to improve outcomes for the child – particularly in the areas of safety, stability, and well-being.

o *How often are meetings held?* The meetings are meant to be convened repeatedly as a tool to maintain family engagement and collaboration with child welfare caseworkers and service providers. In Maryland, meetings are supposed to be held at key transition points:
  ▪ when child is removed from home
  ▪ when child changes placements
  ▪ when family reunification is imminent

o *Who attends these meetings?*
  ▪ older children (usually over the age of 12)
  ▪ birth parents
  ▪ extended family members
  ▪ foster parents
  ▪ community members
  ▪ caseworkers
  ▪ attorneys
  ▪ therapists
  ▪ court-appointed special advocates
  ▪ other current or potential service providers

o *Who facilitates the meetings?*
  ▪ Meetings are led by a facilitator who has been trained in the FTDM approach. This facilitator is usually the caseworker or some other trained staff person at DHR.

o *What happens at these meetings?* Attendees (particularly families) are asked to identify strengths and needs of children and families, with the intent to develop, implement,

and evaluate a plan of action that leads towards positive life outcomes for the child.

STEP TEN: Provide a summary of the key learning points as a take home message for participants. We suggest giving the answers to the "Test Your Knowledge" items from the beginning of the session and using those questions to review and discuss the key learning points.

1. School staff members often have little knowledge of a child's foster care status. **True**
2. A lack of understanding of roles played by adults who live and work with foster care students (e.g., child welfare caseworkers, educators, mental health providers, families) serves as a major barrier to collaboration. **True**
3. Maryland has recently instituted Family Team Decision-Making meetings, which are meant to convene birth and foster families, caseworkers, and other service providers to collaborate in the decision-making and treatment planning processes. **True**

Moving Towards Action

Ideas to Apply What You've Learned in your Mental Health or Child Welfare Practice:

◈ I can identify the ways in which a school-based mental health provider could serve as a liaison to increase communication and collaboration across systems of care.

◈ I can learn about and offer information to foster care caseworkers and parents about the best ways to communicate with and gather information from the school at which I work (e.g., scheduling, consent forms, and how to meet with teachers).

◈ I can increase school's staff awareness about the mental health and bureaucratic issues that arise with children in foster care.

Practical Resources

Mythbusting: Breaking Down Confidentiality and Decision-Making Barriers to Meet the Education Needs of Children in Foster Care
http://www.abanet.org/child/education/mythbusting2.pdf (free download)
Mythbusting is an online, searchable publication that addresses the issues surrounding confidentiality and other barriers that arise when advocating for the educational rights of young people in care.

School Mental Health.org: *www.schoolmentalhealth.org*
This website provides information and fact sheets on children's mental health for clinicians, educators, families and youth. Specific information about mental health for youth in foster care is also available at this site.

Casey Family Programs:
http://www.casey.org/Resources/Publications/MentalHealthReview.htm
Published in 2006, this review surveys major findings gleaned from studies about the evidence base for mental health care and about related class action law suits. The review also outlines steps that will improve the mental health services delivered to children and youth in foster care.

Family Team Decision Making (FTDM):
http://www.acy.org/upimages/FTDM_Issue_Brief.pdf
This issue brief describes the evolution of FTDM, the differences between FTDM and traditional practice, and the reasoning behind this increasingly team-oriented, family-centered approach.

Putting It All Together

This section includes a power point that can be used when presenting this module in a training session.

School Mental Health and Foster Care:
## A Public Health Perspective

STEP ONE: Present the "Test Your Knowledge" questions below and have participants write down their answers. Tell the participants that you will provide the answers at the end of the session.
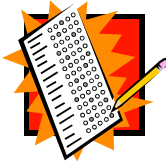
| Test Your Knowledge: True or False |

1) All children in foster care can benefit from receiving mental health promotion, prevention and/or treatment services. **(T/F)**
2) If I think a child in foster care is having emotional difficulties, I should wait a few months to refer the child for mental health services because he/she probably just needs time to adjust. **(T/F)**
3) Schools readily have a list of students in their building who are currently in the foster care system that is available for mental health providers. **(T/F)**
4) Individuals who work with children in foster care should be of the same racial, ethnic, and cultural background to ensure that they are culturally competent to work with the children. **(T/F)**

STEP TWO: Provide the participants with the learning objectives for the session.
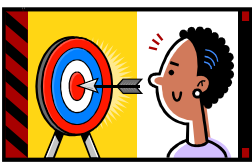
| Lesson Objectives |

Participants will be able to:
1) Be knowledgeable about the three tiered public health model and be able to determine which mental health services are needed based on the child's or adolescent's presenting problems.
2) Be familiar with how to refer children and adolescents in foster care for mental health services in schools.
3) Become familiar with strategies for implementing programs and evidenced-based treatments for children and adolescents in foster care.

4) Be knowledgeable about cultural competency and the importance of being culturally sensitive in working with children from different backgrounds.

STEP THREE: The following activity is meant to provide a brief and quick review of the mental health difficulties children in foster care experience (this is covered in Module 2).This may be done in small groups or with the entire group. Provide participants with the prompt below for brainstorming. If possible, write their responses on a white board or chalkboard.

Activity: Discuss and make a list of the unique mental health needs of children in foster care.

Answers: See below and handout 6.1. If appropriate, you can remind participants that they learned this in module 2 and this activity is a quick review.

- Many symptoms of mental health problems may be mistakenly identified as laziness, lack of interest, or delinquency.
- It is important to recognize that these may be maladaptive coping skills that children have developed in order to handle more serious underlying mental health problems.
- For example:
  - ➢ Sleeping in class, refusal to participate, not turning in homework assignments and failing class are all examples of how child and adolescent depression may manifest in the classroom.
  - ➢ Failing grades, frequent absences and excessive worry about grades and performance may be signs of anxiety.
  - ➢ Avoidance of school and inability to concentrate may be signs of unresolved trauma.
- The handout 6.2 that outlines how common mental health problems may manifest in the classroom and school setting.

STEP FOUR: Present the content of the "Key Sections" using the Power Point provided or other presentation methods. It is highly recommended to utilize the activities in order to keep the participants engaged. The activities may be done in small groups or with the entire group.

Key Sections of Lesson & Activities

Do all children in foster care need mental health services?

- The public mental health model perspective provides us with direction for what types of services children will need. See handout 6.3 for the public mental health triangle.
  - o 80-90% of children need *universal services.* These prevention services are meant to be proactive. The goal is to promote mental health and positive well-being. An example of universal prevention, is Positive Behavior Intervention Supports (PBIS).
  - o 5-10% of children need *secondary services.* These services are provided to children who are at-risk for mental health difficulties. The goal is to provide services to these children before they deteriorate and require more intensive services. Examples of these services are small groups such as elementary social skills group, middle school transitions group, self-esteem building group, etc.
  - o 1-5% of children need *tertiary services.* These services are provided to children who meet criteria for a mental health disorder and/or require more intensive services. Individual therapy is frequently provided at this level.
- All children benefit from universal services (prevention). Prevention and early intervention activities for those youth at risk for developing mental health disorders may be especially helpful for youth in foster care. For children in foster care, they should receive at minimum universal services and/or secondary services.
- Many children, including those in foster care, are not referred for mental health services until they are displaying clinically significant levels of problem behavior. The best option is to provide children with universal (prevention) services before their emotional and behavioral functioning deteriorates.

Using the public mental health perspective, what are the evidenced based practices for the mental health needs of children in foster care?
- There are few programs that are specific to children in foster care. However, we provide some suggestions below.
- Universal prevention programs

- o Programs that improve school climate and behavioral outcomes at systems levels.
- o One example is Positive Behavior Support (PBS)
- o Juvenile Justice/Special Education (JJ/SE) Shared Agenda that establishes a trauma sensitive school culture. Three programs are Helping Traumatized Children Learn, Turnaround for Children, and the Sanctuary Model of Organizational Change for Children's Residential Treatment.
- o Extracurricular activities (art, music, sports, drama, chess).
- Secondary programs
  - o Cognitive Behavioral Intervention for Trauma in Schools
  - o Support groups focused on school connectedness, self esteem, improving academic performance, and/or social skills.
- Tertiary programs
  - o Therapeutic foster care
  - o Intensive case management and wraparound services
  - o Multisystemic therapy (MST)
- Children in foster care experience a variety of mental health difficulties. We refer you to a list of evidenced based programs implemented by expanded school mental health programs for general mental health difficulties, http://csmh.umaryland.edu/resources.html/Summary%20of%20Recognized%20Evidence%20Based%20Programs6.14.08.doc

How can you promote mental health for youth in foster care at school?
- Inquire about the names of the mental health staff (e.g., guidance counselor, school counselor, school mental health clinician, school psychologist, school social worker), as well as names of other non-school hired counselors through other agencies.
  - o Create a resource list for the schools in your region and update the list as new staff is hired.
  - o Make it standard practice to provide the resource list of mental health staff to foster care parents when a child enrolls in a new school.
- When a child or adolescent is displaying warning signs of a mental health disorder, it is important that they be connected to a mental health professional so that the problems do not continue to worsen.

STEP FIVE: The following activity may be done in small groups or with one large group. Provide participants with the prompt below for brainstorming.

> **Activity:** *Brainstorming*
>
> Brainstorm some ideas for some best practices to overcome the
>
> barriers around early identification and intervention for school mental
>
> health services. Focus your ideas on how to better reach out to youth
>
> in foster care in schools and more effectively make referrals and obtain
>
> consent for services.

If I think a child in foster care would benefit from mental health prevention or intervention services, how do I make a referral?

- The issue of how and when to identify youth in foster care for mental health services in schools is complex and no firm guidelines currently exist. Best practice currently suggests that parents and guardians for children in foster care as well as teachers and school staff should be mindful of the mental health warning signs at home and at school and make appropriate referrals if any concerns persist.
- Foster parents and guardians enrolling children in schools should take the time to connect to school mental health professionals (e.g. school counselors, school social workers, or community clinicians co-located in the school) if they believe that prevention, early intervention or treatment services would be helpful for their student, especially in the school setting.
- Ask to make a referral for mental health services early (through the Student Support Team, Child Support Team, or other mental health-related team).
- Help students in foster care learn how to advocate for their needs.
- The process for making a school mental health referral varies across jurisdictions and even across schools. Referral procedures also differ based on whether the referral is to a school employed staff or to a school-based community provider. Many community programs have their own referral forms that can be distributed to teachers, parents and guardians. A handout 6.4 for this module is attached that provides an example of a referral form.

- Obtaining consent for children in foster care to receive mental health services in school can be a challenging process. It is important for school mental health clinicians to be aware of who has the legal authority to provide consent for the child to receive services (e.g. child welfare worker or foster parent). School-based clinicians typically require consent for services. The attached handout 6.5 provides an example of a consent form.
- It is very important for schools to have the most up-to-date contact information in order to contact parents and guardians as needed about available mental health services. Child welfare caseworkers are often the best source for the most up to date information for each child on their caseload.

What are some strategies that I can use to refer children early for mental health services?

- Here are some strategies that may help improve the success of early identification, referral and consent:
  - Request a release of information from child welfare caseworkers as a standard procedure when registering a child in school. This release could then be used to connect with the caseworker around any information that would improve the child's success in school.
  - Provide information to parents/guardians on available school-based counseling services/prevention services as a regular part of the standard school registration process for all incoming students.
  - Empower families/guardians to find out more information about the full continuum of mental health services available in schools and encourage them to ask any questions they may have about mental health when registering the student (e.g. What services are available to all youth? or What happens if my child begins having problems in school?)
  - Encourage families/guardians to always provide up to date contact information for students.
  - Clinicians should share at the start of every school year and throughout the course of the year information on warning signs of mental health concerns and information on when and how to refer students for mental health services.

STEP SIX: As a large group or small group, discuss the brainstorming activity and use the results as a segue into presenting and discussing cultural competency.

Activity: Provide the group with the various statements below and have groups discuss the competency around these statements.

1. You don't know what its like to be poor.
2. You're the wrong color to help these kids
3. Male therapists shouldn't work with girls who have been sexually abused.
4. How can a woman understand a male student's problems?
5. I never feel that young professionals can be trusted.
6. Social Workers (nurses/MD's psychologists/teachers) don't have the right training to help these kids.
7. If you haven't had alcohol or other drug problems, you can't help students with such problems.
8. If you don't have teenagers at home, you can't really understand them.

Children and adolescents in foster care are from all different races, ethnicities, and cultures.

Quote: *Treat people as if they were what they ought to be and you help them become what they are capable of being. -Goethe*

- In pursuing the mission of integrated services for foster children and adolescents in schools, the school's staff must be sensitive to a variety of human, community, and institutional differences and learn strategies for dealing with them. With respect to working with students and their parents, staff members encounter differences in socio-cultural and economic background and current lifestyle, primary language spoken, skin color, gender, and motivation for help.
- Differences can result in problems for students, parents, and staff. Although such problems are not easily resolved, they are solvable as long as everyone works in the best interests of the students, and the differences are not allowed to become barriers to relating with others.

- In this respect, discussions of diversity and cultural competence offer some useful concerns to consider and explore. Below are some baseline assumptions which can broaden:
  - o Those who work with youth and their families can better meet the needs of their target population by enhancing their competence with respect to the group and its intra-group differences.
  - o Developing such competence is a dynamic, on going-process- not a goal or outcome. That is, there is no single activity or event that will enhance such competence. In fact, use of a single activity reinforces a false sense of that the "problem is solved"
  - o Diversity training is widely viewed as important, but is not effective in isolation. Programs should avoid the "quick fix" theory of providing training without follow up or more concrete management and programmatic changes.
  - o Hiring staff from the same back ground as a target population does not necessarily ensure the provision of appropriate services, especially if the staff is not in decision-making positions, or are not themselves appreciative of, or respectful to, group and intra-group differences.
  - o Establishing a process for enhancing a program's competence with respect to group and intra-group differences is an opportunity for positive organizational and individual growth.

STEP SEVEN: Provide a summary of the key learning points as a take home message for participants. We suggest giving the answers to the "Test Your Knowledge" items from the beginning of the session and using those questions to review and discuss the key learning points.

Summary of the Learning Points

1. All children in foster care can benefit from receiving mental health promotion, prevention and/or treatment services. **(True)**
2. If I think a child in foster care is having emotional difficulties, I should wait a few months to refer the child for mental health services because he/she probably just needs time to adjust. **(False)**

Explanation: Many children, including those in foster care, are not referred for mental health services until they are displaying clinically significant levels of problem behavior. The best option is to provide children with universal (prevention) services before their emotional and behavioral functioning deteriorates.

3. Schools readily have a list of students in their building who are currently in the foster care system that is available for mental health providers. **(False)**

Explanation: Due to privacy laws, schools do not possess a list of students who are in the foster care system. To work around this issue, best practice currently suggests that parents and guardians as well as teachers and school staff should be mindful of the mental health warning signs at home and at school and make appropriate referrals if any concerns persist. Foster parents, guardians, and/or social workers enrolling children in schools should take the time to connect to school mental health professionals if they believe that prevention, early intervention or treatment services might be helpful for the student.

4. Individuals who work with children in foster care should be of the same racial, ethnic, and cultural background to ensure that they are culturally competent to work with the children. **(False)**

Explanation: Hiring staff from the same background as a target population does not necessarily ensure the provision of appropriate services, especially if those staff do not fully appreciate or respect group and intra-group differences. Establishing a process for enhancing an individual or program's cultural competence is the best strategy to ensure competent and respectful care.

Practical Resources

School Mental Health.org: *www.schoolmentalhealth.org*
This website provides information and fact sheets on children's mental health for clinicians, educators, families and youth. Specific information about mental health for youth in foster care is also available at this site.

Baltimore City Public Schools School Mental Health Directory:
Can be accessed at *www.schoolmentalhealth.org (see directory section on left hand side)*
This directory provides descriptions of health and mental health services

that are available in schools as well as contact information for key administrators and clinicians at every school in the Baltimore City Public School System. This directory can also serve other communities by providing a model of how to develop a directory of health and mental health services in schools.

Moving toward a Comprehensive System of Learning Supports: Mapping & Analyzing Learning Supports
A tool outlining a six step process that can be used by school improvement planners and decision makers to chart all current activities and resource use (e.g., school, district, community) as a basis for evaluating the current state of development, doing a gap analysis, and setting priorities for moving forward.
http://smhp.psych.ucla.edu/summit2002/tool%20mapping%20current%20status.pdf

Putting It All Together

This section includes a power point that can be used when presenting this module in a training session.

Handout 6.1: *Warning Signs of Mental Health Problems in Children and Adolescents**

A child or adolescent is troubled by feeling:

- Sad and hopeless for no reason, and these feelings do not go away.
- Very angry most of the time and crying a lot or overreacting to things.
- Worthless or guilty often.
- Anxious or worried often.
- Unable to get over a loss or death of someone important.
- Extremely fearful or having unexplained fears.
- Constantly concerned about physical problems or physical appearance.
- Frightened that his or her mind either is controlled or is out of control.

A child or adolescent experiences big changes, such as:

- Showing declining performance in school.
- Losing interest in things once enjoyed.
- Experiencing unexplained changes in sleeping or eating patterns.
- Avoiding friends or family and wanting to be alone all the time.
- Daydreaming too much and not completing tasks.
- Feeling life is too hard to handle.
- Hearing voices that cannot be explained.
- Experiencing suicidal thoughts.

A child or adolescent experiences:

- Poor concentration and is unable to think straight or make decisions.

- An inability to sit still or focus attention.
- Worry about being harmed, hurting others, or doing something "bad".
- A need to wash, clean things, or perform certain routines hundreds of times a day, in order to avoid an unsubstantiated danger.
- Racing thoughts that are almost too fast to follow.
- Persistent nightmares.

A child or adolescent behaves in ways that cause problems, such as:

- Using alcohol or other drugs.
- Eating large amounts of food and then purging or abusing laxatives to avoid weight gain.
- Dieting and/or exercising obsessively.
- Violating the rights of others or constantly breaking the law without regard for other people.
- Setting fires.
- Doing things that can be life threatening.
- Killing animals.

**Warning signs were taken from the SAMHSA Fact Sheet on Child and Adolescent Mental Health. The fact sheet can be accessed at http://mentalhealth.samhsa.gov/publications

Handout 6.2: *Symptoms of Mental Health Problems in the Classroom*

Depression

•Sleeping in class

•Defiant or disruptive

•Refusal to participate in school activities

•Excessive tardiness

•Not turning in homework assignments, failing tests

•Fidgety or restless, distracting other students

•Isolating, quiet

•Frequent absences

•Failing grades

•Refusal to do school work and general non-compliance with rules

•Talks about dying or suicide

Anxiety

•Frequent absences

•Refusal to join in social activities

•Isolating behavior

•Many physical complaints

•Excessive worry about homework or grades

•Falling grades

•Frequent bouts of tears

•Frustration

•Fear of new situations

•Drug or alcohol abuse

Attention-Deficit/Hyperactivity Disorder (ADHD)

Children with **inattentive symptoms** may:

•Have short attention spans

•Have problems with organization

•Fail to pay attention to details

•Be unable to maintain attention

•Be easily distracted

•Have trouble listening even when spoken to directly

•Fail to finish their work

•Make lots of mistakes

•Be forgetful

Children with **hyperactive-impulsive symptoms** tend to:

•Fidget and squirm

•Have difficulty staying seated

•Run around and climbs on things excessively

•Have trouble playing quietly

•Talk too much

•Blurt out an answer before a question is completed

•Have trouble taking turns in games or activities

•Interrupt or intrude on others

Conduct Disorder

•Bullying or threatening classmates and other students

•Poor attendance record or chronic truancy

•History of frequent suspension

•Little empathy for others and a lack of appropriate feelings of guilt and remorse

•Low self-esteem masked by bravado

•Lying to peers or teachers

•Stealing from peers or the school

•Frequent physical fights; use of a weapon

•Destruction of property

Oppositional Defiant Disorder (ODD)

•Sudden unprovoked anger

•Arguing with adults

•Defiance or refusal to comply with

   Adult's rules or requests

•Deliberately annoying others

•Blaming others for their misbehavior

•Easily annoyed by others

•Being resentful and angry

Post Traumatic Stress Disorder (PTSD)

•Flashbacks, hallucinations, nightmares, recollections, re-enactment, or repetitive

   play referencing the event

•Emotional distress from reminders of the event

•Physical reactions from reminders of the event, including headache,

   stomachache, dizziness, or discomfort in another part of the body

•Fear of certain places, things, or situations that remind them of the event

•Denial of the event or inability to recall an important aspect of it

•A sense of a foreshortened future

•Difficulty concentrating and easily startled

•Self-destructive behavior

• Irritability

• Impulsiveness

• Anger and hostility

•Depression and overwhelming sadness or hopelessness

Bipolar Disorder

•An expansive or irritable mood

•Depression

•Rapidly changing moods lasting a few hours to a few days

•Explosive, lengthy, and often destructive rages

•Separation anxiety

•Defiance of authority

•Hyperactivity, agitation, and distractibility

•Strong and frequent cravings, often for carbohydrates and sweets

•Excessive involvement in multiple projects and activities

•Impaired judgment, impulsivity, racing thoughts, and pressure to keep talking

•Dare-devil behaviors

•Inappropriate or precocious sexual behavior

•Delusions and hallucinations

•Grandiose belief in own abilities that defy the laws of logic

Eating Disorders

•Perfectionistic attitude

•Impaired concentration

•Withdrawn

•All or nothing thinking

•Depressed mood or mood swings

•Self-deprecating statements

•Irritability

•Lethargy

•Anxiety

•Fainting spells and dizziness

•Headaches

•Hiding food

•Avoiding snacks or activities that include food

•Frequent trips to the bathroom

Obsessive Compulsive Disorder (OCD)

•Unproductive time retracing the same word or touching the same objects over and over

•Erasing sentences or problems repeatedly

•Counting and recounting objects, or arranging and rearranging objects on their desk

•Frequent trips to the bathroom

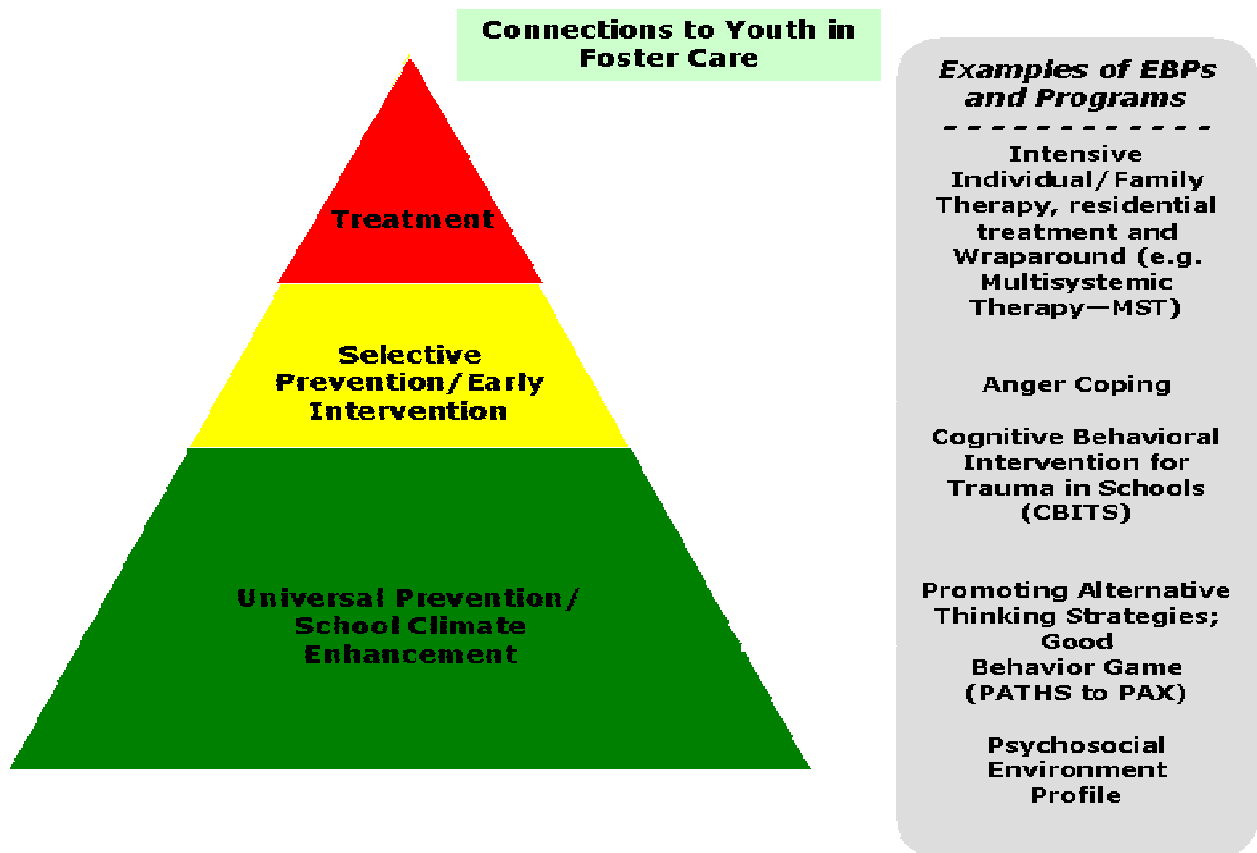•Poor concentration

•School avoidance

•Anxiety or depressed mood

Reactive Attachment Disorder

•Destructive to self and others

•Absence of guilt or remorse

•Refusal to answer simple questions

•Denial of accountability—always blaming others

•Poor eye contact

•Extreme defiance and control issues

•Stealing

•Lack of cause and effect thinking

•Mood swings

•False abuse allegations

•Sexual acting out

•Inappropriately demanding or clingy

•Poor peer relationships

•Abnormal eating patterns

•Preoccupied with gore, fire

•Toileting issues

•No impulse control

•Chronic nonsensical lying

•Unusual speech patterns or problems

•Bossy—needs to be in control

•Manipulative—superficially charming and engaging

Handout 6.3:
A Public Mental Health Promotion Approach for Youth in Foster Care

Connections to Youth in Foster Care

Treatment

Selective Prevention/Early Intervention

Universal Prevention/ School Climate Enhancement

Examples of EBPs and Programs
- - - - - - - - - - -

Intensive Individual/Family Therapy, residential treatment and Wraparound (e.g. Multisystemic Therapy—MST)

Anger Coping

Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

Promoting Alternative Thinking Strategies; Good Behavior Game (PATHS to PAX)

Psychosocial Environment Profile

Handout 6.4: *Sample Referral Form*

Date of Referral: _____ Intake by: _____

Child's Name: _____ DOB: _____ Sex: M F

SS#: _____ MA#: _____

School/Daycare: _____ Grade: _____

Legal Guardian: _____ Resides With: _____

Address: _____ City: _____ Zip: _____

Phone (home): _____ (cell): _____ (work): _____

Additional Contact Info: _____

Mother's Name: _____ Age: _____ Employed _____

Father's Name: _____ Age: _____ Employed _____

Pediatrician: _____ Phone: _____

Referral Information Caller name: _____ Organization: _____

Agency Address: _____ Agency Phone: _____

How did you hear about the CIS? _____

Presenting Concerns: _____

_____

_____

_____

_____

_____

_____

_____

Disposition: _____

_____

_____ Appointment schedule: _____

_____ No appointment scheduled, referred out to: _____

Handout 6.5: *Sample Consent Form*

Consent to Treatment

I consent to mental health care, which encompasses outpatient or school-based treatment, routine diagnostic assessment, therapy and medical treatment, case management and psychiatric rehabilitation services, and emergency psychiatric and medical care if necessary.

I have received and had explained to me the Patient Rights, discharge policy and rules and regulation of the programs within the Division of Child and Adolescent Psychiatry.

Patient Name: _____

Name of Parent (Guardian): _____

Relationship to patient: _____

Signature of Parent (Guardian): _____

Date: _____
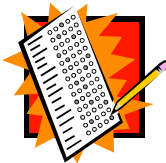
Witness signature: _____

Date:_____

Promoting Family Engagement and Meaningful Involvement

STEP ONE: Present the "Test Your Knowledge" questions below and have participants write down their answers. Tell the participants that you will provide the answers at the end of the session.

Test Your Knowledge: True or False

1) Biological parents must always be included in the decision-making and treatment-planning processes concerning their children in out-of-home placements. **(T/F)**

2) Confusion over the roles of the foster and biological families acts as a barrier to family involvement and collaboration among the different systems of care (e.g., school and child welfare systems). **(T/F)**

3) Parent-child/adolescent involvement in case planning is correlated with greater stability of placement and eventual family reunification. **(T/F)**

STEP TWO: Provide the participants with the learning objectives for the session.
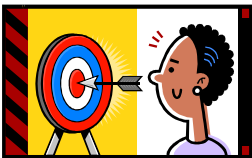
Lesson Objectives

Participants will be able to:
1) Describe three common barriers that impede collaboration and family involvement across systems of care.
2) Outline three strategies for fostering increased family involvement in the decision-making and treatment planning

processes, both across systems of care and within school mental health.

STEP THREE: The following brainstorming activity may be done in small groups or with the entire group. Provide participants with the prompt below for a discussion. If possible, write their responses on a white board or chalkboard.
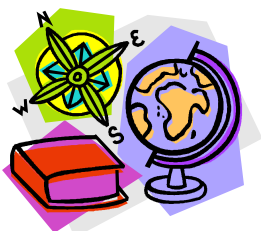
Brainstorm: What are some common barriers to family involvement in the decision-making and treatment-planning processes in schools?

Possible answers:
- Confusion over the role of biological versus foster families in the processes.
- Schools and/or caseworkers may blame the family for problems.
- Schools and/or caseworkers may feel that involving the family slows down progress because they are not familiar with issues and processes associated with mental health.
- Family members may not feel comfortable in the school setting.
- To partner, family may need certain expenses covered like child care and transportation.
- Lack of communication from the school or caseworker leads to families being excluded.

STEP FOUR: Present the content of the "Key Sections" using the Power Point provided or other presentation methods. It is highly recommended to utilize the activities in order to keep the participants engaged. The activities may be done in small groups or with the entire group.

Key Sections of Lesson and Activities

➢ **Before you begin discussing the key lessons, please inform the participants that the primary focus of this module is engaging the <u>foster care</u> family; however, there are some topics that may apply to both the foster family and biological family.**

➢ **What are some common barriers to family involvement in the treatment-planning and decision-making processes?**
   o Families may have negative beliefs and attitudes towards mental health services.
   o Families may not understand the increased mental health needs of youth in foster care.
   o Due to confusion over the roles of foster parents and biological parents, families may not be treated as part of the treatment team; as a result, foster parents and/or biological parents may be excluded from case planning and decision-making.
   o Confidentiality concerns may lead to a lack of communication and/or coordination of care across systems. For example:
     ▪ Schools are often unaware of student's foster care status and possible mental health needs.
     ▪ Child welfare caseworkers are often insufficiently informed regarding youth's academic issues.
     ▪ Parents are not informed about important meetings because of a lack of communication from the school or caseworker (e.g., Individual Education Plan team meeting).
   o Parents may have difficulty getting to meetings due to scheduling constraints, transportation issues, or child care concerns.
   o Some biological parents may be prohibited from taking part in treatment-planning and decision-making for various reasons. For example, some biological parents who abused or neglected their children/adolescents have had their parental rights terminated.

➢ **Why is family involvement so important?**
   o According to the National Resource Center for Youth Development, involved families achieve the following outcomes for children and adolescents in foster care:

- Families feel more empowered and engaged in the process, and can better advocate for their children's needs.
- Their children are more likely to receive treatment that is tailored for their children's or adolescent's needs.
- Their child or adolescent is more likely to receive culturally relevant and responsive care.

o Findings from a federally-mandated comprehensive review of state child welfare services (implemented by Department of Health and Human Services) indicated that family involvement in the child welfare process was highly correlated with foster youth's:
- stability in out-of-home placements
- emotional well-being
- educational outcomes
- shorter out-of-home stays and increased family reunification

o Other studies indicate that family involvement leads to:
- Improved educational outcomes
  - Family participation in schools is associated with children and adolescents' enhanced academic performance and school competence (Kohl, Lengua, & McMahon, 2000).
- Improved emotional well-being
  - Parents' involvement facilitates continuity of care and parent-child attachments and help children cope with the stress of separation and placement (Davis, Landsverk, Newton, & Ganger, 1996).
- Better service delivery from caseworkers and teachers
  - Caseworkers offer more appropriate and relevant services to families that participate in case planning (Rzepnicki, 1987).
  - Teachers pay more attention to child and change attitudes towards parents (Koren et al., 1997).
  - Increased family involvement results in greater collaboration among caseworkers and school staff, better coordinated services, and increased family satisfaction (Koren et al., 1997).
- Improved child behavior

- When compared to individual therapy, interventions involving family support showed a greater reduction in child behavior problems (Meezan, 1998).
  - Improved caregiver self-efficacy
    - Caregivers involved in developing a treatment plan report higher levels of self-efficacy.
    - Caregivers who participated in the treatment process report higher levels of self-esteem, which translates to more positive role modeling for students (Caldwell, Antonucci, Jackson, Wolford, & Osofsky, 1997).
  - Less time in treatment
    - Collaborating with caregivers in the treatment process reduces the amount of time students spend in treatment.

➢ **In Maryland, a common consensus has formed regarding the importance of strong family involvement and team approach in the foster care system:**
  - Maryland's Department of Human Resources (DHR):
    - "Working jointly as a team, foster parents, social workers, mental health professionals, child welfare workers from the Maryland DHR, develop and provide intensive treatment and determine the permanency plans, often with the natural parents or relatives."

  - The Maryland Foster Parents Association (MFPA):
    - "Families need to be valued as part of the team, and seen as sources of strength and expertise."
    - The MFPA stresses the importance of implementing a strong home-school connection and a team approach to assisting foster children. This team should include:
      - teachers
      - health care providers
      - social workers
      - foster parents

  - In a reflection of this increasingly team-oriented and family-centered approach to foster care, Maryland has recently instituted Family Team Decision Making (FTDM). According to the Maryland DHR: "Family team decision-making meetings represent the foundation of family-

centered practice." These multidisciplinary DHR Family Team meetings bring together family, caregivers, and community members to communicate and collaborate regarding the decision-making and treatment planning processes. These meetings take place when a child enters the foster care system, when he or she is transitioning from one placement to another, and when he or she is anticipating reunification with the biological family.

STEP FIVE: The following activity may be done in small groups or with the entire group. Provide participants with the prompt below for brainstorming. If possible, write their responses on a white board or chalkboard.

 Brainstorm or Small Group Discussion: What are some specific strategies that you have found useful in increasing parent involvement (from perspectives of caseworker, school, and school mental health clinicians)?

➢ **What are some strategies to boost family involvement?**
  o Share information
    ▪ Schools should effectively communicate information regarding available services to both foster parents and caseworkers.
  o Create a welcoming climate
    ▪ Schools and child welfare systems should develop and maintain a climate that is respectful of parents and supportive of participation.
  o Offer real opportunities for participation
    ▪ Schools and caseworkers should invite parents (and foster children) to participate in joint collaborative meetings in order to draw upon their expertise in decision-making and case-planning.
    ▪ Family members should be part of the team, and should be perceived as experts on their children and adolescents.
  o Offer concrete assistance to enable participation, for example offer:
    ▪ child care
    ▪ transportation

- reimbursement for expenses and time taken off of work
- provide a contact person at school for the parent

> **What are some strategies to successfully engage families in the school mental health process?**
>   - Utilize all available resources to communicate such as e-mail, home and cell phone, text messaging, work phone if appropriate, fax, and handwritten letters.
>   - Honestly address caregiver concerns before treatment. Ask them about past experiences and how you can improve upon them.
>   - Ask families to openly discuss their expectations about mental health treatment for their foster child. Be optimistic, yet realistic about outcomes that can be expected in a given time frame.
>   - Establish clearly defined short and longer term goals that can be addressed in therapy.
>   - Be willing and open to addressing problems in therapeutic alliance with family and work together to improve relationship.
>   - Be open to connecting families to at least one local resource (e.g., youth groups, sports leagues, mentor programs) because families who are connected to a local resource are more likely to attend and continue mental health services (McKay, 2002).
>   - Deliver on your promises related to the treatment and maintain open channels of communication.
>   - Create a family-centered environment, "a friendly, respectful partnership with families that provides (a) an emotional and educational supports, (b) opportunities to participate in service delivery and to make decisions, and (c) activities to enhance family members' capacities to carry out their self-determined roles."
>   - Have parents be a meaningful part of the team decision making including the development of treatment plans.

STEP SIX: Break into pairs and take 5-10 minutes to reflect upon the following prompt:

Activity/Discussion:

In pairs discuss which areas you excel in with families and which of these areas you could improve in and your plan for improvement.

Use a case example as a means share your experiences. Be ready to

Learning Points

STEP SEVEN: Provide a summary of the key learning points as a take home message for participants. We suggest giving the answers to the "Test Your Knowledge" items from the beginning of the session and using those questions to review and discuss the key learning points.

1. Biological parents must always be included in the decision-making and treatment-planning processes concerning their children in out-of-home placements. **False**
   Explanation: Biological parents who have had a child removed for abuse or neglect reasons may be prohibited from taking part in treatment-planning and decision-making.
2. Confusion over the roles of the foster and biological families acts as a barrier to family involvement and collaboration among the different systems of care (e.g., school and child welfare systems). **True**
3. Parent/child involvement in case planning is correlated with greater stability of placement and eventual family reunification. **True**

Practical Resources

Casey Family Programs:
http://www.casey.org/Resources/Publications/MentalHealthReview.htm
Published in 2006, this review surveys major findings gleaned from studies about the evidence base for mental health care and about related class action law suits. The review also outlines steps that will improve the mental health services delivered to children and youth in foster care.

Family Team Decision Making (FTDM):
http://www.acy.org/upimages/FTDM_Issue_Brief.pdf
This issue brief describes the evolution of FTDM, the differences between FTDM and traditional practice, and the reasoning behind this increasingly team-oriented, family-centered approach.

Casey Foster Family Assessments (self-assessments):
http://www.casey.org/Resources/Tools/CaseyFosterFamilyAssessments.htm
A suite of tools used to help foster parents self-identify their strengths and challenges in caring for children and grappling with issues in the child welfare and school systems.

Powerful Families:
http://www.casey.org/Resources/Tools/PowerfulFamilies.htm
This website offers strategies for foster/biological parents to become better advocates for their children.

Putting It All Together

This section includes a power point that can be used when presenting this module in a training session.