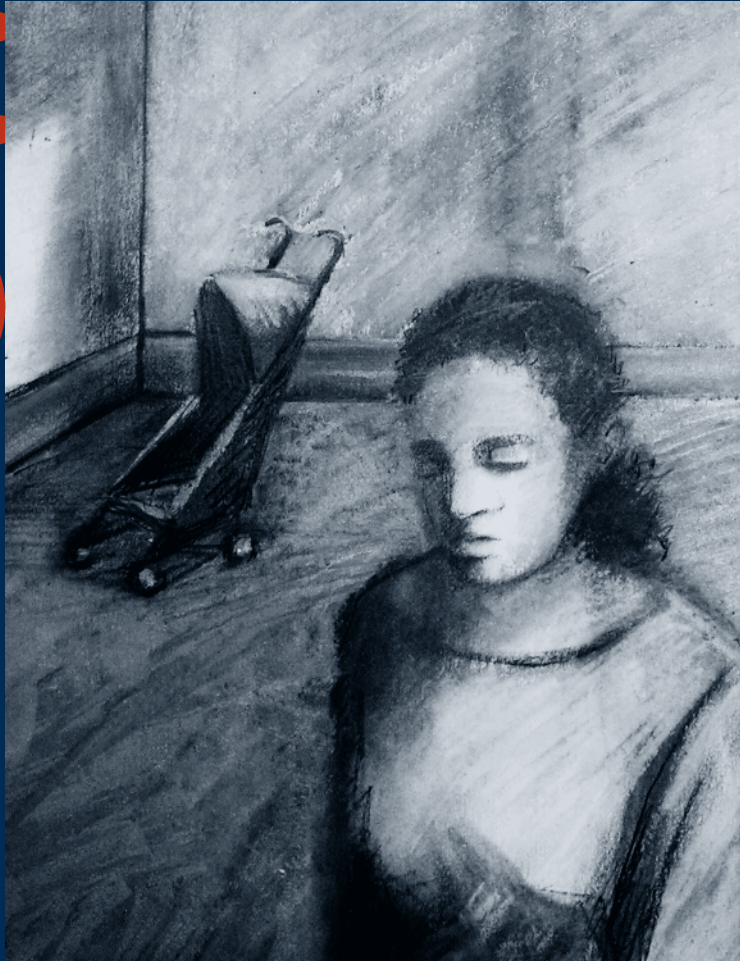


Child Welfare Watch

HARD CHOICES:

Caring for the children of mentally ill parents



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HALF A CENTURY AGO, when people with chronic and severe mental illness routinely spent years in institutions, women with psychiatric conditions were less likely to bear children than they are today. Now, after decades of deinstitutionalization, women with mental illness are just as likely to have children as anyone else.

Mental health experts estimate that nearly half of all women experience psychiatric disorders at some time in their lives. These disorders may be mild and easily treatable, such as some forms of depression, or they may be chronic and severe, such as schizophrenia. How successfully these women care for their children depends not just on their diagnoses, however, but also on the level of support they receive at home, their awareness of their own illness and their willingness to accept professional help. Women with private health insurance and those with supportive partners or other relatives often manage to rear their children quite well. But single mothers living in poverty and without adequate health care and supportive families often wind up with children in foster care.

Joanne Nicholson, a national expert on parents with mental illness, estimates that between one-quarter and three-quarters of parents with serious mental illness lose custody of their children. One small study of inner-city mothers hospitalized for psychiatric illness found that 80 percent lost custody of their children. Deciding whether a mother is fit

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- Nationwide, more than 1 million parents of children under 18 have a psychiatric disability, and nearly half of all mothers experience psychiatric disorders at sometime in their lives, researchers say. (See “A Supportive Home in Brooklyn,” page 5.)
- As many as one-fifth of parents who come into contact with New York City’s child welfare system have a diagnosis of mental illness. (See “Deciding if a Mother is Fit,” page 13.)
- Last year, children were removed from their homes in just 35 percent of Family Court abuse and neglect cases that involved no allegation of mental illness—while in cases that did include such an allegation, children were removed and placed in foster care 56 percent of the time. (See “Deciding if a Mother is Fit,” page 13.)
- New York City foster care agencies referred 148 children with serious mental or emotional problems for inpatient placement at Medicaid-funded Residential Treatment Facilities (RTF), overseen by the state, from September 2007 to September 2008. Only 80 were approved. (See “A Revolving Door of Care,” page 20.)
- Many children with severe mental illness alternate between placements in psychiatric hospitals and foster care residential centers, because they are deemed ineligible for an RTF slot. The foster care residential centers receive a per-child, per-day rate that averages about \$212, while RTFs are fully funded by Medicaid at a much higher rate, about \$455 per day.

to rear a child is never easy. If a mother has mental illness, the decision is even more agonizing and complex. In some states, mental illness—by itself—is grounds for removing a child and not pursuing reasonable efforts to reunite a family.

But advocates say many parents with severe mental illness can safely care for their children, if given the proper supports. In this edition of *Child Welfare Watch*, we look at a supported-housing residence in Brooklyn, the Emerson-Davis Family Development Center, where single mothers with mental illness live with their children and receive the help and supervision of social workers and other trained staff (see “A Supportive Home in Brooklyn,” page 5).

Programs such as these are rare. Nicholson estimates there are only a few dozen programs in the United States specifically designed for mothers with mental illness, and that only a tiny handful, like Emerson-Davis, provide housing. Nationwide, there is little coordination between the adult mental health systems and the child welfare systems designed to protect children. Mental health workers may not even ask a patient if she has children, while child welfare workers typically have little training in how to deal with mental illness (see “When Parents Need Treatment,” page 9). Perhaps most important, parents with mental illness are often reluctant to acknowledge they need help. Women fear if they confide in a therapist—and let someone know how depressed they really are—they will lose their children. We profile the case of a woman who did just that (see “A Depressed Mother Asks for Help,” page 18).

A parent with children in foster care and a diagnosis of mental illness has much more difficulty reuniting with her children. On top of completing the practical preparations for bringing her children back home, such as finding an adequate home, she also must persuade a judge and caseworkers that her mental illness will not get in the way of safe parenting.

In New York City, Family Court makes critical decisions about a parent’s fitness based on mental health evaluations that can be highly subjective and that often offer contradictory diagnoses. Inaccurate diagnoses can hurt families in two ways—by

minimizing the problems of a parent who is seriously ill, or by exaggerating the problems of a parent who is able to cope. The evaluations offer a snapshot of a mother’s condition, often based on a single interview, rather than a detailed study of her medical and family history (see “Deciding if a Mother is Fit,” page 13).

In Chicago, on the other hand, the court system has experimented with a more reliable method of evaluating a parent’s fitness. A team (made up of a psychiatrist, a psychologist, and a social worker) looks at a variety of records including a complete medical history, any criminal or drug reports, and school records. The team interviews the parent together with the child, in a home setting, to observe their interaction. Preliminary results suggest that children of parents with mental illness now have shorter stays in foster care because judges are more willing to return them home on the basis of a thorough and persuasive evaluation (see “A Better Way to Judge,” page 16).

The rising wave of municipal and state budget cuts will hit human services hard, especially those neither mandated by federal and state law—including many preventive family supports—nor funded by Medicaid. These cuts will occur even as families experience intense stresses caused by economic forces well beyond their control. As researchers have shown, the stress of poverty has profound implications for a parent’s mental health—as well as for the brain development of young children.

And yet, even in times when funds were more available, government has made only modest progress toward addressing the needs of low-income families coping with mental illness. Mothers with mental illness have received little attention from scholars or policy makers. Only a handful of researchers have focused on their care and treatment. Policy makers tend to focus either on the needs of children, or on the needs of the mentally ill. With this issue of *Child Welfare Watch*, we hope to focus attention on the needs of both—parents with mental illness and their children—and to show that meaningful solutions are inextricably intertwined across the sectors and generations.

—Clara Hemphill

RECOMMENDATIONS AND SOLUTIONS

THE NEW YORK CITY AND STATE mental health and child welfare systems fail to interact smoothly and often miss opportunities to provide supports that would effectively keep a child out of foster care—or to place them in the most appropriate type of care. Following are recommendations proposed by the *Child Welfare Watch* advisory board to address many of the issues raised in this report:

A PARENT'S ABILITY TO CARE FOR HER CHILDREN SAFELY—NOT HER PSYCHIATRIC DIAGNOSES—MUST BE THE STANDARD FOR DETERMINING WHETHER OR NOT CHILDREN ARE PLACED IN FOSTER CARE.

Data from Family Court reveal that when city child abuse and neglect investigators suspect a parent has a mental illness, the children are far more likely to be removed from their home and placed in foster care. This fact points to the enormous consequences of mental health assessments on the lives of New York families and children. Attorneys who represent parents in Family Court estimate that as many as one-fifth of all abuse and neglect cases include a parent's mental health diagnosis.

But a diagnosis, by itself, is not an effective way to determine who is capable of being a good parent. Many women and men with mental illness are competent parents, particularly if they have lots of support at home and are willing to accept professional help. Others may be unfit parents, even if they have no psychiatric problems.

To have influence in abuse and neglect proceedings, Family Court judges and the city's Administration for Children's Services (ACS) should obtain high quality, team-based evaluations that assess parenting competence. Dr. Laura Miller, a psychiatrist at the University of Illinois and an expert on mental illness, has set up guidelines for just such an assessment. For example, a mother who is aware of her own mental illness is more likely to be an adequate parent than one who denies she has problems. A mother who has realistic ideas about what can be expected from children at certain ages is less likely to mistreat a child than one who has unrealistic expectations. A mother with a strong social support network of family and friends is less likely to mistreat a child than a mother who is socially isolated. The child welfare system should consistently

use criteria such as these, developed by Miller and other experts, to determine who is a fit parent—and not merely stigmatize mothers with diagnoses of mental illness that are too easily used to justify a child's placement in foster care.

MENTAL HEALTH EVALUATIONS ORDERED BY FAMILY COURT OR BY THE ADMINISTRATION FOR CHILDREN'S SERVICES SHOULD BE THOROUGH AND UNBIASED.

In New York City, there is no standard for how these evaluations should be conducted. Some observers consider them inherently biased because they are frequently performed as part of an adversarial court proceeding. They can be highly subjective and separate evaluations routinely offer contradictory diagnoses. They tend to be based on cursory one-time examinations, often without the children present, rather than a thorough review of a mother's medical and family history and an observation of her parenting ability.

Moreover, lawyers representing mothers in Family Court say evaluations are requested far more often than necessary, even in cases in which there is no mental health allegation. The court should limit requests for evaluations to cases in which there is an indication of unresolved mental health issues and not order evaluations indiscriminately.

In addition, the city should set standards for these evaluations. Miller, a psychiatrist who helped set standards for mental health evaluations in Illinois, recommends that evaluations be carried out by a team that includes a psychiatrist, a psychologist and a social worker, rather than by one clinician as is now typically the case. She says they should include a thorough look at a family's medical history and social-support network, an observation of the parent interacting with the children, and a review of pertinent documents such as school records or any criminal records. A neutral party should pay for the

evaluations to minimize the risk of bias.

Such evaluations are initially more expensive, but they can save money in the long run: they put a stop to the duplicative assessments that routinely occur in Family Court cases, and they provide detailed information necessary for a child's permanency planning, which can shorten lengths of stay in foster care.

FAMILY COURT, THE ADMINISTRATION FOR CHILDREN'S SERVICES AND SERVICE PROVIDERS SHOULD USE MENTAL HEALTH EVALUATIONS TO PROVIDE SERVICES FOR A MOTHER, NOT TO PUNISH HER.

Too often, mental health evaluations are used to vindicate the child welfare system's decision to remove children from their home or otherwise make demands of a parent. A better model would be to use mental health evaluations the same way the school system is supposed to use Individualized Education Plans (IEPs) for children with special needs. Just as IEPs outline services that might benefit a child in school, so mental health evaluations should be used to determine exactly what kind of supports a parent needs, and then to obtain those services. For example, the evaluation might state that a mother needs a homemaker to visit daily to help her organize her household and a weekly visit to a therapist to work on anger management. This is already standard practice at some agencies, but it should be the standard by which all use of evaluations is measured.

FAMILY COURT JUDGES, LAWYERS AND CHILD WELFARE WORKERS NEED TO BE BETTER INFORMED ABOUT MENTAL ILLNESS.

Many of the people who routinely make judgment calls about parents' mental stability are not clinically trained. Some confuse parents' reactions to the trauma of having children removed with genuine

mental illness. Others are unaware of how to fairly determine whether a parent with mental illness can care for her children.

The Urban Justice Center recently launched the Parents with Psychiatric Disabilities Legal Advocacy Project, which provides representation, information and advice to parents in Family Court and educates court officials on issues facing parents with mental illness. Training and ongoing coaching around mental health issues should be a routine element of child welfare work for frontline ACS staff, court officials and caseworkers in foster care and preventive agencies.

Similarly, to prevent children from receiving inappropriate diagnosis and treatment, the psychiatrists and therapists evaluating children must be skilled at differentiating between a child who has been traumatized—from, say, being removed from their family—and a child with a genuine mental illness.

Today, ACS field offices and some foster care agencies have skilled clinical consultants who support frontline staff on these issues. Yet there is still much work to be done to clear up misconceptions around mental illness and help the courts and child welfare workers make more informed decisions when working with and planning for families affected by mental illness.

The city should preserve funding for services that allow mothers and their children to get help at home, reducing the need for foster care and psychiatric hospitalizations.

Parents with mental illness may be able to care for their children at home if they receive services such as psychotherapy, child development classes, help with anger management, a homemaker and a social worker to call in an emergency. When they are successful, these services prevent children from going into foster care. State and city funding for nonprofit-run preventive family support services has increased substantially during the last four years, yet providers still speak of severe difficulties obtaining adequate supports for parents and children who need intensive help. Budget makers in the current fiscal crisis have so far largely spared ACS-contracted preventive services, but the outlook for government funding over the coming years is grim. Targeted funding of services for parents with mental health needs who would otherwise lose their children to expensive foster care will not only help families, it can save money

THE PATERSON ADMINISTRATION SHOULD PRESERVE PROGRAMS THAT OFFER MENTAL HEALTH SERVICES FOR CHILDREN IN THE COMMUNITY.

Both the state Office of Mental Health (OMH) and Office of Children and Family Services (OCFS) have expanded community-based services in recent years, in the hopes that children can receive treatment before their conditions deteriorate to the point where they need institutional care. Federal regulations permit states to use Medicaid money to pay for intensive, ongoing outpatient services—not just hospital care—under a program called the Home and Community-Based Services waiver. In New York City alone, the mental health residential support services component of this program has grown from 64 slots for young people in 1996 to 510 slots in 2007. Statewide, the program has grown from 125 slots in 1996 to 1,506 slots in 2007, according to OMH.

Another program, Bridges to Health, supported by OCFS, puts specially trained staff of community mental health clinics in the neighborhood offices of foster boarding home agencies. This improves the quality of care, strengthens case management and increases access to services. This program also offers foster parents long-term extra help dealing with children who have severe emotional problems. For example, if a child has a serious emotional outburst, the foster parent can call a special caseworker who will come to the home immediately to help them cope. The potential payoff is tremendous: foster children are a tightly targeted group that experience a high rate of trauma and other emotional issues. The long-term benefits of proper care at an early age are clear. This program is budgeted to serve 610 children at a cost of \$9.166 million this year, double the number last year.

THE PATERSON ADMINISTRATION MUST USE MONEY SAVED BY SHRINKING OR CLOSING INSTITUTIONS FOR CHILDREN TO PROVIDE ALTERNATIVE FORMS OF COMMUNITY-BASED CARE.

The governor's Fiscal Year 2010 budget recommends closing or shrinking the size of juvenile justice facilities with a savings estimated at \$16.4 million. This savings should be reinvested in alternatives to incarceration, which help keep children out of institutions. Similarly, as the state closes children's inpatient psychiatric hospitals, foster care residences and inpatient drug-treatment

facilities, the money should be redirected to community-based mental health services and supports for foster families. These services help keep families together at a fraction of the cost of institutional care.

THE STATE SHOULD MAKE FUNDING FOR CHILDREN'S PSYCHIATRIC SERVICES MORE FLEXIBLE AND RATIONAL.

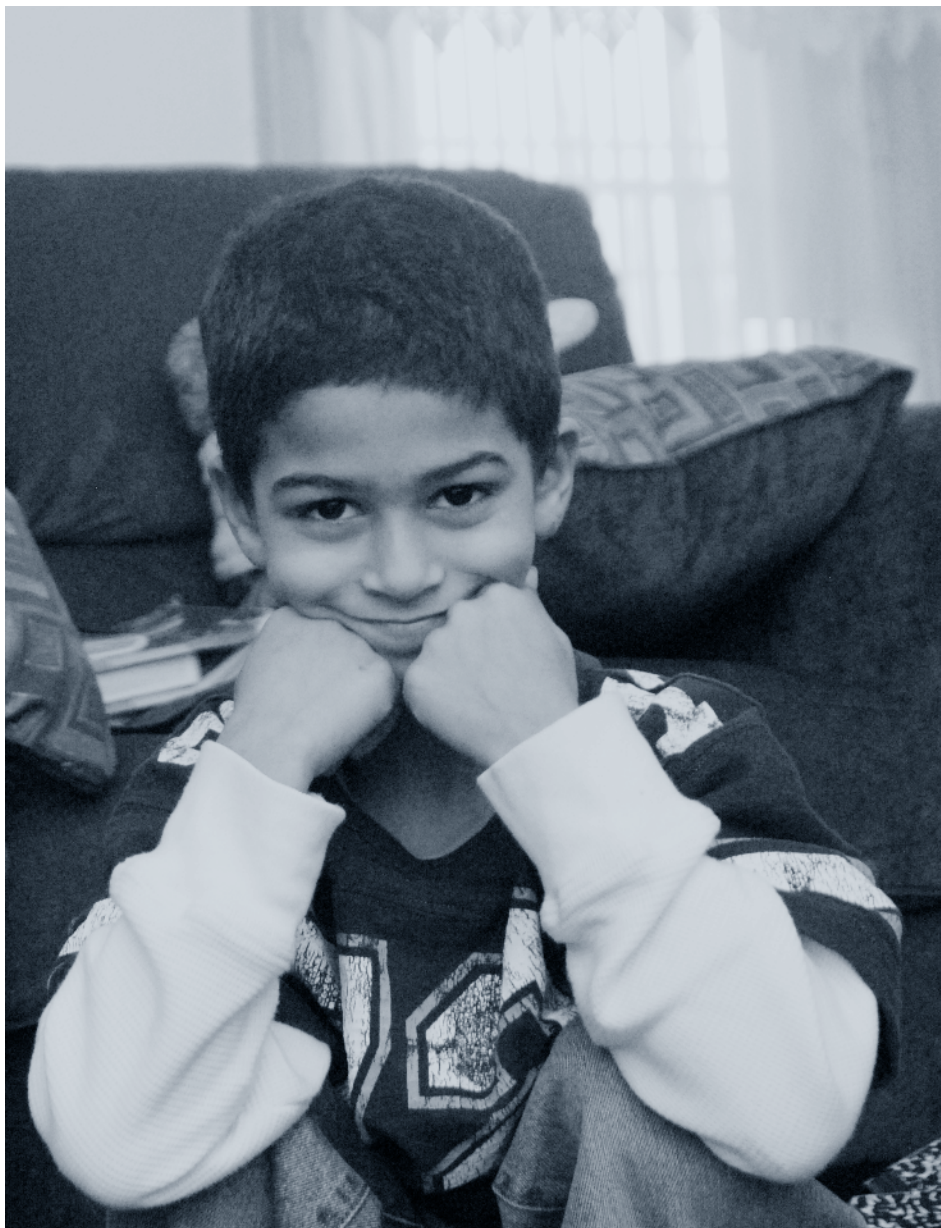
Foster children with severe mental health issues often bounce between psychiatric hospitals and residential foster care institutions, moving back and forth as their conditions improve or deteriorate. Part of the problem is that each institution serving children has rigid requirements of who can be admitted and who will pay for it. Foster care institutions, supported by the child welfare system, frequently aren't equipped to handle a child who is violent or aggressive, acting out sexually or addicted to drugs. However, that same child may not be eligible for intensive inpatient psychiatric services offered at a residential treatment facility funded by the state OMH. As a result, a child may be hospitalized for a brief period, then sent back to foster care.

Moreover, beds paid for by OMH receive rich funding—more than \$400 a day—while those in the child welfare system receive much less, about \$200 a day. The value and quality of resources a child or family receives should be based on need, not on whether or not the child is in foster care.

The state OMH and OCFS should survey all the beds available for children in institutions (including those in foster care, juvenile justice, mental health, and the Office of Mental Retardation and Development Disabilities), assess where the need is greatest, and adjust the funding and services accordingly. For example, instead of creating more inpatient psychiatric beds, the state might broadly expand recent efforts to install clinical mental health services inside foster care agencies to ensure that psychiatrists are available to treat more children—especially those in residential treatment centers that have inadequate clinical and round-the-clock staff support. More foster care institutions might be funded to designate some beds as "crisis" or "respite" beds, in which children would receive intensive services without being hospitalized. There have been recent, admirable state-backed experiments with greater flexibility, yet the current inflexible rate structure still contributes to instability in the lives of fragile children.



Maria Ubiera, who lives with her son, David, receives visits from a social worker for help managing her depression.



BY THE TIME she was 10 years old, Carmen (not her real name) was diagnosed with depression and anxiety. Each subsequent psychiatric evaluation resulted in additional diagnoses, including bipolar, attention deficit and borderline personality disorders. She would fight in school and began cutting herself, a symptom of psychosis. After giving birth in her late teens, she and her son were homeless for a year. At one point, she cut herself so badly that she landed in the hospital. Her son was subsequently removed from her care and placed with her mother.

However, after undergoing psychiatric counseling, parenting classes and other specialized services designed to boost her parenting skills and understanding of her disabilities, Carmen was reunited with her son, now 5 years old. They live together with Carmen's 1-year-old daughter in the Emerson-Davis Family Development Center, a Brooklyn residence that demonstrates it is possible for a single mother with a serious mental illness to care for her children—if given the proper supports.

A Supportive Home in Brooklyn

With help, many parents with mental illness can safely care for their children.

BY ANN FARMER

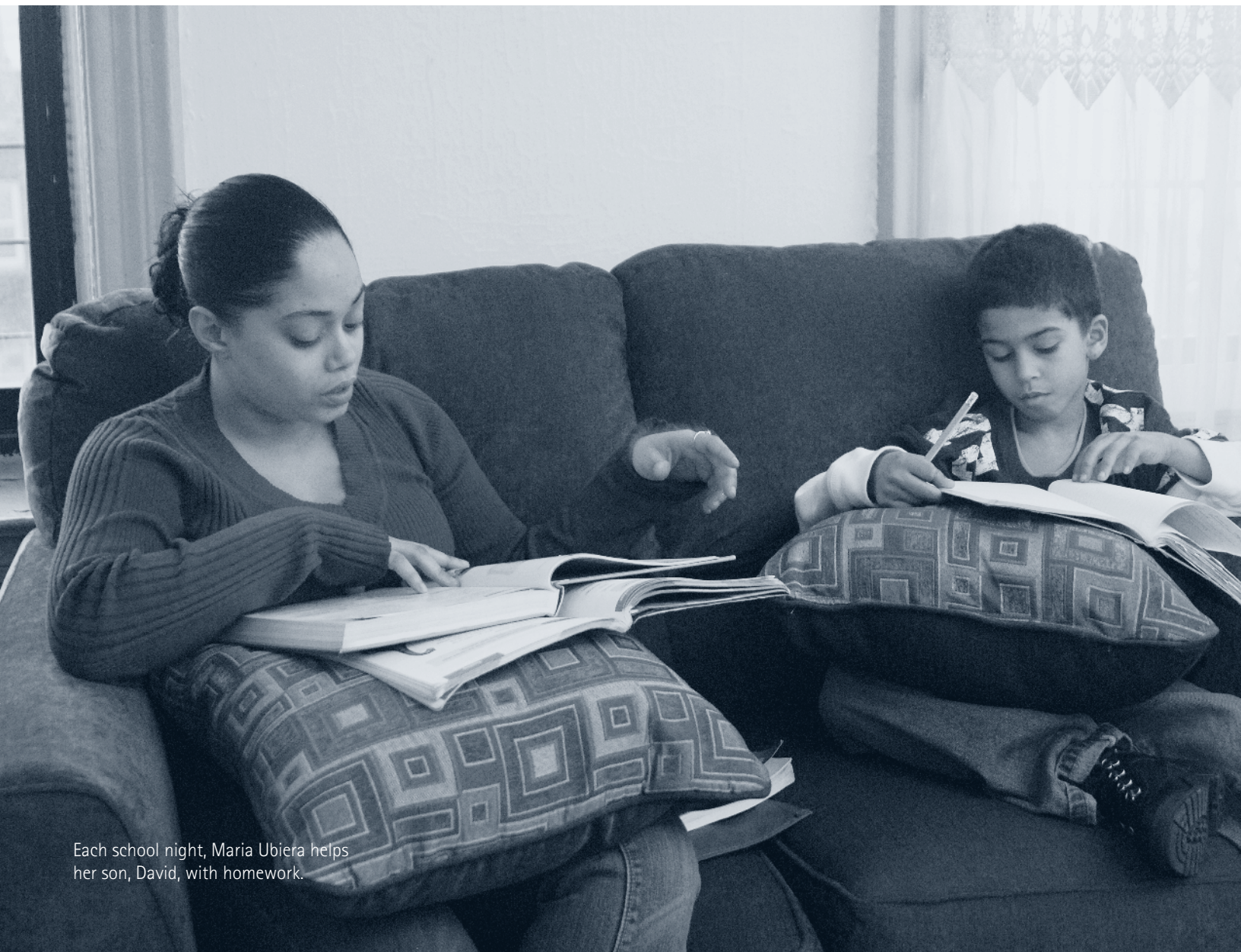
“I learned how to wash clothes here. How to mend clothes,” says Carmen, 24, proudly seated in the tidy living room of her two-bedroom apartment. Carmen says the trained staff, who maintain a 24-hour presence in the building, taught her things like how to safety-proof her home and how to reward her children with stickers for good behavior instead of disciplining them with corporal punishment. “Any problems we have with our kids, we talk about it,” she says.

Founded in 1986 by The Institute for Community Living, a nonprofit supportive housing organization, Emerson-Davis has 16 apartments for families and 22 smaller apartments for single people in a former college dormitory in a leafy neighborhood. It was the first in the country to provide temporary housing and other supports for single parents with mental illnesses and their kids. The parents’ diagnoses range from mood disorders, like depression, to personality and thought disorders such as schizophrenia. Most of the children have been in foster care at some point. Every household has

either experienced separation due to homelessness and mental illness, or was at risk of being separated when they arrived. Yet 90 percent of the residents of Emerson-Davis have retained custody of their children throughout their stay, and 90 percent were stable enough to avoid emergency psychiatric services, according to Stella V. Pappas, chief operating officer of the Institute for Community Living and a trained social worker.

No one knows exactly how many mothers in the U.S. suffer from mental illness. Joanne Nicholson, a national expert on parents with mental illness, estimates that more than one million parents of children under 18 have a psychiatric disability. Nicholson, an associate professor of psychiatry at the University of Massachusetts Medical School and author of a book, *Parenting Well When You’re Depressed*, bases her estimate on an analysis of U.S. Census and other data, including a national survey of adults with disabilities.

Nearly half of all mothers experience psychiatric disorders sometime in their lives, Nicholson says, citing data from the



Each school night, Maria Ubiera helps her son, David, with homework.

National Comorbidity Study, a survey of 5,877 adults conducted from 1990 to 1992 designed to determine the need for psychiatric services nationwide. Nicholson estimates that between one-quarter and three-quarters of parents with serious mental illness lose custody of their children. For example, a study of 32 mothers hospitalized for severe mental illness at an inner city hospital found that only about 20 percent maintained full custody of their children, according to a 1999 article by Jill G. Joseph in the journal *Psychiatric Services*.

Even though federal law requires child welfare officials to make every effort to reunite families, parents with mental illness face enormous obstacles in trying to regain custody of their children in foster care. In fact, a number of states, including Alaska, Arizona, California and Kentucky, list mental illness as grounds for not pursuing efforts to reunite a family. Programs designed specifically to deal with parents with mental illness and their children, such as Emerson-Davis, are scarce. Researchers at the UPENN Collaborative on Community Integration of Individuals with Psychiatric Disabilities in Philadelphia have identified fewer than two dozen programs across the country that are specifically geared to assisting parents with mental disabilities. Emerson-Davis is one of the very few that provides housing as well as mental health services.

Advocates for the mentally ill say that more families headed by a parent with a mental illness could stay intact if they received specialized help and support. “What people need to understand is that having a mental illness doesn’t [necessarily] mean you’re going to be a bad parent,” says Katy Kaplan, Coordinator of the UPENN Collaborative, which is a rehabilitation research and training center that promotes community integration for individuals with psychiatric disabilities. “The supports just need to be in place.”



At Emerson-Davis, the residents have access to a lounge, community room and day care center, facilitated by an after-school tutor who teaches the children socializing skills and provides homework help. Staffers occupy an office by the front door, monitoring who enters and exits the building. They assist the residents throughout the day, intervening in conflicts if necessary.

The workers also conduct routine apartment checks to ensure that all the households are functioning properly. “It’s a very active program,” says Pappas. “You need to be actively involved and let the staff into your business. They’re looking in your cupboards and refrigerator to see that your home is clean and appropriate for children.”

While the staff doesn’t monitor the residents while they are taking their psychotropic medications, “they do go in and count pills,” says Pappas, adding that because of the intimate nature of the program, they attempt to hire workers who resemble the residents. “We try to hire people in the neighborhood so we can be as culturally sensitive as possible.”

The residents are also assigned individual case managers

who provide them guidance in terms of formulating educational and job goals, so they can eventually re-integrate back into the larger community. No one is pushed out. But once a family is stabilized, the organization will help them relocate to apartments scattered throughout the community, where they live on their own and continue to receive visits from their caseworker.

Residents say they are grateful for help with things like directions to a doctor’s appointment. “I call it my concierge,” laughs Kathy Alicea, 42, who moved in with her infant son 9 years ago and who has lived in the building longer than any other resident. Alicea says her son doesn’t see it as anything but his home. “My son loves it. He doesn’t see it as a program or a shelter.”

Before Alicea moved in, she was living—without her son—in a residence for individuals with mental illnesses in Queens. Her cozy apartment at Emerson-Davis has a fireplace mantle that she’s lined with Buddha statues. She recently gave birth to a second son, whom she rocked to sleep on her shoulder. She describes having a nervous breakdown when she was younger.

“I guess it took a toll on me. I was feeling very devastated,” says Alicea explaining that she went from a “high moving girl to a very non-functional person.” A psychiatrist diagnosed her with depression, bipolar and dysthymia, a chronic mood disorder characterized by depressive and manic symptoms. She keeps her symptoms under control with a daily dose of Prozac. Currently, Alicea is one semester away from getting her bachelor’s degree. She hopes to become a social worker and work with parents who have mental illnesses.



Even with supports in place, it’s not always easy for the residents and the child welfare workers who deal with them. Crystal Thomas, the director of Emerson-Davis, says she observed a situation in which a caseworker misinterpreted a depressed resident’s withdrawn behavior as being hostile. “She said she wouldn’t help her get her child back because she had a bad attitude,” says Thomas. But the parents, whom she calls “consumers,” can also make it hard on the caseworkers. “The consumers, they can be rude,” says Thomas. “They can curse them out.”

Maria Ubiera is a former resident of Emerson-Davis who suffers from depression and other mental disabilities. She says she lost custody of her son after she experienced what she calls a “disorientated episode” caused by some depression medication. While eating at a diner, she went into a state in which she failed to notice her son was throwing up. Taken to a nearby hospital, where she was heavily medicated, she was unable to respond to the caseworker’s questions about him or where they lived. As a result, her son was placed in foster care where he remained for 18 months while she moved into a shelter.

To get him back, she relocated into one of Emerson-Davis’s 22 small apartments designed for people without children and began meeting the various requirements set forth by her

It is possible for a single mother with a serious mental illness to care for her children—if given the proper supports.

caseworker from the city's Agency for Children's Services (ACS). She entered a drug rehab program and started taking parenting classes. She also started a book club at Emerson-Davis and became the community president. Still, her relationship with her ACS caseworker was rocky.

"She started telling other caseworkers that she was afraid of me. She told me she never had a case with someone diagnosed with bipolar," says Ubiera. The caseworker, who spoke with a heavy Russian accent, would say she didn't understand Ubiera. "She'd say, 'I think you need to switch meds,' like she was my doctor. She didn't understand my diagnosis," says Ubiera. Eventually, Ubiera signed a release allowing the caseworker to talk to her therapist as a way for her to better understand her condition. She has since moved out of Emerson-Davis and is living with her son in her own apartment, supervised by a social worker from the Institute for Community Living.



Few other residential-type programs for families exist in the United States, probably due to the overwhelming amount of paperwork and administration that is required to piece together all the funding sources necessary to keep this type of operation going. Emerson-Davis cost about \$57,000 per family per year and is funded by a combination of federal, state and city agencies, benefit entitlements and private donations.

Funders include the city Department of Health and Mental Hygiene, the city Department of Homeless Services, the state Office of Mental Health, the state Office of Mental Retardation and Developmental Disabilities, the state Department of Health, as well as Medicaid and two federal agencies: the Substance Abuse and Mental Health Services Administration and the Department of Housing and Urban Development.

When asked which residents seem to do best, Pappas says, "Surprisingly, the most important factor is a parent's motivation and their understanding of their disability and needs. Sometimes we have parents with more severe disabilities but they're highly motivated and insightful and will do better." The program, she says, "requires a certain confidence level and openness to learning and learning new skills." Staff

members interview prospective residents and choose people who have a good attitude and are likely to be successful living at Emerson-Davis. Prospective residents may hear about the program by word-of-mouth, or may be referred by mental health or social services workers.



It took time for Carmen to get on track. She'd heard about Emerson-Davis while living in a shelter. After an interview with staff members, she was assigned to one of the 16 coveted family apartments. Shortly after moving in, however, she cut herself with a knife in an intentional act of self-injury. ACS removed her son and placed him with her mother. She initially reacted by spending a lot of time hanging out on the streets. "I was fighting the program," she says.

"We'd see her one or two times a month, just to change her clothes," says Thomas. Eventually, Thomas had a sit-down with Carmen and told her that if she didn't begin complying with ACS requirements, she would move her to a smaller apartment designed for individuals that would have precluded her son from moving in with her.

"I remember the meeting," says Carmen. "I had to go outside to think about it. I feared losing everything I fought for." She made up her mind to adapt to the challenge. "I started staying in the building and going to meetings," she says. "It calmed me down. I felt in a safe place."

Now, she has a hard time imagining leaving the residence. She keeps her apartment fastidiously clean. In the kitchen, spice containers are neatly lined up along side bottles of flavored cooking oils that she mixes herself. On the wall in the living room, boxes of colored markers are hung beside a dry erase board that she uses to teach her children. She learned to cook in a culinary class at Emerson-Davis. Her favorite dish to make is an elaborate concoction of stewed chicken with rice and vegetables. "Spanish style," she says, practically smacking her lips. She does her own shopping and runs her own errands. She visits friends, just as she would if she lived on the outside.

"When I move out, it will feel lonely, because this feels like a community," she says. "I'll stay as long as I can. The same way I'm okay here, I want to be okay out." ❄

When Parents Need Treatment

Supports are scarce for mothers with mental illness.

BY ANN FARMER

WHAT SUPPORT CAN a mother with mental illness count on if she wants to be a better parent? The short answer: Not much. Nationwide, there is little coordination or communication between the mental health system—geared to treat adults—and the child welfare systems that are designed to protect children. Mental health workers may not even ask a patient if she has children, while child welfare workers typically have little training in how to deal with mental illness. Perhaps most important, parents with mental illness are often reluctant to acknowledge they need help—for fear their children might be removed if they do.

Advocates for the mentally ill say prejudice against parents with mental illnesses is based on a misunderstanding of mental illness and generalized assumptions about its debilitating effects. For instance, schizophrenia is a chronic disease that can cause sufferers to hear voices in their head and can be difficult to control. Maternal depression, on the other hand, may be episodic and is usually easier to treat.

Mood and anxiety disorders are the two most common mental illnesses. “Depression is considered the common cold of mental illness,” says Edie Mannion, co-founder of the Training and Education Center of the Mental Health Association of Southern Pennsylvania. Depression can make parents irritable, withdrawn, unavailable and inattentive. When it hits, some people have difficulty getting out of bed and managing the most basic parental responsibilities such as feeding and cleaning their children. “It affects whether the child feels loved and cared for,” says Mannion. Mannion, who is also a family therapist, teaches a one-day course to child welfare caseworkers in Philadelphia with an overview of the symptoms and treatments of major mental illnesses.

Mannion says parents have confided to her that the service they most need is some kind of respite emergency child-care that they can tap into when they’re getting sick. Parents can be afraid to ask child protection services for such help

because it can open the door to scrutiny, which might result in losing their kids.

How much help a mother gets depends in part on how much money she has—and whether she has private health insurance. “If you have money, you can check yourself into a hospital if you have post-partum depression,” says Sharman Stein, spokeswoman for the city’s Administration for Children’s Services (ACS). “But for poor women, what’s going to happen?”

...

Years ago, women with mental illness were often sterilized to prevent them from having children. While involuntary sterilization no longer exists, some children are taken at birth from mothers whose psychosis seems to prevent them from being an effective parent. Older children may also be placed in foster care.

Few believe foster care is a long-term solution for children, and adoption can take years. Social service agencies routinely try to determine if families can be kept together safely. Putting children in foster care doesn’t help the parent get better, says Jan McCarthy, former director of Child Welfare Policy at Georgetown University’s National Technical Assistance Center for Children’s Mental Health. “And the move itself creates all

Parents can be afraid to ask for help because it can open the door to scrutiny, which might result in losing their kids.

kinds of trauma for the kids. You lose your family, your home, your school, your friends,” she says.

“We know significant numbers of parents with children in the child welfare system have mental health needs,” adds McCarthy, co-author of a 2004 national report on the state of mental health for the U.S. Department of Health and Human Services. Nevertheless, she says, she knows of no state that requires its child welfare workers to receive training in how to identify and communicate with parents with mental illness.

Child welfare agencies in some cities and states are beginning to conduct more comprehensive family assessments, McCarthy says. “One thing the child welfare system is trying to do is individualize services for families,” she says, describing how agencies are cobbling together peer advocates and teams comprised of family members and community mem-

bers to help parents with mental illnesses develop an appropriate service plan for their family and better navigate the child welfare system.

A new study by the National Technical Assistance Center outlines some of the ways states are beginning to fund behavioral health services for parents and children. Arkansas, for instance, has begun providing parents who are ineligible for Medicaid with intensive family services, psychiatric evaluations and counseling. In Arizona, Medicaid is now being used to pay for “family education and peer support, respite, behavioral management skills training and other supports to families if these supports are geared toward improving outcomes for the identified child.”

Parents with mental illness are entitled to the same preventive family support services that any parent involved with the child welfare system may receive, including parenting classes, drug treatment, therapy, and help with housekeeping.

In New York City, a small number of parents with chronic and serious mental illness who come in contact with the foster care system eventually move to supported housing programs where they can raise their children with supervision. Child welfare workers note that the need for these programs far exceeds what’s available.

A handful of city-funded community-based family service agencies have clinicians who can offer therapy sessions in the homes of parents who are not stable enough or are unable to attend weekly therapy sessions at a clinic. Some of these agencies also have clinical consultants who advise family support workers on the nuances of the mental health issues facing the families they work with. These clinicians train and consult with child welfare workers and sometimes accompany them on home visits or family conferences. The use of these consultants has recently increased significantly, says Marilyn Johnson, director of preventive services at Jewish Board of Family and Children’s Services. Her agency also provides clinical consultants based in ACS child protective field offices, where they offer advice to child abuse and neglect investigators.

But advocates for the mentally ill say that to make use of services like these, child welfare workers need a basic understanding of mental illness. Child welfare workers may not recognize or understand a parent’s psychiatric disability. For example, a caseworker may assume a mother is being neglectful for not providing her child breakfast, not realizing that she’s taking medications that make her especially groggy in the morning, says Chip Wilder, director of Family Options, a program based in Marlborough, Massachusetts, one of the few in the nation that offers intensive services to parents with major mental illnesses and their children. “Our argument is, you have to have an understanding of mental illness and treatment if you’re going to help a patient,” he says.

Family Options is affiliated with the Center for Mental Health Services Research, part of the psychiatry department

of the University of Massachusetts Medical School and one of the few organizations that compiles research and treatment information on parents with mental illness.

Wilder says that approximately 70 percent of the referrals to Family Options come through the child welfare system

How much help a mother gets depends in part on how much money she has—and whether she has private health insurance.

after caseworkers have determined that the usual family supports are insufficient. “We try to partner with child welfare workers and talk about what’s going on,” says Wilder. “And we try to help the parent engage in the child welfare plan,” explaining that its main goals for the family are safety and well being, and permanency for the children.

The staff includes three family coaches, a parent peer coordinator, and a consulting research and clinical psychologist. They begin the process by developing a trusting relationship with the parents. “We don’t say, ‘What are your problems?’” explains Wilder. “We say, ‘What are your needs and those of your children?’” Wilder says the parents are asked to make a prioritized list of their needs, which is turned into an intervention plan. It might involve helping them secure jobs or housing, improving their relationships with their children’s schools, or getting them a stove.

“A lot of their problems are with organization. Their houses are messy, dirty, disorganized,” says Wilder. “They’ll say, ‘I need help organizing my house.’ We tackle that. When you start tackling things that they say are priorities and you don’t blame them, you start to build a trusting relationship.”

These interventions, which usually last 12 to 18 months, are funded by grants and cost anywhere from \$15,000 to \$17,000 a year per family. In the 2 ½ years since the program began, they’ve helped about 30 families. Although parents often need more time, Wilder says they’ve seen improvement at each stage of the process. “People can get better. People can recover,” he says, describing how they’ve been able to engage parents who haven’t successfully engaged in any other child and family support services. “That’s the piece we do really well—engage the parent.” ✖

Like Family

I get help when I'm in crisis—so I can keep my daughter.

BY ERICA HARRIGAN

LAST OCTOBER MY boyfriend and I had our small wedding ceremony at City Hall. We already had a baby girl, Emma, and I was close to delivering number two. My mother came to stay with us for the weekend, and at one point she went out to the store and didn't return until about three hours later. It was clear that she'd been drinking, and I could smell the booze on her breath.

I didn't want her drinking around my child, so I tried to talk things over with my mother, but she started to get all crazy. She held me tight around my waist, causing me to feel pressure. I worried that I was having contractions. As she was holding me, I slowly started moving myself over to the phone and called the police. "I am seven months pregnant, with a 1-year-old, and alone with my drunken mother who is out of control. I'm scared for my life," I told them.

By the time the police came, my mother was gone but I was still frantic. I have a mental illness, a borderline personality disorder that makes it difficult for me to soothe myself, and I could not calm down.

The police wanted me to go to the hospital because of the pressure I felt and because I was so frantic, but the baby had no one to attend to her. My husband, Michael, was working, and babies are not allowed to enter the psychiatric emergency room. At that moment, I thought, "Thank God I have preventive services, because otherwise the police would call ACS [The Administration for Children's Services] to take the baby." So I gave the police my social worker's number, and they called her. She insisted that they let my daughter stay with me at the hospital until her father got released from his duties at work. Later, my husband came to get us at the hospital because the workers didn't want me to go home alone with the baby.

On Monday morning, my worker from Good Shepherd Services came early to develop a plan in case another emergency comes up. With my mental illness, it's important that I can feel safe going to the hospital, even if there is no one near to help. We decided that after I deliver my second baby, the homemaker would stay longer hours. I felt good knowing I had people who support me and services in place in case I get into another crisis.

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I got preventive services soon after finding out I was pregnant with my first child, Emma. From the start of my pregnancy, I was scared—I wasn't sure how to be a mother. I didn't grow

up with my mother as a role model. Like me, my mother has a mental illness, but unlike me, she was into the party life more than into being a mother. The foster care system took care of me.

Since I never had my mother take care of me, I thought, "How am I going to take care of my own child?" I had heard it was important to attend prenatal care, so I did. When I told staff at the hospital about my past history of being in foster care and being hospitalized on and off during those years, and my fear of having my child taken from me and placed in foster care, just like me, they gave me information about preventive services. Preventive services are supports for parents designed to prevent a child's placement in foster care. I got set up with the closest preventive organization to my apartment in the Bronx, Good Shepherd.

Good Shepherd helped ease my fear of having my daughter taken away from me. They gave me a team that includes a social worker who I meet with once a week, a case manager I meet with monthly, a therapist I see weekly, and a home-

Good Shepherd helped ease my fear of having my daughter taken away from me.

maker. I also have a phone number I can call anytime of the day or night if I need extra help. My team enrolled me in anger management classes and parenting classes, and put me in day treatment, where I learn skills like how to find a job and handle depression. I attend day treatment five days a week for three hours each day.

The most important help I've gotten is the homemaking service. A homemaker comes to my home five days a week to help me with the normal day-to-day tasks of being a mother. She not only gives me practical information about feeding, playing with and soothing my daughter, but gives me emotional support the way close family might.

When Emma was a few months old, I decided I needed more help dealing with my emotions so my up-and-down feelings would not affect my daughter. I knew I had to go to my day treatment center more often, but my husband worked during the program's hours, so there was no one to attend to baby Emma while I went. I felt overwhelmed and was concerned that I'd lose it completely if I didn't get the treatment I needed. The homemaker was nice enough to come early to look after the baby until one of us came home.

The homemaker also notices when I'm having trouble and she helps me resolve problems I'm facing before I feel out of control. One day I was talking to a friend on the phone

A Patchwork of Support

ERICA HARRIGAN'S FAMILY is one of nearly 14,000 New York City families receiving help as part of the city's preventive services designed to keep children out of foster care. These services, which are coordinated by nonprofit agencies under contract with the Administration for Children's Services, range from the simple—giving mothers parenting classes or connecting their children with daycare—to the complex. The city's total budget for foster care preventive services is \$229 million for fiscal year 2009.

Cases like Harrigan's are the most complex of all, says Ellen O'Hara, who supervises prevention workers at Good Shepherd Services. Case management for a parent with serious mental illness usually involves coordination of services performed by a number of different agencies. Typically, such cases remain open longer than the one or two years normally allotted for preventive services.

Harrigan's services include a homemaking service and weekly therapy sessions. She takes part in a day treatment program and she also has an emergency number she can use to call for help anytime, day or night. These supports feel seamless to Harrigan, but they actually consist of a patchwork of programs and agencies coordinated by Good Shepherd Services. Though O'Hara was not familiar with her case, she says Harrigan most likely receives her weekly therapy and day treatment from a hospital or local mental health clinic funded through Medicaid, and the Administration for Children's Services provides and pays for the homemaker.

It's hard to say how much this costs overall, since the supports Harrigan receives come from so many different places. "As much as what's invested in Erica, it's a lot less than if it's one child or two children in foster care," says O'Hara. "Not just monetarily, but when you look at what children in foster care go through, their own struggles and issues, and how society keeps paying for that." —Kendra Hurley

My homemaker not only gives me practical information, but also gives me emotional support the way a close family might.

when the homemaker came in. When she asked how I was, I said, "Everything's fine," but she could tell I was upset. Instead of just forgetting about me and attending to the baby, she took the time to sit down and talk to me.

She explained that every time I talk to my friend from the program I am not myself. She was right on point. I do start getting headaches and feeling a little down after speaking to my friend, but I had never seen it as a problem.

The homemaker warned me not to help out anyone but baby Emma. She was right. My friend is grown and doesn't need me to look after her; my child needs love, guidance and knowledge from her mother. By trying to be helpful to my friend, I was forgetting my daughter's needs and my own.

I am so thankful for the program and especially my homemaker. She helps make sure that I'm not competing with my daughter for attention, or letting friends or my family overshadow my daughter's needs and my own.

It can be tough for me to have to turn to these services for help. I would love for my family to help me out with the baby instead of strangers, but that's not realistic, so my husband and I look toward these services as our support system. My team helps me to not abandon my own child just because that happened to me. ✕

Erica Harrigan is a writer for Rise, a magazine providing peer-support to parents involved in the child welfare system. She recently gave birth to a baby girl and is caring for both children at home. This piece was written for Rise.



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Each year, Family Court decides the fate of hundreds of families headed by parents with mental illness.

Deciding if a Mother Is Fit

Mental health evaluations are far from scientific.

BY KENDRA HURLEY

WAS 22-YEAR-OLD Jenna Jacobs (not her real name) an attentive and affectionate mother who was able to care for her children despite the fact that she was slightly depressed and mildly mentally retarded? Or did her “psychiatric and cognitive difficulties” mean she would never be able to provide even “minimally adequate care?” The answer—and the future of

her family—depended on which of two psychological evaluations the New York City Family Court chose to believe.

Two agencies evaluated Jacobs, using very different methods. Their contradictory conclusions highlight what observers of the foster care system consider an uncomfortable truth: the evaluations and diagnoses that are used to determine the fates of many families are far from scientific, and can be flawed or misused.

The two assessments could not have been more different. The mental health clinic where Jacobs had received therapy for more than a year said she was learning to “take control of her life, and make life better for herself” and her two children, one of whom had been in foster care for about four years. The clinic’s evaluation said she was taking good care of her infant daughter and there was no reason to believe she would not be a “loving and effective parent” if she regained custody of her son.

The other assessment was performed by Family Court Mental Health Services, a division of the city’s Health and Hospitals Corporation. There, a psychiatrist interviewed Jacobs for two and a half hours and concluded that she suffered from “chronic” mental illness, adding that her son would be “at risk for neglect” if he were ever allowed to live with her.

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As many as one-fifth of parents who come into contact with the child welfare system have a diagnosis of mental illness, according to several attorneys who work in Family Court. More importantly, though, when city investigators allege that a parent’s mental illness is a factor in suspected child abuse or neglect, the children involved are far more likely to end up in foster care, according to data collected by the New York State Office of Court Administration.

During the fiscal year that ended in June 2008, children were removed from their homes in just 35 percent of newly-filed Family Court abuse and neglect cases that involved no allegation of mental illness—while in cases that did include such an allegation, children were removed and placed in foster care 56 percent of the time.

Even parents who are not initially alleged to have a mental illness often undergo court-ordered or mental health evaluations, as Jacobs did. In the 12 months ending in June 2007, Family Court Mental Health Services received 485 referrals for mental health evaluations for parents charged with abuse or neglect. Other parents and caregivers are often referred to private clinics or hospitals by the city’s Administration for Children’s Services (ACS), the private foster care agencies ACS oversees, or by their own attorneys.

Almost everyone who is evaluated is given a diagnosis, say court officials, lawyers and advocates. And as Jacobs’ case shows, the diagnosis can vary dramatically depending on who is doing the evaluation. “When you’re dealing with mental health issues, there’s plenty of subjectivity and plenty of grounds to disagree,”

explains Phil Segal, a former Family Court judge who is now a private attorney practicing family law.

Mental health evaluations are designed to help decipher a parent's potential or actual mental health issues and plan for the family accordingly. The evaluations attempt to answer important questions: Does the parent really have mental illness, or is she just going through a rough spell? Is the illness treatable, such as a mild case of depression, or is it more intractable and chronic, such as schizophrenia? If a parent receives proper treatment is it likely she can safely care for her children? What treatment and support services might she need? How likely is it that she will stick with a treatment plan?

These evaluations and their diagnoses carry great weight. They frame a parent's encounters with child welfare workers, helping to determine the supports, services and treatment with which they must comply, often under court order. They can influence the court's decision about whether children will return home or remain in foster care, and whether or not to terminate parental rights. These diagnoses stay in a parent's records permanently, even after their children are back home.

Most social service practitioners in child welfare agree that a good evaluation can be a tremendously helpful step toward addressing a parent's difficulties. "If anything in the intake or in our work with the parent seems to indicate that there are some mental health issues, we try as early as possible to get a clinical evaluation of that parent so that we aren't sending that parent to inappropriate services," says MaryEllen McLaughlin, executive director of foster care/adoptive services at Good Shepherd Services.

Others say it's clear some parents with serious mental illness cannot safely raise their children. They recall notorious cases, such as Andrea Yates, a Texan mother who drowned her five children in a bathtub in 2001 after years of suffering from post partum depression and psychosis.

But lawyers and social workers who represent parents with children in foster care say frontline child welfare workers—who are not trained to diagnose mental illness—are often too quick to label parents as "mentally ill," ordering mental health evaluations for behaviors that may in fact be reasonable responses to extreme pressure and stress.

"There are many diagnoses that get used liberally to describe stress and poverty," says Jessica Marcus, a super-

vising attorney with the Brooklyn Family Defense Project of Legal Services NYC. "Somebody is angry and they are classified as hostile. Well, who wouldn't be angry or hostile if somebody had removed their child from them or threatened to remove their child? It's a way of basically taking someone's poverty and powerlessness and treating it like it's a diagnosis and a disease, when it's really a natural response to a difficult situation."

Jacobs' lawyer, Chris Gottlieb of New York University's Family Defense Clinic, agrees. "If a caseworker doesn't like the parent's attitude, that may be that the parent doesn't like her and doesn't like the intrusion of child welfare," she says. "But that's not viewed anymore as a conflict with these two people who don't like each other. All of a sudden it's an 'anger management problem' which is a symptom of a 'personality disorder.'"



A parent with children in foster care who is ordered by the courts to undergo a mental health evaluation must do so in order to begin taking steps to bring her children back home. And yet, staff at private foster care agencies report that it can be very hard to secure these evaluations for parents in a timely manner, especially by private clinicians who receive relatively little reimbursement for conducting evaluations, or at overstretched hospitals. When parents do get mental health evaluations, Gottlieb and other advocates say that too many are of poor quality, put together hastily by psychologists or psychiatrists who meet the parent once and don't have a chance to see a parent interact with a child.

Inaccurate diagnoses can hurt families in two ways—by minimizing the problems of a parent who is seriously ill, or by exaggerating the problems of a parent who is able to cope.

"This label gets slammed on people, and some really sick people might end up reunifying and well people might end up losing children," says Jill Zuccardy, a lawyer with Lansner & Kubitschek, which represent parents in Family Court.

Some of the mental health evaluations are sloppy and carelessly written, while others are thorough and thoughtful, says Sandra Walrond, a parent advocate at the foster care agency Leake and Watts. Walrond has worked with several parents who received mental health evaluations scrawled in illegible handwriting. They sometimes describe a person radically different from the parent she knows. "Part of the time we can't

“When you’re dealing with mental health issues, there’s plenty of subjectivity and plenty of grounds to disagree.”

even read it and they don’t get enough information for us to know a diagnosis,” says Walrond. “It’s overwhelming.”

One recent evaluation of a parent Walrond works with was only three lines long, and claimed that the parent attended therapy regularly. In fact, says Walrond, she’d only been six times in the last year. “We came to the conclusion that maybe this is not the right evaluation, or maybe the mom didn’t share enough with them,” says Walrond. Indeed, a parent’s discomfort at being interviewed by someone she sees as an extension of ACS or the courts can dramatically affect the evaluation’s outcome.

But other evaluations are done well. Walrond recalls one in particular that included tests for behavior, cognitive and intellectual functioning, speech and mood. It outlined a recommended treatment plan for random drug testing, parent-child counseling sessions to enhance the parent’s discipline skills, and no use of psychotropic medication.

“It was so well-written,” marvels Walrond. “Come on, this is what we need! It’s so hard to get something like this. If we are going to help these parents, we need places that give something that is credible, that we can read, and we’re not getting that.”

Dr. Richard Dudley, a forensic psychiatrist who is frequently called to provide expert opinion and testimony for both criminal and civil cases, says parents who have multiple evaluations receive contradictory diagnoses in about 20 percent of the Family Court cases he has seen. Schizophrenia, for instance, is often confused for bipolar disorder, says Dudley. It is also quite easy to mistake situational depression—triggered by an event, such as the death of a parent or partner—for chronic depression.

He recalls instances in which a parent has had cases in both Family Court and Criminal Court, and the Family Court’s mental health evaluation found her unfit to be a parent because of a mental health issue while the Criminal Court found no grounds for an insanity plea.

Dudley says he has also seen numerous mental health evaluations that accept a previous diagnosis as accurate without further investigation. “We far too easily just assume that the person had been accurately diagnosed in the past,” says Dudley. Similarly, he says, nearly all evaluations result in a diagnosis—whether or not one is justified. “Sometimes you don’t have all the information you need to make an accurate diagnosis, but that doesn’t mean that a diagnosis isn’t made.

Particularly in a treatment setting, something has to go on your record to bill it.”

Marcia Werchol, director of Family Court Mental Health Services in Manhattan, says there are other reasons why most evaluations lead to a diagnosis. “You could say there’s a bias factor if everyone referred gets a diagnosis, but if everyone referred had a history of diagnosis or something happened [that makes caseworkers suspect mental illness] than that would make sense,” says Werchol. “That wouldn’t mean that people are being promiscuously diagnosed.”

The problem is, once a parent with children in foster care receives a diagnosis of mental illness, it is much more difficult for her to reunite with her children. A parent must not only prove she has made all the practical preparations for bringing her children back home, such as food and adequate shelter. She also has the difficult task of convincing a judge and caseworkers that her mental illness will not get in the way of safe parenting, which can be tricky to prove.

Whether or not she has been accurately diagnosed, a mother must act as if her diagnosis is indeed accurate in order to get her children back, says Kara Finck, an attorney with the Bronx Defenders, which is funded by the city to provide parents with legal representation in Family Court. “You have to accept the services and admit to the allegation to get your kids back,” explains Finck. The client who does not, she adds, “is viewed through the lens of, ‘you must not want your children back enough, and that’s a bad parenting decision, and that’s perhaps a result of mental health issues.’ And it all spirals out.”

Werchol says a tight budget puts her team of about 25 psychologists and psychiatrists under pressure to act efficiently. As a result, the mental health evaluation clinics in Family Court are “sort of set up to basically be more or less a one shot deal,” she says. Occasionally the evaluator will request permission from the courts to observe a mother with her children or to interview her more than once, but in general evaluations are based on one meeting. “They are not longitudinal evaluations. We’re more about slices as opposed to timeline,” Werchol says. “We’re looking at the bang for the buck issue: what will give us more information in a shorter time frame that is valid? We want to do the best we can as efficiently as possible, and that doesn’t necessarily mean doing the best that can be done if you have unlimited time and resources.”

A Better Way to Judge: Evaluating Parents in Illinois

IN THE EARLY 1990s in Illinois, a number of mothers with schizophrenia and other forms of mental illness killed their children. In at least one of these highly publicized cases the child welfare system had returned a child from foster care to live with his mother. The deaths prompted the state to form a task force to look into how the child welfare system assesses the ability of parents with severe mental illness to care for their children. The result is one of the nation's most extensive examinations of what does and does not work in evaluating parents with mental illness.

Dr. Laura Miller, a professor and director of the Women's Mental Health Program at the University of Illinois' Department of Psychiatry, was part of the task force. She says the researchers found something she had long suspected but that had never been directly studied: A mental health diagnosis is not an effective way to assess whether someone is capable of being a good parent.

Most methodologies used to determine parental fitness are "very sadly lacking in terms of their accuracy," says Miller.

She explains that for mothers with mental illness, there are two key factors that correlate well with good parenting. The first is a mother's insight into her own mental illness—including whether she is able to see the warning signs of an episode coming on. The second is a parent's insight into their child's development. A mother who has unrealistic ideas about what can be expected from children at certain ages is more likely to mistreat a child than a mother who holds realistic expectations. A mother who is willing to acknowledge that she has problems and is willing to accept help is less likely to mistreat a child than one who denies she needs help. Social supports are also key: mothers who have supportive partners, neighbors or family members are less likely to abuse their children than mothers who are socially isolated.

The task force helped develop guidelines for measuring parenting competence. It recommended that parent evaluations be performed by a team that includes a psychiatrist, a psychologist, and a social worker, rather than by just one clinician. The task force recommended that evaluators observe parents inter-

acting with their children, preferably in a home setting. It said evaluators should use multiple sources of information (medical records, criminal reports, drug screens, school records and child welfare files) and minimize the risk of bias by not having the evaluation paid for by any part of an adversarial court proceeding. Finally, the task force recommended using a standard of minimal—rather than optimal—parental competence to measure fitness.

In many ways, this is a significant departure from common practice. In New York City, for example, most evaluations are performed by a single clinician; many are performed without ever meeting the children, much less observing a parent's interaction with them; and evaluations are frequently performed and paid for as part of a court proceeding.

The task force used its findings to develop a model "assessment team" to evaluate parents with severe mental illness in Chicago. The team prioritized two types of cases: those in which a parent had been hospitalized with mental illness within the past eight years, and those in which previous evaluations had been contradictory or confusing to such

insight a parent has into her mental illness, and how much practical knowledge she has of child development.

The assessments included direct observations of the mother with her children; a developmental screening of each child; interviews with each child; videotaped observations of the parent interacting with the child both in a clinic and at home; parents' responses to questionnaires; and a review of previous records and psychiatric evaluations. Each individual on the team wrote a report summarizing his or her area of the evaluation, and a team coordinator compiled the reports, wrote a summary of the findings and made recommendations for services and supports likely to help the parent.

One drawback to these evaluations is their cost—about \$1,700 per family. But the task force suggested that a comprehensive evaluation might cost no more than a series of less detailed evaluations. Before this comprehensive method was developed, parents would often undergo multiple evaluations at a cost of about \$500 each—either because the parent's lawyer challenged an evaluation as biased, or because a court believed an

A mental health diagnosis is not an effective way to assess whether someone is capable of being a good parent.

a degree that child welfare workers and the courts were unable to make a recommendation on whether to return a child home or terminate parental rights

Under the model, child welfare workers or the court could refer a family to the team with specific questions, such as: Will this mother's mental illness affect her parenting capacity? If so, what kind of interventions would help? These questions focused the examinations, which included a psychiatric evaluation as well as an assessment of how much

evaluation was incomplete or confusing. Hasty, incomplete evaluations can lead to longer stays in foster care because courts are afraid of making incorrect decisions, notes Miller.

"At present, many individuals with severe and chronic mental disorders are evaluated several times over a long period using unsound methodologies that do not directly assess parenting competency or potential for violence," explains the report, titled "Focus on Women: Mentally Ill Mothers Who Have Killed," which Miller

Werchol acknowledges that advocates' claims that mental health evaluations are too often biased against parents may have some truth to it. When Mental Health Services first began evaluating parents in the 1970s, Werchol points out, child welfare was focused almost completely on protecting children's safety, and less on preserving families.

Since then, the city's foster care system has come to acknowledge that "foster care is not a solution," she says. "The real issue is working with families." And in some ways, the agency has yet to catch up with this new way of thinking. "There is some element in which we're more trapped in the adversarial way of thinking," says Werchol. "Our culture and perspective has not been strength based, it's too pathologized."

For Family Court Mental Health Services, says Werchol, this involves training evaluators to identify what services a parent needs, rather than simply deciding whether a child is in danger. "Rather than starting off from the viewpoint of, 'there is a neglect finding, and we're just going to see what's wrong with this person,' it's looking at it from a different perspective of, 'what went into this, and what is there to build on?'" says Werchol. "If we want to be really neutral, we need to look at this more strength-based."

Changing the philosophy of an organization requires changing not only its culture, but also the perspective of its evaluators, who as clinicians tend to be trained to look for problems instead of strengths and solutions. Through trainings and direct supervision, Werchol says her organization is also trying to acknowledge that the caseworkers and court officials reading the evaluations are not trained in the clinical jargon of her evaluators, and they're spending more time trying to communicate their findings in lay person's terms.

Werchol says this kind of "change of culture and perspective" for any organization takes time. "It's not easy, because it's really a different way holistically of looking at these things."

"There are many diagnoses that get used liberally to describe stress and poverty."

Jacobs lost both of her parents when she was 7 years old. After her parents' deaths, she lived in several foster care homes. A planned adoption didn't work out. As a teenager, Jacobs lived with an aunt. She would sometimes disappear from her aunt's home for long stretches of time, sometimes to spend time with boys her aunt did not approve of. She suffered from depression and had attempted suicide as a teen, according to evaluations from hospitals and health centers where her aunt took her for treatment, copies of which were subpoenaed by Family Court Mental Health Services. One mental health evaluation described her as suffering from post-traumatic stress disorder.

She gave birth to her first child, Bobby, when she was 18 years old. Child protective workers removed Bobby on the grounds that Jacobs' struggles with mental illness were interfering with her ability to care for her child. A mental health evaluation ordered by Family Court at the time said she had an abusive boyfriend and that foster care caseworkers had observed troubling interactions on supervised visits she had with Bobby.

Sometime later, Jacobs began attending weekly psychotherapy sessions. She gave birth to a second child, a girl. A mental health evaluation conducted by the clinic where she

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co-authored. "Use of comprehensive, sound assessments when a case first enters the system could help considerably in shortening the length of time that children of mentally ill parents remain in foster care."

In Chicago, says Miller, the team quickly gained a reputation for helping "to clear cases that had been conundrums for years held up in the child welfare system."

However, there were unintended consequences of the evaluation reform. The original mission of the team was to conduct evaluations when a mother first came

into contact with the foster care system, in order to determine what services and supports she needed to bring her children home. Instead, when Chicago attorneys saw how seriously the judges took these evaluations, they began to use them to speed the termination of parental rights for mothers whose children had been in the system for years.

Rather than using the evaluation team to help mothers who were new to the foster care system, says Miller, "they would find it was much easier to take a case that was languishing for five or six years and ask us to evaluate the case and subpoena us, and they could get the

case off their hands much faster because the judges always listened to us because our evaluations were very sound. And it wasn't that these cases shouldn't have been terminated. It was just a poor use of our resources that ran counter to our mission. We weren't in the business of wanting to spend our time terminating rights for mothers."

As a result, the original parenting assessment team closed shop. However, two other groups in Chicago are using a similar method to evaluate parents involved in some of the most severe cases of abuse and neglect whose children have recently entered foster care. —Kendra Hurley

A Depressed Mother Asks for Help—and Loses Her Children

STEPHANIE, 22, ONCE confided to a therapist that she was so depressed she might harm her three children. Three weeks later, the city's Administration for Children's Services (ACS) placed the children in foster care. Now she is afraid she will never get them back.

Stephanie is composed but nervous as she waits for her Family Court hearing with her mother, her sister and the father of her children. She worries about how to present herself to the judge, how to prove she is sane. Stephanie's lawyer, Rafael Gelpi, plans to tell the judge that Stephanie's mother has space to take in Stephanie's children, if ACS will allow it.

Stephanie has had two bouts of major depression in her life. The first occurred in 2005, when she had postpartum depression after giving birth to her second son. The city's child protective services did not remove the children at the time, but they gave Stephanie a treatment plan that included therapy and regular visits from social workers. Stephanie says she successfully completed the plan, but her lawyer's records indicate she did not.

The second episode was a year ago, shortly after she gave birth to her third child, a girl. Her father had just died. Two weeks later, she lost the apartment she had shared with her father and her children. Stephanie and her children moved

into a homeless shelter.

Reeling from the loss of her support system, Stephanie sank into a deep depression. "I was in crisis," she recalls as she waits for her Family Court hearing. "Anyone can sink into depression when they're going through a tragedy," she says earnestly, as though she's still trying to convince herself of the fact.

At first, she says, it seemed there was a silver lining to living in the shelter, because there was a therapist on site and Stephanie was able to seek his help. She was completely candid, and during her third session, Stephanie remembers, "I had told him that I had a fear that one day if I don't get the help that I needed, that I had a fear in my heart that I might do something that I regret. I had a fear that one of these days if my children keep aggravating me and I didn't have nobody to help me, I had a fear that I might hurt them one day."

Stephanie told the therapist she was afraid she might drown her children.

"I get so depressed and angry, I tend to black out, and when I black out I don't be knowing what I do," remembers Stephanie.

Stephanie's depression deepened further after ACS removed her children. Graham Windham, the privately-run foster care agency assigned to her case, ordered a mental health evaluation

which Stephanie says found her to be "psychotic," a diagnosis that sometimes accompanies severe episodes of depression and which is considered serious. This diagnosis did not ring true with Stephanie. She says she is adept at recognizing the symptoms of her depression—which some studies have shown to be a measure of parent capability for those with mental illness. (See sidebar, "A Better Way to Judge," on page 16.) And Stephanie says she knows when she needs to ask for help.

After the children were removed, she says, Stephanie went to a therapist she found herself, who diagnosed her as depressed with mild bipolar disorder, a diagnosis that corresponded more with what Stephanie knows of herself and her previous brushes with mental health professionals.

Today, as she sits outside the courtroom, Stephanie wants to regain custody of her children. But the diagnoses of "psychotic" remains in her file.

Jacquelyn Israel, a parent advocate from Leake and Watts, a foster care agency, is assigned to help Stephanie navigate the system. She tries to brace Stephanie for the possibility that she may never live with her children again, gently letting the young mother know just how hard it will be to prove the children should come back to her. "It's

received therapy said she was making steady progress in therapy and she appeared to be taking good care of her daughter. "She is attentive and expresses affection, and appears able to interpret the infant's cues and respond appropriately," the evaluation said.

When Jacobs was 22 and Bobby was 4, New York City's Family Court was struggling to decide whether to sever her parental rights to Bobby. Gottlieb knew that if Family Court relied on Mental Health Services' evaluation, Jacobs would almost certainly lose Bobby forever.

The Mental Health Services psychiatrist interviewed Jacobs for two and a half hours, and did not observe her with Bobby. The psychiatrist deemed her unequivocally unfit to parent.

"Both her psychiatric and her cognitive difficulties are seen as chronic in nature, and it is unlikely that she could achieve the level of stability and consistency within her own functioning which would permit even minimally adequate care of the subject child within the foreseeable future," the

report states. "It is thereby concluded with reasonable professional certainty that this respondent does suffer from Mental Illness as a result of which she is and will remain for the foreseeable future unable to care for the subject child. Such child, if placed in her care, would be viewed at risk for neglect."

In most cases, a verdict so emphatically against a mother's parenting ability nearly guarantees that the mother and child will never live together again. To ensure a child's safety, child protective workers and Family Court officials frequently err on the side of ensuring the child is safe. Consequently, an evaluation like Jacobs' "is usually the turning point of the case," says Gottlieb. "If you get a court ordered evaluation that says the mental illness is to an extent that the client can't care for the child, it usually means that the person is never getting the kids back and that parental rights to the child are terminated."

However, the evaluation by the clinic where Jacobs had attended weekly psychotherapy for over a year suggested she

“I was just trying to get some help . . . I’ve regretted it every day for the past seven months.”

very hard for parents who have mental illness,” says Israel, who has worked with parents involved in the foster care system for nearly 20 years. “They have to really prove beyond doubt that they won’t do anything.”

In Brooklyn’s Family Court, the four members of Stephanie’s family make a solid, composed front, talking softly amongst themselves and shaking their head in silent disapproval when other families in the waiting room display strong emotions—like the family bickering about having told too much to the judge, or the man who exploded at a court official who told him his case would be rescheduled. “I traveled five hours to get here! You can’t do that! You can’t!” he shouts.

At this, Stephanie’s mother, who speaks Haitian Creole, raises her eyebrows to Stephanie’s sister as if to say: that man does not have manners.

But moments later, when the judge explains how hard it will be for Stephanie

to get her children back because she had an earlier involvement with child protective services at the time of her postpartum depression, Stephanie’s mother cannot control her own emotions. She slams her fist on the bench, saying, in English, so the lawyer can understand: “My daughter not crazy! She not crazy!”

The father of Stephanie’s three children puts his arm around Stephanie’s mother and quickly guides her out of the room. The lawyer sternly tells Stephanie’s sister, “Tell your mom, if she wants custody of the children, she has to calm down.”

The message is clear: too much emotion will make her seem mentally unstable, as well.

When the father of Stephanie’s children returns, it is clear he is upset too, and is trying hard not to show it. “They want to break us,” he mutters to Stephanie’s sister. “ACS is calling her crazy. That’s not a diagnosis, that’s defamation.”

Nearly two months later, Stephanie’s

mother would still not know whether or not she could become a foster parent to her three grandchildren. Stephanie would still not know if there’s a possibility that she could bring her children home one day. The uncertainty of it all would have upset her so much that, prior to her next court hearing, she would walk out of Family Court before she was even summoned to see the judge.

But for now, on the benches outside Judge Susan Danoff’s courtroom, Stephanie still seems to believe that if only she can make her lawyer understand that none of this was supposed to happen, she will be able to bring her children home.

“I was just trying to get some help, the help I wasn’t getting from anybody,” Stephanie tells her lawyer, sounding apologetic about the words she spoke to her therapist during the dark weeks following her father’s death. “I’ve regretted it every day for the past seven months.” —Kendra Hurley

was indeed ready to bring her son home. Jacobs’ diagnosis of a mild form of depression “is a common and mild disorder and does not have to interfere with parenting,” the evaluation from this clinic explained. The clinic also observed Jacobs’ interactions with her new daughter. The report concludes: “I have witnessed no behavioral observations which make me feel as though Jenna cannot at this time be a loving and effective parent to her children.”

Jacobs got extremely lucky. She had spent years doing what all parents with mental health allegations must do to get their kids back, complying with a treatment plan that assumed she was mentally ill as the courts deliberated whether to terminate her parental rights. But things turned around for her when Gottlieb became her lawyer and fiercely advocated for her, challenging the mental health evaluation conducted by Family Court Mental Health Services.

By the end of the case, Gottlieb says, everyone who knew Jacobs believed her to not have a serious mental illness,

though they did agree she had mild mental retardation. Eventually, Bobby returned to his mother’s care, where Gottlieb says he continues to live today along with his father, his sister and a new baby. A few years have passed, and Gottlieb says the last she heard, Jacobs had been raising her three children without any new allegations of abuse or neglect. ✖

“Some really sick people might end up reunifying and well people might end up losing children.”

At the August Aichhorn Center for Adolescent Residential Care for teens struggling with mental illness, child care worker Maribel Rosado visits with Aichhorn alum Melvin Echevarria.



A Revolving Door of Care

Children with mental illness bounce from foster care to hospitals.

BY KENDRA HURLEY

FIFTEEN-YEAR-OLD JAMES, a boy who was abused as a child and who has symptoms of schizophrenia and psychosis, has been hospitalized for psychiatric issues nine times in the past eight years. James (not his real name) picks fights regularly with other boys at MercyFirst, the residential treatment center for foster children where he lives on Long Island. He has propositioned others on campus for sex, pulled his pants down in public, and once tried to sexually violate a resident in another foster care program, says Cathy Menzies, senior vice president of MercyFirst Campus Programs in Syosset. When the group moves to a new location, James often refuses to budge. And he does things that baffle and frustrate everyone, like insisting on wearing a winter coat and hat in 90 degree weather. Once he ran into traffic.

Even though James is housed in MercyFirst's specialized program for young sex offenders, he needs more supervision and intensive psychiatric care than the residential center can provide, Menzies says. But a hospital will only take him when there is a crisis—if he is an imminent danger to himself or others. Menzies tried to get him admitted to an inpatient psychiatric facility designed for children who are not in crisis, called a residential treatment facility (RTF), licensed and funded by the New York State Office of Mental Health. He was rejected, she was told, because he needed a higher level of care than the RTF could provide.

The irony is not lost on Menzies: James is too ill for a Medicaid-funded RTF, but not ill enough for a hospital. The only system designed to look after children with serious mental illness, she says, claims it can't help him.

James' story is far from an anomaly. MercyFirst attempted to move seven of its residents to an inpatient RTF over the last year, but only two were approved. New York City foster care agencies referred 148 children with serious mental or emotional problems for inpatient RTF placement from September 2007 to September 2008. Only 80 were approved. Foster care agency executives say children are typically rejected either because they are too aggressive and disturbed, or because they are deemed stable enough not to need the round-the-clock psychiatric care an RTF provides.

"Either kids are seen as being not disturbed enough or not stable enough," says one foster care agency manager who

wanted to remain anonymous for fear that speaking publicly would jeopardize her relationship with the state Office of Mental Health. “That slot in between where you can get a kid in it has gotten much, much narrower.”



Foster care agencies say children with severe mental illness frequently bounce between residential treatment centers, which are the most intensive form of group-based foster care, and psychiatric hospitals. The hospitals return children to the residential centers as soon as their most serious symptoms subside. Back in foster care programs with only limited psychiatric services, their conditions typically deteriorate until they are ill enough to be admitted to a hospital again, say foster care executives.

“Child welfare has become the default system for kids with intense mental health needs,” says Jeremy Kohomban, president and CEO of Children’s Village in Dobbs Ferry, NY, which provides foster care and other services. “To constantly default children with significant mental health needs back to us creates a situation that is completely unwinnable for us, because foster care is not designed for longer mental health care.”

The state Office of Children and Family Services (OCFS), which oversees foster care systems statewide, agrees there is a problem. “If a child’s condition is more severe than what the child welfare system can handle but not severe enough for a (psychiatric) hospital to maintain a child, the child is stuck,” says Mimi Weber, director of OCFS’s Bridges to Health program, which offers non-traditional, community-based outpatient mental health services to a few hundred foster children in New York City.

Foster care agencies say the state-licensed RTFs are the logical place for these children because they provide more supervision and more intensive psychiatric services. But the organizations that operate RTFs say state law is clear: violent children or children who are likely to harm themselves or others cannot be admitted. The state Office of Mental Health (OMH), for its part, opposes long-term institutional care for children, and by law, the committee that rejects and approves applications for RTFs must consider placing children in less restrictive settings before settling on inpatient psychiatric programs.

“Every community has a range of alternatives to institutional care,” says OMH spokeswoman Jill Daniels. Applications for New York City youngsters to be placed in an RTF must be approved by a panel made up of a child psychiatrist and representatives from OMH, the city Department of Education, and the Administration for Children’s Services.

New York State has expanded community-based mental health services in recent years, in the hopes that children will receive treatment before their conditions deteriorate to the point where they need institutional care. Federal regulations permit states to use Medicaid funds to pay for intensive, ongoing outpatient services—not just hospital care—under a program called the Home and Community-Based Services

waiver. In New York City alone, the mental health residential support services component of this program has grown from 64 slots for young people in 1996 to 510 slots in 2007. Statewide, the program has grown from 125 slots in 1996 to 1,506 slots in 2007, according to OMH.

In addition, Bridges to Health provides support services to 310 children statewide in foster families under the Medicaid waiver. That number was expected to nearly double to 610 by March 31, 2009, Weber said.

But these programs work with children living in foster families, and can’t help those in residential institutions. Some foster care agencies say the state should create more RTF beds and change the statute to permit RTFs to admit violent children, sex offenders, and those with substance abuse problems. Others say a better solution is to provide more intensive psychiatric care within the foster care residential centers—and increase the amount of money agencies receive to provide care for these children.



Certainly a large part of this dispute is about funding. Statewide, about 3,400 children are housed in foster care residential centers, which, like MercyFirst’s, are designed for foster children who have emotional or behavioral problems. These centers typically look a little like boarding schools, with children living in supervised cottages and attending school on the center’s campus or nearby. The centers receive most of their funding through the foster care system, based on a per-child, per-day rate that averages about \$212.

Children with more severe mental health problems may be assigned to residential treatment facilities (RTFs), which are fully funded by Medicaid at a much higher rate, about \$455 per day. The average length of stay there is 14 months. These inpatient facilities are designed for children ages 8 to 18 who are well enough to leave a hospital but not well enough to go home. They typically have 14 beds, a nursing station and much closer supervision than the foster care residential treatment centers. Some organizations, including MercyFirst, have both types of programs on their campuses, but they can’t move children from one to the other without state approval.

New York City children have more competition gaining admission to the RTF beds than those from suburban or rural communities. Of the 539 RTF beds in New York State, only 125 are reserved for children from New York City. About 32 of those accept only younger children, and 61 are open only to teenagers who are dual-diagnosed with a mental illness and low IQ. That leaves just 32 available for teens with normal IQs. Another 137 beds, located in the suburbs, are open to either city or suburban children.

Foster care agencies complain that the rigidity with which beds are assigned to city or suburban children means some beds remain empty even when demand is high. Madonna Heights Services in Dix Hills, Long Island, largely shelters kids who are not from the city—but it has had two of its 14



Former residents of the August Aichhorn Center for Adolescent Residential Care gather for a reunion with the Center's social workers, Tonya Parker (above left) and Lisa Ginsburg (center), as well as child care worker Carolyn Brindle (above right).

beds sit empty for about a month, says Adria Filmore, RTF program director. The program is run by SCO Family of Services, which is also one of the largest providers of foster care services in New York City.

Nearby in Syosset, MercyFirst's RTF has had three beds sitting empty for over a month, says Menzies. She adds that she desperately wants to fill those beds with teens housed in her foster care residential center, but the beds are not earmarked for New York City children.



The problem of revolving-door care for children and teens with serious psychiatric problems is not new. In 1999, the Legal Aid Society filed a class action lawsuit accusing New York State's mental health system of allowing hundreds of mentally ill children to languish in hospitals, juvenile jails and foster care placements instead of providing them a place in their programs. Back then, the state kept a waiting list of about 400 children who had been approved for OMH-run programs, but who had not yet found a slot. Some had waited for a year.

The lawsuit was settled in 2005 with an agreement that children placed on the waiting list would receive an RTF placement within 90 days of certification. While some advocates hoped this would mean OMH would open more beds for New York City children needing to live in RTFs, no new permanent beds opened.

Service providers say that instead, it became increasingly difficult to get children on the waiting list in the first place.

"One way to not have a wait list is to provide services to anyone who needs them. Another way is to not approve anyone," says James Purcell, chief executive officer of the Council of Family and Child Caring Agencies, the umbrella organizations that represents foster care agencies. "They've simply reduced the visible waiting list by not approving the applications."

The Office of Mental Health maintains that no additional RTF beds are necessary. "OMH has been steadily developing a comprehensive array of services that moves away from institutional placement and instead allow children to remain at home while receiving levels of treatment formerly available only in RTF or hospital settings," says Daniels, the OMH spokeswoman.

The Administration for Children's Services in recent years has also moved away from institutional or congregate care in all but the most difficult cases. This means a higher concentration of the children in foster care residential treatment centers have mental health needs. "The kids we are getting are kids who need a lot more," says Kristin Boyle, director of social services at the foster care agency Green Chimneys in Brewster, NY, which has both a residential treatment center and an RTF.

"It stresses and strains every area of the program," adds Boyle. "It takes away from the kids. It takes staff. It's like a bucket with holes. You put your finger in but then water

pokes up somewhere else. If you have 12 kids here who require you to take all of your resources from other places to put those on the 12 kids, how well are you serving the other 68 kids?"

Sixteen-year-old Shanell (not her real name), hospitalized 13 times for violent behavior and other psychiatric issues, assaulted staff and residents and tore apart the cottages at a residential treatment center operated by the Jewish Child Care Association (JCCA) in Pleasantville, NY. "She is going to need mental health services all her life, it's crystal clear," says Candace Tinagero, JCCA's senior vice president of foster care and residential services. "We think an RTF would work for a girl like this because they're heavily staffed. With this girl, when she gets the attention and care she doesn't go off, she doesn't get crazy. Kids like this calm down considerably with more people around."

But the application to place Shanell in an RTF was rejected, Tinagero says.

"Every kid we refer, they say is too disturbed or too acting out or too aggressive," she says. "It's unbelievable to me that the highest level of care in the system can't take the kids that we can't manage."



There is some evidence teens who live in the more secure RTFs are less likely to commit crimes after they are released. The August Aichhorn Center for Adolescent Residential Care, an RTF for 32 young people between the ages of 13 and 19, produced a study comparing the outcomes of young people admitted to Aichhorn with teens who met the criteria for admission but were rejected because beds were not available. The state Office of Court Administration reported that about 39 percent of Aichhorn's alumni were subsequently arrested, compared to 60 percent of the group that was not admitted, according to executive director Michael Pawel.

Meanwhile, social workers for foster care agencies say they are discouraged by the application process for RTFs. Missing paperwork or even a form filled out incorrectly can delay the process for months. Social workers say they put an enormous amount of time and energy into the applications, even if they know it is likely to be rejected.

Some foster care agency executives say that to keep up with the kids they're serving, they must reinvent themselves. They would like to create programs with much lower staff-to-child ratios and richer clinical services, but the funding for such programs simply doesn't exist. So for now, these agencies care for children with severe mental illnesses as best they can, referring them for inpatient care when they feel they must, and struggling with the often complex admissions policies to the RTFs.

"Our workers are stretched thin," says Kohomban at Children's Village. "You keep getting these answers back and forth and some of these reasons [for rejecting kids] are so elaborate. You give up. You say screw it." ❀

A Mother's Illness Can Hurt Her Children, Too

A parent's stress and depression can affect a child's developing brain.

BY MAIA SZALAVITZ

BRAIN DEVELOPMENT IS front-loaded in early childhood. A baby's brain grows to 90 percent of its adult size during the first three years of life. That's significant because new research shows that exposure to stress in early childhood can have a profound and lasting impact on brain development. Stress can actually affect the brain's ability to retain information, making it more difficult to succeed in school, new studies show.

Levels of stress are particularly high for children who live in poverty, who are victims of abuse or neglect, or who have a parent who suffers from depression or other mental illness. People who live in poverty in America lack control over huge aspects of life like employment, housing and sometimes even regular access to food. This leads to what researchers call "uncontrollable stress."

If people (or even animals) can control the things that distress them, there is little health impact, research shows. But uncontrollable stress is another matter. One large series of studies of British public servants found that the health effects of being low on the totem pole with little control over job stress were as bad as those of smoking—even when they controlled for actual smoking.

"All of the major stressors are greater for people of low socioeconomic status," says Martha Farah, director of the Center for Cognitive Neuroscience at the University of Pennsylvania. "And high levels of uncontrollable stress are bad for the developing brain." What's more, she says, the best way to reduce the impact of stress is through social support—but poor people typically

know fewer people, have less stable relationships and a generally frayed and fragmented social and family network.

Uncontrollable stress dramatically increases the risk for mental illness, obesity and disease, particularly heart disease. It can cause depression and memory loss by damaging certain cells in the hippocampus, the region of the brain which is involved in turning short-term memory into long-term memory. If the hippocampus is removed, most new memories cannot be stored. An excess of the neurotransmitter glutamate is released during stress and this can damage or even kill cells in the hippocampus. All effective treatments for depression—whether talk therapy, drugs or ECT (electroconvulsive therapy), help reverse this damage.

Farah has examined the effects of stress on particular brain regions and related functions in poor children. "Kids from lower socioeconomic status homes did less well on retaining information in memory," she says. Intriguingly, among the poor kids, those who had the most nurturing parents did the best on tests that measure this aspect of memory, given in middle school.

"We know from animal research that the more nurturant the mama rat is, the more stress levels drop in the baby and they grow up with better rat memories," says Farah. "It looks like the same is true in people." Maternal affection lowers stress, sparing memory cells in the hippocampus from harm. Simply responding affectionately to a child actually protects brain cells in the hippocampus from stress-related damage.

Farah found that these differences were reflected in brain scans of this region in these children. She also found that the reduced stimulation seen in poverty—less time being spoken to or read to by parents, less access to a variety of books, toys, and activities—had an effect on brain regions involved in language.

Poverty, by itself, can be hard on children's brains. But if you add parental mental illness, it gets even worse. Maternal depression is the mental illness that has been studied the most and is the most common.

Around 25 percent of low income women suffer depression each year. One study found that 52 percent of mothers with children in Early Head Start programs had some depressive symptoms. Maternal depression makes it harder for the mother to bond with her child and increases the child's risk of substance abuse, behavioral disorders, and depression. Depressed mothers are more likely to let babies cry for longer and give them less attention, spending less time doing things important for language like talking with and reading to children.

"There are huge developmental consequences," says Janice Cooper, Director of Child Health and Mental Health at the National Center for Children in Poverty at Columbia University. "Research suggests that children of depressed moms have a lower level of language acquisition"—and language is key to early school success.

More prosaically, depressed mothers are less likely to take their children for preventative medical care, less likely to take appropriate safety measures like strapping children into car seats and

blocking electrical outlets and more likely to be neglectful or abusive. These children are thus more likely to wind up in the child welfare system.

“No matter what neuropsychiatric illness it is, it has the potential to compromise your capacity to be present, to be attuned, to be nurturing, to be all the things that developing children need,” says Bruce Perry, founder of the Child Trauma Academy in Houston and a leading speaker and consultant on child welfare. “And it doesn’t mean that you are a bad parent; it just means that it’s much harder to parent.”

Early life stress, particularly child abuse or other traumatic experiences, can have lifelong consequences by making genetic predispositions into actual disorders or behaviors, Perry says. “Under extreme stress, any of your genetic vulnerabilities will be more likely to be expressed earlier and with more severity,” says Perry. “And even if you have very hardy genetics, this will wear out your body.”

He says one study found that abused children with a certain variation of the MAO-A gene were at higher risk for becoming violent and antisocial as teens. But the teens with the risk gene who weren’t abused weren’t any more likely to develop behavior problems.

These studies have implications for policy makers.

“In child welfare one of the most important things you could do is decrease the number of transitions that these kids experience,” Perry says, “If a decision is made that a child cannot be cared for in the home, when you remove the child, you should make every effort to keep the child in that community and school and maintain their healthy connections with people around them.”

If mental illness and substance abuse problems in parents can be detected early, this could prevent the need for many transitions from one home to another.

Cooper says her organization’s efforts have been focused on maternal depression—not only because it is the most common disorder and has such

negative effects, but also because effective treatments are available. Cooper’s colleagues at the National Center for Children in Poverty have reviewed the literature on what works, and have highlighted a number of programs in a recent report on maternal depression.

Cooper cites a program in Rhode Island in which case managers check in over the telephone with depressed mothers who are receiving public assistance. The case managers make sure that the mothers are taking any needed medication and attending therapy or other medical appointments. “There was a 75 percent reduction in depressive symptoms,” says Cooper.

In Boston, a program called Family Connections has trained staff of Head Start and Early Head Start to identify depressive symptoms in parents and help them improve their parenting as they fight the depression. Research suggests that the training has improved teachers’ ability to help with mental health problems and has also reduced staff turnover.

Oddly, although pediatricians are most likely to see the impact of maternal depression on children, many aren’t trained to identify it in their patients’ mothers and intervene, even though a pediatrician may be the only doctor the mother sees. North Carolina has worked successfully with pediatricians to help address the problem and provide care or referrals.

All of this research suggests that the best way to help kids growing up in poverty—especially those whose parents are mentally ill—is to focus on helping the youngest children and supporting their parents.

“There is a mismatch between opportunity and investment when it comes to how our society invests in programs dedicated to ‘changing the brain,’” says Perry. “We are spending billions of dollars on education, mental health, special education and juvenile justice services to influence brain function at times later in life when, relatively speaking, the brain is much harder to change. Yet in the first years of life, when the brain

is most malleable, and capable of being influenced—in ways good or bad—our society dedicates few resources.” Ending this disparity could make a real difference for children—and for the adults they will become. ✖

Further Reading

The research studies cited in this article can be found as follows:

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A Child of Mentally Ill Parents Speaks Out

I had to get out from under my mother's addiction.

BY HATTIE RICE

I WAS 9 YEARS OLD when my dad told me that he and my mom were schizophrenic. He was scared of people but could function. He was able to work. He said my mother had it worse. She heard voices and thought people were trying to drive her crazy and kill her. To cope with the pain, she started smoking crack.

Soon her addiction started to show. She would steal money from the family. Sometimes we'd have no food in the house and would have to go to churches or beg at the welfare office. It made me embarrassed.

A typical day with my mom started with her using half of the food money on crack and then coming home and smoking it. I'd usually check on her (because I could hear her talking to the voices) and she'd tell me to tell the voices to stop hurting her. I'd say a prayer for her and we'd play her favorite card game or watch television. Then I'd give her my usual lecture, telling her the voices are in her head and that other people aren't doing it to her. My mom would hold me and cry when I comforted her.

It was hard feeling responsible for her, and sometimes it was overwhelming because I had my own problems. I'd tell myself not to be upset, because she wasn't trying to hurt me. But as much as I tried to understand, I also felt angry and abandoned.

Over time, I got depressed. When I woke in the morning, I didn't want to leave the house because I felt like the world had nothing to offer me. Eventually I figured I should just stay at home and avoid the world. When I was 13, I stopped going to school.

I didn't think anybody would realize I was gone, but the attendance office called child welfare. A psychiatrist diagnosed me as having social phobia and I ended up being taken away from my family because they failed to make me go to school and didn't get my psychiatric prescription filled.

When I entered foster care, I was terrified. The first week, I stayed in my room and cried day and night. I just wanted to go back home.

It was strange to have nobody to say "I love you" to, and being in care felt scary because I knew my mom had nobody to console her. My parents came to visit every weekend. I felt

better then because we'd go out for a walk and my mom would cry on my shoulder just like the old days.

But I soon began to feel relieved that the weight of my family's problems had been lifted off my shoulders. I realized that caring for my mom was hurting my life.

As I got settled into my placement, I noticed there was not a lot of stress in the group home and if I needed someone to talk to there was always a staff on duty. I felt good knowing I had staff that led me in the right way and girls that helped lift my spirits. That's when I started to think that foster care was where I needed to be.

In the group home, I started focusing on my education and dealing with my fear of people. I started interacting with the girls well (and that had never been one of my specialties) and opening up about the anger I felt toward my mom.

During the first year living without my parents, my depression lifted tremendously. As I talked more about my feelings and let them out, I didn't wake up crying like I did at home. I started to realize that the world had many wonderful things to offer me, because I started to go outside, hang out with my friends and have fun. I was even able to go back to school and keep up an 85 average. It felt great to feel stronger and in control.

On my home visits, I felt glad that I could see my parents, but I also appreciated having the option to leave when things got too intense. I wanted to be close to my mom, but I also felt like I needed to stay detached so her problems wouldn't affect me the way they used to. And when her problems did become unbearable, it was back to my home away from home.

I did have doubts about putting myself first, though. I wondered, "Who is my mom going to have?" And it was scary to focus on myself. Before, whenever I was confused or frustrated about my own problems, I could focus on my mom instead. After entering foster care, I had nobody else's problems to get me away from my reality. And in the end, I think that's what I needed. ✖

This article is adapted from a piece that originally appeared in Represent, a magazine written by and for teens in foster care. Rice, a writer for Represent, completed her sophomore year of college at SUNY Binghamton.

A six-year statistical survey monitoring New York City's child welfare system

WATCHING THE NUMBERS

PROTECTIVE SERVICES

	FY 03	FY 04	FY 05	FY 06	FY 07	FY 08
REPORTS OF ABUSE AND NEGLECT	53,894	51,477	50,251	62,585	64,190	64,572
The pace of state hotline reports remained very high more than two years after the 2006 Nixzmary Brown murder.						
PERCENTAGE OF REPORTS SUBSTANTIATED	33.6	33.7	32.6	36.7	39.8	39.9
The tendency to validate more reports has persisted for two years.						
PENDING RATE	5.2	5.9	6.1	7.5	6.0	5.4
The monthly average of new cases per child protective worker returned to 2003 levels.						
AVERAGE CHILD PROTECTIVE CASELOAD	11.2	12.1	12.1	16.5	15.1	11.6
Caseloads fell following substantial growth in the child protection workforce.						
FAMILIES RECEIVING ACS COURT-ORDERED SUPERVISION (ACTIVE, JUNE)	2,506	2,289	1,947	2,689	3,570	3,836
Total families supervised by child protective services under court orders sought by ACS doubled from 2005 to 2008.						
CHILD FATALITIES IN CASES KNOWN TO ACS (CALENDAR YEAR)	24	33	30	44	41	49

PREVENTIVE SERVICES

FAMILIES RECEIVING ACS-CONTRACTED PREVENTIVE SERVICES (MONTHLY AVERAGE)	11,700	11,622	11,542	11,695	12,889	13,868
The number of families receiving preventive services each month continued to grow.						
NUMBER OF CHILDREN IN PREVENTIVE CASES (ACTIVE, JUNE)	30,368	30,033	29,405	28,663	30,358	33,022
Preventive programs were operating at full capacity most of FY08.						
PERCENT OF PREVENTIVE CASES REFERRED BY ACS	52	50	49	52	68	76
The rate of new cases referred to general preventive agencies from ACS continued to increase sharply.						

FOSTER CARE SERVICES

NUMBER OF CHILDREN ADMITTED TO FOSTER CARE	6,901	6,201	4,813	6,213	7,132	7,451
The number of children placed in care stabilized more than two years after the Nixzmary Brown murder.						
NUMBER OF CHILDREN DISCHARGED FROM FOSTER CARE	9,594	8,854	7,907	6,625	7,219	7,466
Discharges kept pace with admissions.						
TOTAL FOSTER CARE POPULATION (ANNUAL AVERAGE)	25,701	22,082	18,968	16,805	16,988	16,947
The number of children in foster care remained near its lowest point in decades.						
MEDIAN LENGTH OF STAY FOR CHILDREN BEFORE RETURN TO PARENTS (MONTHS)	6.8	7.6	8.2	10.3	11.5	9.3
A growing number of children are returning home quickly.						
PERCENTAGE OF CHILDREN WITH REUNIFICATION GOAL (PREVIOUS CALENDAR YEAR)	43.8	44.0	44.3	45.5	55.3	51.3
More than half of the children in foster care in December 2007 were expected to return home.						
PERCENTAGE OF SEPARATED SIBLINGS (PREVIOUS CALENDAR YEAR)	52.4	51.4	50.7	49.3	47	48.3
The sibling separation rate remained at about the same level as a decade ago.						
RECIDIVISM RATE (%) (PREVIOUS CALENDAR YEAR)	13.6	12.8	13.6	11.5	9.1	10.0
One-in-ten foster children returned to care within two years of discharge.						
PERCENTAGE OF FOSTER CHILDREN IN KINSHIP CARE	26.8	26.0	24.6	24.3	28.3	32.2
The proportion of children in kinship care returned to a level not seen since 1998.						
PERCENTAGE OF FOSTER BOARDING HOME PLACEMENTS IN-BOROUGH OF ORIGIN	74.9	72.4	76.8	74.1	65.7	54.0
The rate of in-borough placements dropped sharply in FY 2008.						
PERCENTAGE OF FOSTER BOARDING HOME PLACEMENTS IN COMMUNITY DISTRICT	22.1	23.7	21.7	17.8	13.5	11.2
A small minority of foster children are now placed near home, despite stated ACS policy goals.						

ADOPTION SERVICES

PERCENTAGE OF CHILDREN WITH ADOPTION AS A GOAL (PREVIOUS CALENDAR YEAR)	39.4	38.8	39.8	38.0	30.4	28.6
As of December 2007, fewer foster children were moving toward adoption.						
NUMBER OF FINALIZED ADOPTIONS	2,849	2,735	2,364	1,831	1,562	1,287
Finalized adoptions have declined by 55 percent since FY 2003.						
AVERAGE TIME TO COMPLETE ADOPTIONS (YEARS)	3.6	3.6	3.4	3.5	3.5	3.4
This number has remained constant for nearly a decade.						

All numbers above reported in NYC fiscal years unless otherwise indicated. Sources: NYC Mayor's Management Reports, NY State Office of Children and Family Services Monitoring and Analysis Profiles, NYC Administration for Children's Services Updates

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