Advocating for Appropriate Mental Health Treatment for Children in Care

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**Introduction**

In this article, we briefly explore the scope of mental health needs among children in foster care. We then focus on advocating for appropriate and effective mental health treatment. Sidebars include resources for further research and tips for volunteers. In addition, our two editorials from experts in the field and our youth essay are important complements to this story.

**Prevalance of Mental Health Issues Among Children in Care**

While definitions of mental illness change over time, from state to state and across cultures, mental illness diagnoses in the US are currently based on the nature and severity of an individual’s symptoms. Those who meet the criteria set forth in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) may be diagnosed with a particular disorder such as depression, anxiety or post-traumatic stress disorder. About one in four adults suffers from a diagnosable mental disorder in a given year. (National Institute of Mental Health)

Studies vary widely in identifying the number of youth in foster care affected by a mental health disorder in their lifetimes, with estimates ranging from 40% to 85%. The latest research comes from Casey Family Programs, which reported the following findings from the *Casey Field Office Mental Health Study* involving 188 youth between the ages of 14 and 17:

While in foster care, “Bobby” started acting out in preschool to the point of being expelled. He was receiving therapy, but it was not helping much. The caseworker obtained a psychiatric evaluation. As a result, the care team was planning to put him on antipsychotic medication and considering a day treatment program. Cindy Everett, a volunteer with CASA for Children in Portland, OR for six years, advocated strenuously and successfully for a therapist who had experience working with children in foster care. After just a few sessions, Bobby’s behavior improved markedly. He is now in a regular kindergarten class, on no medication and about to be adopted.
• 63% of youth in care had had at least one diagnosis of a mental health disorder in their lifetimes, compared with 46% in the general youth population of the same ages.

• 23% of youth in care had had three or more diagnoses in their lifetimes, compared to 15% of the general youth population.

(Mental Health, Ethnicity, Sexuality, and Spirituality Among Youth in Foster Care, Casey Family Programs, 2007)

This difference in prevalence of mental health problems is to be expected. Children in foster care have typically faced abuse or neglect by their own families, compounded by the trauma of being removed from their homes and often shuttled from one temporary placement to another.

For an overview of challenges at the nexus of mental health, foster care and family systems, as well as descriptions of common diagnoses in children, see “Mental Health Needs of Youth in Foster Care: Challenges and Strategies” (from casanet.org/communications/connection-magazine.htm, scroll down to the article from the winter 2004 issue of The Connection).

Mental Health Treatment Challenges

Financial Access to Care

“Cost, cost, cost,” replies Georgie Scurfield, CASA coordinator at the Sarpy County CASA Program in Papillion, NE when asked about obstacles to appropriate mental health treatment for children in care. She is well qualified to speak on this topic, having earned a master’s in social work and being a licensed mental health professional in addition to running a CASA program.

“Funding is the primary issue because what states and agencies tend to do is to place kids on Medicaid in the lowest level of care,” says Scurfield. “And only when they fail do they move them up to a higher level. If you’ve got a child in outpatient therapy whose behaviors are deteriorating, it may be that they need some inpatient care. But you’ve got to give them enough time to fail and then carefully document their failures.”

Michael W. Naylor, MD is associate professor of psychiatry and director of the Clinical Services in Psychopharmacology Program at the Institute for Juvenile Research based at the University of Illinois at Chicago. Naylor provided expert testimony at the July 2007 hearing of the House Committee on Ways and Means Subcommittee on Income Security and Family Support [see resources sidebar].

“First of all, there’s a huge shortage of child psychiatrists,” says Naylor. “On average, there are about 8 child psychiatrists for every 100,000 kids. But in rural areas that drops to about 1 for every 100,000.”

And when you narrow that down to child psychiatrists who treat children in foster care, the numbers plunge further, according to Naylor. “Without a government- or donor-supported clinic, it’s next to impossible to find child psychiatrists because the professional fee reimbursement doesn’t even pay office expenses let alone salary. It’s a rare child psychiatrist past training who will take a Medicaid patient.”

Donna Russow has run the family counseling program at Family & Children First in Louisville, KY for the past nine years. In her program, about 25 therapists provide office-based family counseling as well as community-based child welfare services and in-home therapy.

“Like most communities, our county contracts out mental health services for children in care,” Russow explains. “But my agency’s in-home services can only be used to prevent out-of-home placement. We would need to obtain a grant or other private funding to allow counselors to do in-home services for children already in care.”

Lack of Continuity and Coordination of Care

Obstacles to mental health treatment appear at every stage. Providers have difficulty obtaining a thorough mental health history for children moving from placement to placement. Then a fragmented system makes it difficult to get a good assessment and diagnosis.

“Add to that the lack of providers trained in treating children with major issues around attachment, grief and anger management,” says Russow.

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Tips for Working with Children

General Considerations
1. Do not take it upon yourself to diagnose mental illness. This task is for professionals.
2. Educate yourself about local mental health resources and how to penetrate the system.
3. Maintain extensive documentation. You may end up having the most complete history and most consistent information related to the child’s mental health.
4. Be aware of warning signs that may affect the health or safety of the child so that you can alert the caseworker about your concerns. See Dr. Richard Adams’s editorial on p. 3 for a list of behaviors to watch for.
5. Recommend a mental health assessment of a child (or parent) if you see any of these warning signs.
6. Request consultations with a child’s (or parent’s) mental health care providers if you need to know more about their situation. Talk to your volunteer supervisor about confidentiality concerns and gaining access to information.
7. Educate yourself about ethnic and cultural considerations related to mental health labels, diagnoses and treatments.

Questions to Ask when a Child Is Receiving Mental Health Treatment
1. What psychiatric diagnosis has been formally applied? (Your CASA program may have a Diagnostic and Statistical Manual of Mental Disorders in the office.)
2. What are the goals for treatment, and how does this intervention make these goals more likely to be achieved?
3. How do these goals fit into the client’s culture, motivation and expectations?
4. What criteria are we looking at to determine what a “success” would be?
5. What are the possible negative impacts and risks of this intervention?
6. When and how will these questions be reviewed and the success of treatment be reassessed?

When a Child Is Prescribed Psychotropic Medication
1. Understand that many people are very positive about their experiences with psychotropic drugs. They are a useful tool.
2. Consider asking the following questions of the provider, within the child’s care team or even in court:
   A. What psychiatric diagnosis has been formally applied?
      • Was the diagnosis based on multiple observers’ input or on a single, brief assessment?
      • Who prescribed the medication? What are this person’s qualifications?
      • Are there valid questionnaires that can be used to track improvement or worsening over time?
   B. What target symptoms are identified for change, and are there rating scales that can be used to best track behavioral outcome goals?
   C. Are the present or proposed medication doses considered to be in a low range or a high range?
   D. What co-existing developmental disabilities are present, and how do they and their treatments affect mental/behavioral health care plans?
3. If a new drug is started, or if a dosage is changed, watch for immediate behavior changes, positive and negative, and document them. Have caregivers do the same when possible.
4. Make certain any medical follow-ups are happening (heart check, lithium levels).
5. Make sure that caregivers, attorneys, social workers and the judge are informed about intended benefits and possible side effects. Children should also be informed at a level they can understand.
6. Check any new problems that emerge against the list of possible adverse effects, and discuss any concerns with your volunteer supervisor.
7. If there is any indication that a child is suffering significant side effects of the medication, talk to the child’s social worker, caregiver and medical provider as needed and express your concerns.
8. If your concerns are not addressed, talk to your volunteer supervisor about further strategies. Outside evaluations and second opinions can be ordered by the court as needed.

Adapted from materials by this issue’s two guest editorialists, Stephen McCrea and Richard C. Adams, MD.
Dixie Williams is in her 11th year as a volunteer with the Sarpy County CASA Program in Nebraska. Her current case has spanned the past two years and involves a 17-year-old girl with mental health problems. Williams finds the lack of continuity of care extremely frustrating.

“This young lady has been in over 40 placements in the past five years,” says Williams. “She’s had numerous diagnoses. She goes to the hospital psychiatric unit for two or three weeks, then into residential treatment for several months, and all the while no one is getting at the heart of what is most troubling her. She progresses, she gets into a foster home, then boom—it blows up and she’s back in a psychiatric unit again.”

Not only is this cycle a source of hopelessness to the girl and her care team, but Williams fears that the child is being damaged by having to repeat her story of maltreatment.

“There’s not one psychiatrist or therapist following this child, so she has to explain her past again and again until she says, ‘I’m just not going to do it anymore. Nobody’s listening to me anyway.’”

**Concerns About Overmedication**

Psychotropic drug prescriptions for teenagers skyrocketed 250% between 1994 and 2001, according to a Brandeis University study published in the journal *Psychiatric Services.* And among children in foster care, the rates are much higher. US Congressman Jim McDermott (D-WA) was a child psychiatrist by profession before he entered politics. His concern about the mental health of children in care has led him to research the issue in depth.

“Studies in Texas and California have shown that foster kids are three to four times more likely to be prescribed psychotropic medications than others on Medicaid,” says McDermott. “Research has also shown that an alarming rate of foster children have been prescribed four or more drugs.”

McDermott understands that children coming into foster care have suffered various degrees of trauma. “I do not doubt that some children may benefit from medication,” says McDermott. “Still, I also worry that foster children may sometimes be prescribed psychotropic drugs because such treatment is easy and quick—as opposed to effective and appropriate.”

Cindy Everett, the Oregon CASA volunteer whose story opened this article, had to be especially persistent to prevent Bobby from being medicated unnecessarily.

“I work with kids his age as a special education teacher, and I know some do need medication,” says Everett. “But this boy didn’t seem to fit that profile. He needed a teacher with better skills at managing his behavior, and he needed a place to grieve where people allowed that—he needed a lot of things before he needed medication.”

It can be difficult for CASA volunteers when they are the lone voice. “The other people on his care team didn’t want to deal with his behavior, so they thought medication would be a good answer,” says Everett. Nobody except her CASA volunteer supervisor agreed with her at the time.

Scurfield, the CASA director in Nebraska, believes that medications should rightly be seen as a “useful piece in the toolbox” to help children get well. But she and others caution that psychotropic drugs need to be monitored regularly and carefully because as children grow their reactions to medications change.

Sometimes CASA volunteers prevent major difficulties with medication just by asking questions.

“We just had an example here where a young man living in a group home had his medications changed,” recounts Scurfield. “His behaviors became quite dramatically different. At a team meeting, the group home staff said, ‘Well it’s because his meds have changed.’ So the CASA volunteer asked, ‘Who ordered the meds to change?’ And nobody in the room knew. So they called his prescribing doctor who said, ‘No, I never made any changes.’ Somewhere along the line a mix-up occurred, and the young man’s behavior tumbled out of control.’”

CASA volunteers should also be aware that if a child is on a medication, he or she should also have supportive psychosocial services, such as therapy or school intervention.

“Don’t get me wrong,” says counseling director Russow of Louisville. “A lot of kids need medication. However I’m always very nervous when I hear a child is on medication but they’re not getting any kind of counseling to go along with it. Studies show that medication without therapy for children is not that effective.”

**Promising Practices and Glimmers of Hope**

**Public Policy**

Some states are doing better than others at addressing the challenges of treating mental health problems of children in care. In Washington state, Representative McDermott points out, “The Department of Social and Health Services (DSHS) has made great strides in ensuring more coordinated care for all foster children. DSHS has worked with others to create regional centers for foster care health throughout the state, to establish safety and quality standards for mental health care and to provide more access to guidance for providers.”

McDermott is concerned that many other states have done much less and believes that the federal government needs to step in. “I co-sponsored legislation with Rep. Jerry Weller of Illinois that has been overwhelmingly approved by both parties in the House of Representatives,” says McDermott. “The Fostering Connections to Success Act
Treatment Costs Lead Some Parents to Relinquish Their Children

In a number of states, the financial burden of getting their children treated for mental illness has led some parents to do the unthinkable: to voluntarily relinquish custody to the state. A 2003 report by the US General Accounting Office estimated, with only 18 states reporting, that about 12,700 children had been made voluntary wards of the state in one year to get mental health services.

Karyn Spencer wrote in the Omaha World-Herald on December 16, 2007 about Megan Byers, whose middle-class professional parents made her a ward of the state to get her the intensive treatment the family’s insurance would not cover. Spencer’s investigation was prompted by the rampage of 19-year-old Robert Hawkins, who killed eight others and himself at Westroads Mall last December. He had been in the child welfare system since the age of 14 and faced difficulty getting mental health treatment.

Aims to Provide Better Health Care

Aims to provide better health care for kids in foster care. It requires states to develop a coordinated health care plan for every child in foster care that will ensure that they receive the proper screenings and treatment, to protect them from overmedication and to ensure the continuity of their care when they are moved from one home to another.” At press time, McDermott urged CASA volunteers to notify their senators of the importance of passing these reforms.

[Contact National CASA Deputy CEO Carmela Welte at carmela@nationalcasa.org for further information about national legislation. —ed.]

Efforts to Monitor Meds in Various States

A number of states are working on ways to oversee the prescription of psychotropic drugs to children in foster care.

“We encourage child welfare agencies to partner with academic child psychiatry programs to monitor statewide psychotropic medication prescription patterns and to improve the consent procedure,” says researcher Naylor. “I think Illinois is probably furthest along in working on oversight. We’re different from many child welfare agencies because it’s a state-centered system. We review all of the requests from every region of the state, which allows for a degree of consistency.”

Several states are making efforts to replicate aspects of the Illinois oversight system or to create their own reforms. Naylor pointed to Connecticut as being ahead of many others along with California, Florida, New York, Tennessee and Texas.

Experience of CASA Programs

Mental health concerns are addressed in National CASA’s new volunteer training curriculum. Volunteers and staff may refer to Chapter 4, Unit 5 of the Volunteer Manual for the impact of mental illness on children and families and to Chapter 6, Unit 6 for children’s psychological and educational issues. The “Web Resources” section of the manual lists many helpful websites and organizations.

In their efforts to face the myriad challenges laid out above, CASA for Children in Portland, OR developed a new mental health lesson plan a few years ago to supplement the National CASA training curriculum.

“We try to stay away from having volunteers worry too much about diagnoses and technical issues but rather to develop their ability to ask helpful questions,” says Stephen McCrea, the organization’s program coordinator. “We demystify the diagnoses found in the DSM and help volunteers see that these are primarily descriptions of common behavior patterns that children engage in, for a variety of reasons, and that there is a wide range of options available to help.”

McCrea does his best to make sure that volunteers are not intimidated by experts. “Sometimes it is easy for volunteers to feel, ‘Who am I to question the wisdom of a psychiatrist or a therapist?’ But we encourage volunteers to think, ‘If I were this child’s parent, what are the kinds of questions I would ask?’ As individuals, that is what volunteers can do better than anybody else in the system—ask the hard questions.” [Also see McCrea’s editorial on page 12.]

Questioning the effectiveness of services is exactly what happened in the opening story, according to CASA volunteer Everett. “After Bobby got thrown out of preschool, I advocated for a new therapist who specialized in dealing with children in foster care. Then he went into a daycare with a teacher who actually ‘got’ how you manage children like this, and he never had any behavior problems there.”

Williams, the volunteer from Nebraska, talks about the importance of establishing credibility. “You have to be very persistent and prove yourself so that people take you seriously. You have to take really good notes and have excellent documentation: times, dates and as many quotes as you can get. So if you’re asked a question, you can say, ‘On this date, this is what this person said to me.’”

Naylor believes that volunteers can play an important role in watching for significant behavioral, emotional or academic problems in a child. When these come up, the advocate can ensure that a mental health evaluation is carried out by a qualified provider. According to Naylor, “If you can see that the clinician’s assessment reflects the symptoms you’ve observed, and that their treatment plan is supported by a diagnosis, you can feel that the child is getting decent care.”

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Resources

The following tools are helpful in understanding child and adolescent mental health issues and advocating for proper treatment and resources for youth in the child welfare system.

Organizations and Websites

American Academy of Child and Adolescent Psychiatry (AACAP)  
aacap.org
AACAP works to assist parents and families in understanding developmental, behavioral, emotional and mental disorders affecting children and adolescents. The website includes resources and legislative updates.

American Academy of Pediatrics (AAP)  
aap.org
AAP’s website provides information on various children’s health issues—including mental health—for parents, health care providers and social services providers.

The Arc  
thearc.org
The Arc provides services, support and advocacy for people with intellectual and developmental disabilities and their families. The website includes topics such as the Americans with Disabilities Act, managed care and fetal alcohol syndrome.

Bazelon Center for Mental Health Law  
bazelon.org
The mission of the Bazelon Center is to protect and advance the rights of adults and children with mental disabilities. They publish handbooks, manuals, issue papers and reports explaining key legal and policy issues in simple terms.

Child and Adolescent Bipolar Foundation (CABF)  
bpkids.org
The Learning Center on CABF’s website provides information about bipolar disorder in children and adolescents, including links to support groups and resources.

Child and Adults with Attention Deficit/Hyperactivity Disorder (CHADD)  
chadd.org
CHADD publishes a variety of materials for educators, professionals and parents, including information on research advances, medications and treatments of ADHD.

Child Welfare League of America (CWLA)  
cwla.org
According to CWLA, more than 80% of children in foster care have developmental, emotional or behavioral problems, and a large proportion of these children do not receive the services they need. The Child Mental Health section of CWLA’s website provides fact sheets, publications and links to resources.

Hearing on Health Care for Children in Foster Care  
waysandmeans.house.gov
From the Ways and Means Committee home page, click on Committee Hearings and select the hearing from July 19, 2007. Of particular interest is the testimony of Michael W. Naylor.

A Home Within  
ahomewithin.org
A Home Within addresses the mental health needs of current and former foster youth by offering pro bono psychotherapy services in many US cities.

Internet Mental Health  
mentalhealth.com
This site provides descriptions of many mental health disorders and medications, lists of general publications and research as well as links to other medical sites.

Medscape  
medscape.com
The Psychiatry and Mental Health section of this website provides information on many issues and disorders.

National Alliance on Mental Illness (NAMI)  
nami.org
NAMI provides resources to improve the lives of people with mental illnesses and their families. The website provides in-depth information on specific disorders and medications. The site’s Child and Adolescent Action Center includes a Juvenile Justice and Child Welfare section.

National Institute of Mental Health (NIMH)  
nimh.nih.gov
NIMH is the largest scientific organization devoted to research focused on the understanding, treatment and prevention of mental disorders. The website provides a wealth of information on the mental health of children and youth.

New York University (NYU) Child Study Center  
aboutourkids.org
This site includes a wide array of information for parents and professionals about child mental health disorders, including a list of disorders, a dictionary of terms related to mental health and a guide to medications. It also features materials developed by the center’s faculty.

Parents Med Guide  
parentsmedguide.org
This site contains two medication guides: one for treating ADHD and one for treating childhood and adolescent depression.

Screening for Mental Health (SMH)  
mentalhealthscreening.org
SMH works with local health care providers, social services agencies, schools and other organizations to implement in-person and online screening programs for depression, bipolar disorder, generalized anxiety disorder, post-traumatic stress disorder, eating disorders, alcohol problems and suicide risk.
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Substance Abuse and Mental Health Services Administration (SAMHSA) samhsa.gov
This site includes general mental health information, data on new forms of treatment, publications on mental health topics and links to local professionals. For a description of the Comprehensive Mental Health Services Program for Children and their Families, go to mentalhealth.samhsa.gov/cmhs/downloads/information_packets/Mental_Health.pdf.


“Mental Health Services for Children in Foster Care,” by N. Halfon, A. Zepeda and M. Inkelas, Health Services for Children in Foster Care, no. 4 (September 2002), UCLA Center for Healthier Children, Families and Communities, healthycild.ucla.edu.


Scurfield stresses that volunteers should not worry that they are insulting a therapist if they say treatment is not working. “It’s a professional service. Remember to individualize. One therapist, one medication may be great for one child but not so great for another. And sometimes you need to advocate to stop therapy altogether. Therapy should stop after meeting treatment goals and start again if needed.”

**Where Do We Go From Here?**

There are a variety of things that CASA volunteers and other concerned adults can do to improve the situation of children in foster care who have mental health needs. Russow recommends, “Become active in the community in trying to get mental health funding for children. Join your local Citizens Review Board. Write letters. Oftentimes CASA volunteers may see a gap that other people don’t see, and they can be a voice for kids throughout a county in a way that nobody else could.”

And in the words of volunteer Everett, “Trust your instinct and don’t back down. You have to fight for what you know in your heart is the right thing for this child. Bobby has done just fine without medication. He’s in a regular classroom and day care doing regular stuff. And now he’s transitioning into a loving adoptive home.”

What could be better than that?

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**Improving the Mental Health System to Improve Lives**

Stephen McCrea  
CASA Program Coordinator  
CASA for Children  
Portland, OR

A number of barriers make it difficult to obtain appropriate mental health services for children in foster care. CASA volunteers, staff members and supporters can be leaders in advocating for systemic changes that will benefit the children we serve.

**Limitations Inherent in Medicaid**

The fact that children in care are generally on Medicaid in some form limits their options. Child welfare agencies usually contract with specific providers, which often employ a range of therapists, some of whom are new graduates who are just starting their careers. But youth in the dependency system are arguably those with the most complex mental health needs, requiring professionals with the greatest level of experience and subtlety in knowing how to handle overlapping issues. The providers who deal with our children—at least in our Oregon service area of Multnomah and Washington counties—sometimes find the issues our children bring to therapy to require highly advanced skills that they are still working to develop.

**Lack of Availability of Newer Interventions**

A related challenge is that services for foster children tend to be limited to traditional models—in-office individual therapy and medication—when often there is a need for in-home family therapy. When a parent makes big changes, such as successfully completing drug rehab, and the child will be returned to the home, there is almost always a need for family therapy. After all, a child is going to have a very different experience at home than before his or her removal. While family therapy is crucial, it is not often funded.

Another underfunded and thus underutilized tool is behavior management. Without specialized training, some foster parents are not prepared for the kinds of behavior problems we see when kids are separated from their families. To have a professional come into the home to work with the foster parent and the child and develop a positive reinforcement program can be a huge step toward stabilizing placements. CASA volunteers can be instrumental in advocating for this kind of support before a foster home is in jeopardy.
Additional Challenges Facing Families of Color

Families of color can have an even more difficult time in our mental health system. There is a lack of practitioners of color, and there are language and cultural barriers. If you have a Spanish-speaking client, finding a therapist with appropriate experience and background—and who takes the Oregon Health Plan—can be difficult. But it goes beyond that. The very way in which mental and behavioral issues are conceptualized by our society differs from many other cultures. It is common for people of color to bump up against our mental health system and find that it just does not make sense to them. The way that some professionals talk to them about their problems may not make sense within their culture, and the solutions may not be perceived as helpful.

There is a new program run by a traditional local mental health agency that collaborated with nine local tribes to devise a specialized treatment program for American Indian children. Other kids use this program and often benefit from it as well. But it involves Native healing practices that would not be found in a standard residential treatment program, including sweat lodges and various ceremonies. We are very excited about the way this program was devised, using the wisdom of the people from the culture being served.

Treatment Complicated by Class Barriers

People from a working-class background sometimes have trouble with the idea of therapy because it seems impractical to them. In a recent study [See “Why Lower Income Mothers Do Not Engage with the Formal Mental Health Care System” in the resource sidebar. —ed.], researchers talked to low-income mothers who encountered the mental health system and quickly dropped out. The women were asked why, with researchers expecting that the mothers were not accepting the common diagnoses of anxiety and depression. But in fact the women had no trouble accepting that they were anxious or depressed. It just seemed that sitting there talking about it was not going to help. They had practical needs such as obtaining food and shelter and sometimes protecting themselves from violent boyfriends. They said things like, “If you could set me up with a good job and some daycare, you bet I’d feel less depressed and less anxious.”

Over-Prescription of Psychotropic Drugs

Several years ago, the judges in the two counties our program serves raised concerns about the over-use of psychotropic medications with children in care. They were noticing a number of trends, one being that very young children were being prescribed medication—even those under 4. The judges also noticed that the number of medications per child was going up, sometimes to four or more. With some additional research, they discovered that the local foster care population has a much higher rate of psychotropic medication use than the general public—perhaps five or six times higher.

Role of CASA Programs in Advocating for Systemic Change

CASA volunteers and staff members are uniquely positioned to call attention to the way that the mental health system currently treats foster children. Real systemic change is going to require mental health providers themselves to rethink what they are doing. A new system delivery model is needed. Appropriate treatment is going to depend a lot on an individual’s culture; it is going to depend on recognition of the kinds of stresses and traumas that they have experienced historically and that they may continue to be under. If these things are not taken into account, a diagnosis alone is a relatively ineffective tool.

An example of success in Portland is our work to address the over-prescription of drugs and other mental health issues related to children in care. We helped form a multi-disciplinary work group in the two counties we serve, with attorneys, case workers, psychiatrists, state policy makers, the attorney general and CASA program representation. The group made recommendations to the local and state Department of Human Services offices based on our discussions. To a large extent, these recommendations have been taken seriously, and a number have been implemented both locally and statewide.

Perhaps as importantly, we saw a cultural change begin to develop very quickly after the work group began meeting. When we first started talking about this issue, medication was rarely a topic of discussion during court hearings. That has changed significantly. Caseworkers are feeling empowered to ask more questions about doctors’ prescriptions because they have more information and more support from the courts and their own agency to do so. Certainly CASA volunteers have been recognized as leaders in raising these issues before the courts and in the community.

Creating a collaborative mental health work group like we did in our service area is an effective way to examine child welfare systems and recommend needed changes. If a CASA program gathers the support of its courts, local child welfare agency and the local bar, a great deal can be accomplished. If this has not happened yet in your community, I strongly encourage you to start now!

System change can start small. Fortunately, CASA programs are uniquely positioned to build on those small changes and help new ideas become a normal part of the child welfare system.

Stephen McCrea has worked for CASA programs in Oregon for the past 11 years. With a master’s degree in education and a bachelor’s in chemistry, most of his post-university training and experience have been in the field of mental health.