

**Risk, Responsibility and Opportunity: Facing the Facts about
the Social-Emotional Health Needs of Mecklenburg County's
Most Vulnerable Young Children**

Prepared by Natalie Conner, Ph.D.

For the Infant Mental Health Working Group

July 21, 2009



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Dear Friends of Young Children,

It is my pleasure to introduce the evaluation report for FY 08-09 presented to the Board of Smart Start of Mecklenburg County and the community of practitioners, agencies and stakeholders interested in the social-emotional well being of children birth to age five in Mecklenburg County. This report details the content and outcomes of one of the main service and evaluation components of the Zfive Infant Mental Health Working Group (Zfive Group):

Increasing awareness of and support to the mental health needs of very young children, particularly those who interface with the child welfare system in Mecklenburg County.

The intent of this report is to tell a story of the situations, incidents, systems and responses that are often experienced by some of the youngest citizens of our community who encounter some of the direst circumstances imaginable. This report, developed through careful research, interviews, and case finding, paints a picture that is at times disturbing. The intention of this evaluation is not to point fingers or assign blame to determine culpability. However, the report is hopefully clear on this point: there is a lack of awareness of the impact that traumatic circumstances have on the social emotional development of young children and an inadequate response on the part of the community to address these needs. We are all responsible for ensuring improvement in the supports and services that young children and their families receive. If the report is successful in bringing together informed collaboration to that cause then it has been successful in achieving the outcome desired by the Zfive group.

In a meeting last month sponsored by Zfive, an overview of this report was presented to local community health, mental health and social service leaders. Those present voiced a very personal level of interest and a strong commitment to develop a better understanding of and response to the problems outlined herein. It is our hope that this will become the catalyst for bringing about real change in the supports and services available to the future of our community – Mecklenburg County's youngest citizens.

With Best Regards on Behalf of the Zfive Group,

John L. Ellis, Ph.D., Chair

Zfive Infant Mental Health Working Group

Risk, Responsibility and Opportunity: Facing the Facts about the Social-Emotional Health Needs of Mecklenburg County's Most Vulnerable Young Children

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Introduction

This report reflects the collective decision making processes of the Infant Mental Health Working Group (IMH Group), a collaboration of about 25 early childhood professionals representing about 20 agencies, dedicated to creating “a high quality, integrated, and easily accessible array of services and supports to meet the needs of young children aged 0-5 with mental health issues and their families in Mecklenburg County.” The IMH Group has chosen to focus much of its effort on a subset of young children particularly vulnerable, those involved in the child welfare system. The mental health needs of these children, who have a number of significant cumulative risk factors, are the subject of this report. After a brief description of the evolution and background of the IMH Group, this report describes the social and emotional needs of this target population in relation to the current infrastructure in place to meet those needs. Finally, recommendations, based on stakeholder interviews and review of current research, are offered.

Background

In October 2007, The Lee Institute received funding from Smart Start of Mecklenburg County to work with the IMH Group. During the first phase of funding, The Lee Institute and the IMH Group completed an assessment of needs in the field of infant mental health (referring to children ages 0-5), and began social marketing initiatives. In July 2008, The Lee Institute’s focus shifted from study to action as the IMH Group agreed to move toward implementation of initiatives in three areas.

The first initiative targets children in the age range 0-5 involved with the Mecklenburg County Department of Social Services Youth and Family Services Division (YFS). Here, an infant mental health specialist has been housed on site at the Geo District 1 office since November 2008, and provides both educational materials and trainings to introduce case workers to infant mental health, resilience theory, social-emotional development, effects of trauma on development, and identification of resources for children in need of support. In addition, the IMH specialist provides case consultation, assessment and screenings using the Devereux Early Childhood Assessment (DECA; LeBuffe, & Naglieri, 1999), and strengths-based solutions to nonclinical problem behaviors.

Second, to increase the local supply of clinicians skilled in providing treatment for the population (children aged 0-5 with social, emotional, and/or mental health needs), a mentor/mentee program was created and officially launched in January 2009. To date, an LCSW clinician has delivered on training and mentored five licensed psychotherapists in the application of specific therapeutic techniques, diagnostic assessment procedures, and management of treatment goals.

Finally, efforts at social marketing (including presentations, branding, website

development, “elevator speech” cards, and a video for parents) are intended to raise awareness about the importance of social-emotional development of young children and to connect parents and professionals with resources and information.

At the request of The Lee Institute, the work of evaluation was begun in October 2008. Preliminary steps included interviews with stakeholders, attendance at meetings of the IMH Group, and review of national and state-level legislative pieces impacting current functioning of the public systems serving children 0-5. Subsequent steps included secondary data analysis and another round of interviews of stakeholders. The final phase of the evaluation of the year ending June 30, 2009 includes the beginnings of an outcomes evaluation to determine:

1. the efficacy of the IMH specialist at Geo District 1 in
 - a. identifying social-emotional needs for the target population;
 - b. her ability to link children and families with appropriate resources; and
 - c. the increase in awareness among YFS caseworkers of the mental health needs of this population.
2. the increase in knowledge, competence, and application thereof for clients aged 0-5 among the private sector of mental health professionals currently involved as mentees.

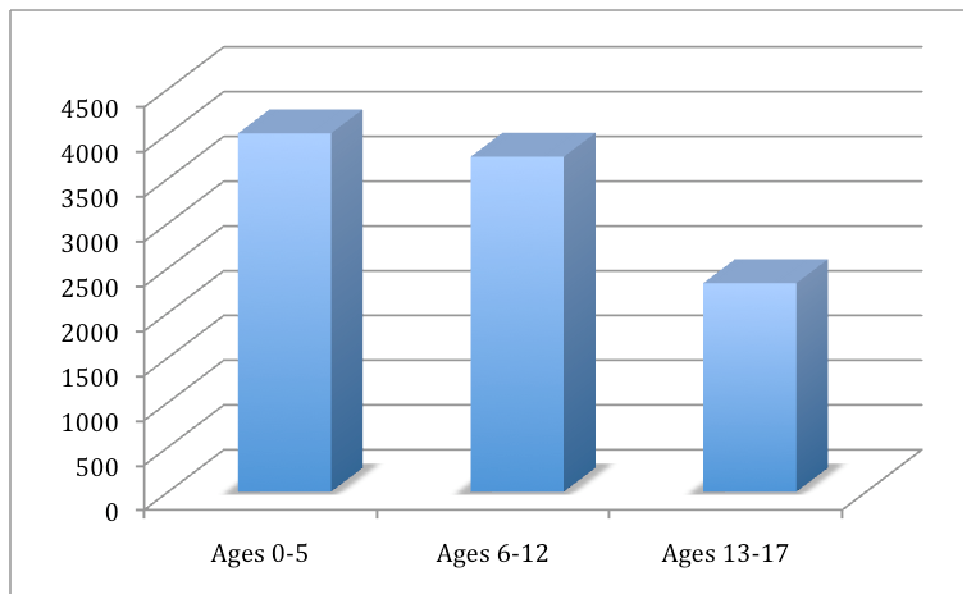
This report will describe: (1) mental health issues for the target population; (2) current infrastructure in place to meet the needs of this population; and (3) recommendations based on stakeholder interviews for meeting these needs in the future. A separate report contains more in-depth data that specifically address the assessment the pilot phase of the IMH specialist and the clinical provider mentoring group outlined above.

Target Population

Because a major focus of the IMH Group specifically targets children aged 0-5 with mental health needs in the YFS system, the preliminary analysis of the ability of the overall public system to provide integrated services starts with the point of entry of Mecklenburg County YFS population. The questions asked: (1) *How many children in this age group suffer abuse and neglect?* (2) *What does placement in foster care look like for these children?* (3) *What demographic data are available?* (4) *How are social-emotional needs of these children addressed and identified currently?*

According to data from the NC Child Welfare Program at the Jordan Institute for Families, 10,152 reports were made to Mecklenburg YFS alleging abuse and/or neglect in FY 2007 (the latest complete year data is made available). Of these, 39.45% of all allegations were made concerning children between the ages of 0-5:

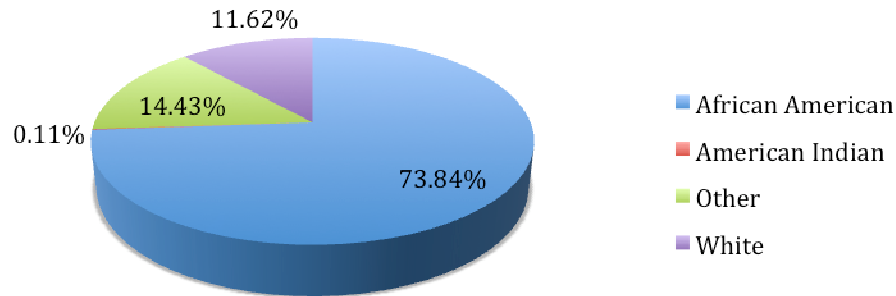
Mecklenburg County Abuse and Neglect Reports by Age Groups (2007)



Using structured decision-making tools, caseworkers conducted investigations to determine the need for future services. A sketch of data about these cases follows:

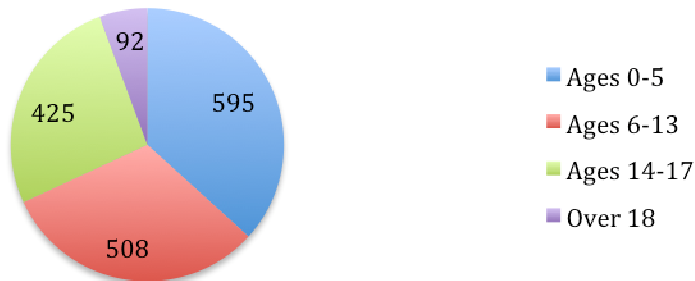
- Of this total number of reports, after an investigation was conducted, a total of 586 cases (ages 0-5) in FY 2007 were substantiated.
- For the vast majority (around 96%), out-of-home placements were arranged. (These include kinship care, foster care, and group homes.)
- The median number of days in custody for children ages 0-5 was 616 days.
- The most current data (April 2009) indicate that 73.84% of these children are African American, 11.61% are white, 14.43% are listed as “other”, and 0.11% are American Indian.
- Children living in NC Judicial District 26 experienced more placement disruptions during the course of overall time in custody than the national average.
- Although these data are not separated by age, it appears that 40.53% of children in Mecklenburg County experienced more than two placements, while nationally, 33.90% of the population were placed in three or more foster care or group homes.
- The NC average of four or more placement disruptions for the 0-5 age group is about 20% (2002 data, Duncan et al.).

**PERCENTAGE DISTRIBUTION OF
TOTAL IN YFS CUSTODY BY RACE
(APRIL 2009)**



At this writing, almost 600 children ages 0-5 in Mecklenburg County are in custody and have been removed from their parent(s) after a finding of abuse and neglect was determined. The most recent data available for substantiated cases grouped by age follow:

**NUMBER OF CHILDREN IN YFS
CUSTODY BY AGE GROUP (FY
2007)**



A conclusion can be drawn, based on these data, that the majority of children in custody are African American, almost half are aged 0-5, and spend about two years in out-of-home placements.

Consequences of Abuse and Neglect:

What do we know, based on evidence, is likely to become of these children? The psychosocial effects of abuse and neglect are well known. The immediate emotional effects of abuse and neglect— isolation, fear, and an inability to trust— can yield lifelong consequences, including substance abuse, antisocial behavior, low self-esteem, depression, and relationship difficulties. Researchers have identified links between child abuse and neglect and the following:

Difficulties during infancy. Depression and withdrawal symptoms were common among children as young as 2 who experienced emotional, physical, or environmental neglect. (Dubowitz, Papas, Black, & Starr, 2002).

Poor mental and emotional health. In one long-term study, as many as 80% of young adults who had been abused met the diagnostic criteria for at least one psychiatric disorder at age 21. These young adults exhibited many problems, including depression, anxiety, eating disorders, and suicide attempts (Silverman, Reinherz, & Giaconia, 1996). Other psychological and emotional conditions associated with abuse and neglect include panic disorder, dissociative disorders, attention-deficit/hyperactivity disorder, depression, anger, posttraumatic stress disorder, and reactive attachment disorder (Teicher, 2000; De Bellis & Thomas, 2003; Springer, Sheridan, Kuo, & Carnes, 2007).

Cognitive difficulties. An April, 2008 report from the National Study of Child and Adolescent Well-Being (NSCAW) found that children placed in out-of-home care due to abuse or neglect tended to score lower than the general population on measures of cognitive capacity, language development, and academic achievement (U.S. Department of Health and Human Services, 2003). The Longitudinal Studies Consortium on Child Abuse and Neglect (LONGSCAN, 1999) study also found a relationship between substantiated child maltreatment and poor academic performance and classroom functioning for school-age children (Zolotor, Kotch, Dufort, Winsor, & Catellier, 1999).

Social difficulties. Children who experience rejection or neglect are more likely to develop antisocial traits (including conduct disorder, violent aggression, and oppositional defiant disorder) as they grow up. Parental neglect is also associated with borderline personality disorders and violent behavior (Schoore, 2003).

Behavioral problems. Not all victims of child abuse and neglect will experience behavioral consequences. However, behavioral problems appear to be more likely among this group, even at a young age. An NSCAW survey of children ages 3 to 5 in foster care found these children displayed clinical or borderline levels of behavioral problems at a rate of more than twice that of the general population (ACF, 2004). Later in life, child abuse and neglect appear to make the following more likely:

Difficulties during adolescence. Studies have found abused and neglected children to be at least 25 percent more likely to experience problems such as delinquency, teen pregnancy, low academic achievement, drug use, and mental health problems (Kelley, Thornberry, & Smith, 1997). Other studies suggest that abused or neglected children are more likely to engage in sexual risk-taking as they reach adolescence, thereby increasing

their chances of contracting a sexually transmitted disease (Johnson, Rew, & Sternglanz, 2006).

Juvenile delinquency and adult criminality. According to a National Institute of Justice study, abused and neglected children were 11 times more likely to be arrested for criminal behavior as a juvenile, 2.7 times more likely to be arrested for violent and criminal behavior as an adult, and 3.1 times more likely to be arrested for one of many forms of violent crime (juvenile or adult) (English, Widom, & Brandford, 2004).

Alcohol and other drug abuse. Research consistently reflects an increased likelihood that abused and neglected children will smoke cigarettes, abuse alcohol, or take illicit drugs during their lifetime (Dube et al., 2001). According to a report from the National Institute on Drug Abuse, as many as two-thirds of people in drug treatment programs reported being abused as children (Swan, 1998).

Abusive behavior. Abusive parents often have experienced abuse during their own childhoods. It is estimated approximately one-third of abused and neglected children will eventually victimize their own children (Prevent Child Abuse New York, 2003).

Clearly, the aftermath of abuse and neglect for children and communities warrants serious, immediate, and consistent public attention to the emotional, mental, and behavioral consequences of the family's failure to maintain safety. While not every child who experiences abuse and neglect develops later difficulties, it is undeniable that early childhood abuse is a serious risk factor that must be investigated further.

In a time when public dollars are weighed carefully, it is important to address costs associated with meeting societal needs. What is the cost of undiagnosed, untreated, or undertreated mental health issues in this population?

Cost-benefit analyses of a long list and a wide range of early childhood intervention programs for children at risk of poor outcomes have undeniably illustrated that many programs reduce the costs of future treatment by mitigating future poor outcomes. Some of these studies indicate that these programs more than pay for themselves (Rosenberg et al., 2007). Research suggests that high quality mental health services in the early years, particularly for children in foster care, help decrease the incidence of later mental health problems, increase the likelihood of academic success, and prevent out-of-home placement for their own children---considerable cost-savings for society (Pecora et al., 2006).

Children in Mecklenburg County

There are no consistent data collecting mechanisms available for demographics and mental health diagnoses for children 0-5 seen by mental health providers. However, it is safe to assume that most children in Mecklenburg County who experience the multiple risk factors of abuse, neglect, and poverty fail to develop positively, and experience preventable further problems from absence of intervention. It is reasonable to draw the conclusion based on these data, interviews with stakeholders, case studies, and the

literature, that frequent placement and child care disruptions are linked to unrecognized, unresolved, and unsupported mental health issues. Moreover, after nearly a decade of untreated mental health issues in the 0-5 population (see the historical disaggregation of public mental health service provision below), we must ask whether a measure of the increase in middle and high school mental health problems we are seeing in the CMS population is connected with early childhood abuse and neglect. For example, data from the Centers for Disease Control's Youth Risk Behavior Survey (2007) indicate that about one in ten high school students meets the DSM-IV-TR criteria for Major Depressive Disorder. The rate is slightly higher for middle school students, with about one in six students. (For more information, please refer to: www.cms.k12.nc.us/cmsdepartments/csh/Documents/Highlights.pdf).

Clearly, local research is needed to test this hypothesis: without mental health support, children who experience abuse and/or neglect in early childhood develop mental health issues in later developmental periods at a greater rate than children who do not experience abuse and neglect.

National research shows that less than one-third of investigations overall lead to a substantiation of the abuse or neglect allegation (Everson et al., 2007). Indeed, it appears that rates of abuse occur at a rate four to six times higher than in CPS records. However, a number of allegations are not substantiated due to lack of evidence, even when caseworkers judge children to have suffered harm or be at moderate to high risk (U.S. Department of Health and Human Services, 2008). Also, we know that even children in unsubstantiated cases have disproportionate exposure to risks, have correspondingly high rates of developmental deficits and mental health problems. In many ways, outcomes for children in unsubstantiated cases are the same as those of children in substantiated cases.

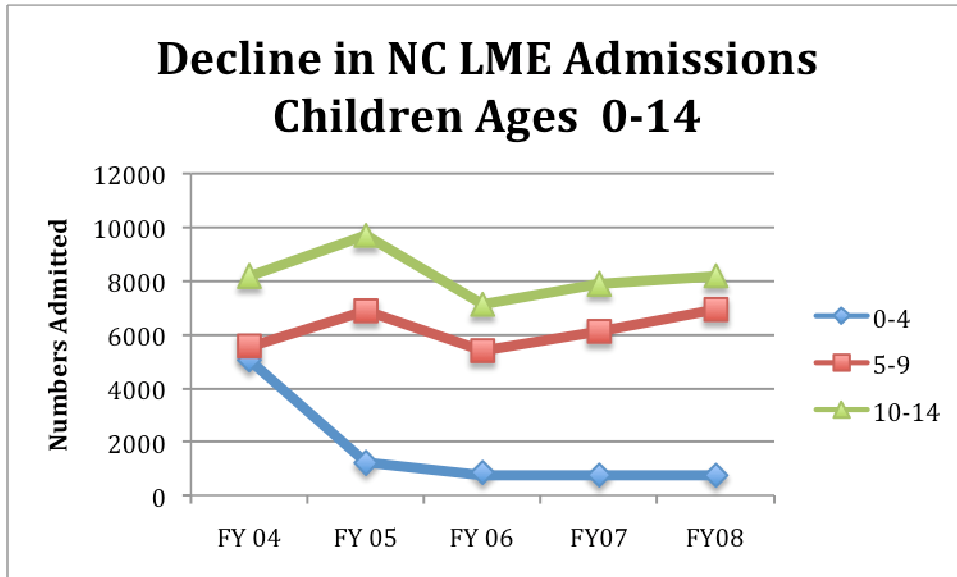
The responsibility is large when the public child welfare system is granted legal custody of these children. YFS takes custody when a child is placed in foster care and often when placed with relatives. YFS then has legal responsibility for ensuring that children are kept in a safe and stable environment, are returned home whenever possible, and receive services needed to address abuse, ensure positive development, or both. Even when children have left YFS custody, there is a societal responsibility to understand their development: as noted earlier, child abuse and neglect can have long-term negative effects on child victims' cognitive, emotional, and social development.

It can be concluded that when a moderate degree of risk is ascertained, or when a substantiation of abuse and neglect is reached, **a complete evaluation of mental health and psychosocial functioning is warranted**. Ideally, children whose families receive YFS investigations that raise red flags should also receive an assessment and referral to appropriate services.

Where Is the Help?

Based on stakeholder interviews, it seems there is a widely held assumption on the part of other service entities (CMS, YFS, CDSA) that mental health service provision and coordination for children 0-5 occurs at the "public mental health" level. This is untrue.

Statewide, children ages 0-4 served by Area Mental Health Programs (or Local Management Entities) declined by 38.3% between FY 2004 and FY 2008. This age group experienced the highest decline in service utility of any other age groups. In FY 08, children ages 0-4 comprised .3% of the total population served in NC. Within the children (non-adolescent) age groupings, the decline is depicted below:



What accounts for this discrepancy? A brief history of public mental health service provision reveals a complicated fragmentation that has blurred service provision, fiscal responsibility, and obfuscates an absence of tracking un- and underserved populations such as the 0-5 age group. Specific questions about the sharp decline between FY04 and FY 05 have been posed to Susan Robinson of the NC Division of MH/DD/SA; a response is pending.

In 1971, North Carolina passed its own legislation (reflective of a national call to deinstitutionalize and to create community mental health systems) establishing an Area Authority system to deliver and manage mental health, developmental disability and substance abuse services. From 1971 to 2001 the public mental health system in North Carolina operated under this system, and provided and managed services in clinic settings.

In 2001, the North Carolina General Assembly passed legislation (GS 122C-115.4) restructuring this system to one where direct service provision would be provided by private or other government entities. Area Authorities, now known as Local Management Entities (LMEs), were given the responsibility of managing the system and performing a set of functions that were both clinically and business oriented. Some LMEs lost their direct clinical service provision, a result of the rapid transformation process and the attempt by LMEs to comply with statutory requirements and policies that included the performance of specific business functions. This was not the case with the Mecklenburg LME which was allowed, as a part of its divestiture plan with the Division of MH/DD/SA

Services, to continue direct provision of some services to all disability groups. Moreover, the divestiture in Mecklenburg County did not disrupt the longstanding inter-local agreement with Carolinas Healthcare System for the operation of outpatient services child and adult mental health services through the Behavioral Health Center-Randolph. Statewide, the time and effort required to make this transition related to business functions seems to have supplanted the focus on clinical systems.

Dr. Thomas Smith, MD of NC Policy Watch says,

When the public community mental health clinics went “with the wind”, so also did an exceedingly important part of our state’s patient safety net - a truly staggering loss. The safety net was made up of facilities and caregivers who were readily and promptly available to serve, among others, needy patients who could not afford (neither) health insurance nor out-of-pocket pay, or who earned a bit too much to qualify for Medicaid. This was made possible by the community clinics’ policy of “cost-averaging”. Furthermore, the mental health clinics maintained a walk-in service, had all disciplines (psychotherapy, psychiatry, case management, etc.) conveniently located under one roof and were readily accessible to those who lacked transportation or who had no other place to turn for quick and readily responsive help.

The omission of provision of mental health services for children under the age of three through the public mental health system was a deliberate legislative decision, referred to as a “carve out”. This deletion was undertaken based on an (erroneous) assumption that the Early Intervention Program, under the Division of Health and Human Services – Department of Public Health, would cover services for this population. This has not happened. Furthering their exclusion, the eligibility criteria for children in this age group served by the North Carolina Infant-Toddler Program was revised in 2006, omitting the eligibility category of Atypical Development. Children’s Developmental Services Agencies have continued to look at social-emotional development as a part of the initial evaluation process that assesses all areas of a child’s development. However, children with *atypically* developing patterns of social-emotional development became more difficult to find eligible for early intervention services with an eligibility definition that focuses almost exclusively on developmental *delay*.

Where minors under the aegis of state guardianship are concerned, according to Grayce Crockett of Mecklenburg County AMH (LME), mental health treatment cannot be authorized unless a community support organization has taken the case.

According to the Division of Medical Assistance DMA policy index page (<http://www.ncdhhs.gov/dma/mp/mpindex.htm>), community support services are “community-based rehabilitative services and interventions necessary to treat children and adolescents 20 years old or younger (for State-funded services youth 3 through 17 years of age) to achieve their mental health and/or substance abuse recovery goals and to assist parents and other caregivers in helping children and adolescents build resiliency.” **Already, by this definition, children under the age of three are omitted.**

In Mecklenburg County, there are currently two CSOs serving specifically the age group 0-5: Thompson Child and Family Focus and Alexander Youth Network and between the two of them they are providing Community Support to a total of two children at the present. The limited census at these and other organizations is further reflection on the

underserved nature of this population. There is recognition on the part of the Mecklenburg LME as to the need for both a broader array of services and expertise in relation to early childhood mental health needs. “We need a continuum of services,” says Ms. Crockett. “We are not sure what to do when we get calls. We need a way of identifying these needs, and a place to refer, and we need to develop a strong community provider organization to develop that expertise.”

In summary, this brief history generates more questions than answers, most along the lines of responsibility and ownership. Why has no entity taken charge of this age group? A population of 0-5 year old children, whose externalizing behaviors are not problematical in the same way those of an adolescent might be, has received little to no attention from the public service system, and is unlikely to create a barnstorm of policy-galvanizing headlines. Moreover, with no broad-based case finding and management system in place for this age group, there is no oversight specifically related to the needs of the children. Guardians ad Litem in NC are lay volunteers, and cases in Mecklenburg County frequently go unstaffed (or understaffed) by GALs (4,618 trained volunteers served 17,701 children, staffing 38, 828 hearings in FY 2008, according to the GAL website).

In short, if there is no adult charged with tracking down and ensuring mental health services for this population, it is certain their needs will go unmet. Perhaps the lack of public awareness, political will, and resource allocation stem from the relative quiet young children with mental health needs exhibit.

A Human Face: Edward’s Story

To illustrate the schism between the public human service network’s ability to detect and treat mental health issues and the ever-present needs of young children, the following case story is related. More case histories appear in Appendix A. To be sure “data is not the plural of anecdote”; these stories are included not to constitute faux data, but to provide a range of examples of the social-emotional needs of children ages 0-5. This story was brought to the attention of the IMH Group by the IMH specialist embedded at YFS Geo District 1.

Edward came to the attention of the Mecklenburg County DSS on April 2, 2008, at the age of two, when a report was made alleging neglect and abuse. The informant stated that when his mother was working, Edward was left with a maternal aunt experiencing postpartum depression, and perhaps psychosis. The aunt had allegedly attempted suicide while in her third trimester by ingesting pills, and was released from a psychiatric hospital after a ten-day stay. Since the birth of her baby, six weeks prior to the report, she had moved in with her sister to provide care for Edward, and had locked him in the bathroom for an excessive amount of time. The investigation evaluated Edward’s family as “moderate” level of risk, based on a form used to calculate the risk of future abuse and neglect occurring. The case was closed in June.

The case was reopened on December 18, 2008, when the Cabarrus County DSS requested immediate assistance in locating Edward’s family. The report recommends an

examination to look for physical marks on Edward, and that his mother receive a drug screening. The follow-up report was missing from the files reviewed for this evaluation, but it can be assumed that findings substantiated these suspicions, as Edward was removed from his mother's care two weeks after the call from CCDSS was made. He was found to have multiple bruises, and a healed fracture. The report suggested that his mother beat him daily, and that she drugged him to make him sleep at night. It is not hard to imagine the terror of this child's life, and the consequences of such abuse.

He was placed with his maternal grandmother (against whom substantiated claims of abuse and neglect were made when her daughters, Edward's mother and aunt, lived with her; they had been placed in foster care as children). His older sister also lived with the grandmother. However, for reasons not discovered, Edward was removed from that placement about two weeks later, and moved to a foster home under the direction of a foster home placement coordinator not specifically trained in working with children 0-5. Edward received an evaluation from the CDSA on January 7th, the recommendations after which included: case management, ophthalmological assessment, physical therapy, child and family psychotherapy, and assessment by the CMS Exceptional Childhood program (based on DOB issues).

Edward was removed from his first foster care placement two days later, and was moved into a new foster home (January 22, 2009) with three additional foster children. He had begun day care when placed with his grandmother, and his first meeting with his new foster mother was at the childcare setting. On his third placement in as many weeks, Edward began exhibiting problem behaviors such as aggression, noncompliance, and inappropriate verbal reactions. His behaviors were reported to be increased in intensity surrounding bedtime.

About three weeks later (February 18, 2009), Edward was expelled from daycare after an incident of aggression with a teacher. The IMH specialist had been asked to assist in early February, and her conversation with the foster home placement coordinator (based in a CSO) revolved around these disruptions. According to the IMH Specialist, the CSO foster home placement coordinator dismissed her suggestions both to make efforts to understand Edward's behaviors, as well as the need to talk to Edward about his situation. Recommendations made by the IMH specialist included ways to support foster parents, referral to the Polliwog program to enlist services to support the childcare providers. The coordinator recommended an institutional placement. He was taken to the Behavioral Health Center-Randolph that day, and was prescribed clonidine. He began a new day care placement in a family day care home the next day, as the foster care mother could not support him at home.

Also as a result of the IMH specialist's involvement, Edward's case came to light at an IMH Group meeting. The CDSA Director, recognizing the substantial needs of this child, took the lead on calling treatment team meetings; a new foster care provider was located and a private sector mental health therapist, specializing in early childhood issues was secured.

At this writing, just past his third birthday, Edward has been expelled from his most

recent childcare setting, not due to his unmanageable behavior, but due to questions that were being asked about Edward by the parents of other children. He was enrolled at Thompson Child Development Center on April 27, 2009. He has seen his therapist two or three times, and the new foster home placement coordinator in charge of his case has been collaborating with his YFS caseworker.

However, prior to the involvement of the IMH specialist and the IMH Group, there were several missed opportunities to increase the stability of his foster and childcare placements, and to increase the likelihood of positive mental health outcomes. Routine services such as competent case management sensitive to his developmental stage, wraparound and other supportive services for the foster family, support services in childcare settings, psychotherapy to facilitate the multiple losses experienced by the child, and exploration of issues such as fear of bedtime are interventions that should be available to every child who has been subjected to the horrors of abuse.

Summary:

- There is no clearly demarcated public mental health system readily available to children ages 0-5 in Mecklenburg County.
- Young child victims of abuse and neglect in Mecklenburg County do not receive mental health evaluation or treatment under the auspices of the existing public service system.
- Children have no consistent adult representing their best interests throughout the term of the state's guardianship.
- Children's comprehensive assessments across entities lack uniformity in protocol and instrumentation, and give scant attention to mental health functioning.
- The overarching question must be addressed without finger pointing, eyeing a better future: Who is ultimately responsible for the welfare of these children?
- Tracking child outcomes longitudinally, across systems, is necessary if agencies are to be effective and accountable.
- Amongst the agencies interviewed (CMS, YFS, AMH, CDSA, CSOs), most indicate a willingness and commitment to serve the needs of this population.
- Most agencies indicate a need for the development of expertise in serving the 0-5 population.
- These findings mirror the results of current research at state and national levels (see, for example, *The Developmental Status and Early Intervention Service Needs of Maltreated Children Final Report*: <http://aspe.hhs.gov/hsp/devneeds/index.htm>)

Recommendations

1. Build a better boat: map out a comprehensive system with checks and balances; include buy-in from multiple agencies with an oversight system of case management built in.
 - a. Understand the current system and its gaps (See Appendix B);
 - b. Identify ideal service delivery system based on best practices;
 - c. Include instrumentation based on good science (reliable and valid instruments to assess risk, mental health needs, and to monitor progress in treatment).
 - d. Identify "shovel-ready" agencies with the vision, commitment, and capacity to educate case managers to serve as CSOs for this population;
 - e. Identify and seek to resolve barriers to participation from other relevant agencies not currently connected to the IMH Group.
2. Research the work done in other states around similar issues (particularly those that have included an "at-risk" category for Part C of IDEA);
3. Implement a better detection system at the YFS risk assessment level (see, for example, McCrae & Barth, 2008);
4. Specify a theory of change for the coordination of the fragmented public service system (see, for example, Appendix C).

APPENDIX A

Dishon's Story

Dishon's story was told by a 12-year teaching veteran of the Double Oaks' Bright Beginnings Program.

Dishon is an African American four-year old boy currently living in the Salvation Army shelter with his mother. They have been homeless for two years. Until the past year, Dishon lived with his mother, older brother (Sam, age 14) and older sister (Angela, age 17). Last year, both older siblings were placed in foster care.

Dishon's behaviors were initially noted on the first day of school. When asked to transition from an activity, Dishon protested, at first verbally, and then physically. Once the cycle had been launched, he would not stop until he completed the series of severe head banging, after which, dazed and sometimes bleeding, Dishon would calm down, "as if nothing had ever happened," said his teacher.

The teacher sought help from the school psychologist, the Salvation Army caseworker, and from DSS. No one was able to provide her with alternatives to simply remaining with Dishon and trying to prevent him from hurting himself. His self-violence increased, until both the teacher and her aide were required to restrain him. "It got to the point where anything out of the norm would set him off. In circle time, I can't tell you how many times we just left the other kids sitting there for about fifteen, maybe twenty minutes while Dishon went off."

The school psychologist suggested they send him home when he started to exhibit these behaviors. Ironically, as pointed out earlier in the story, Dishon had no home. The caseworker was worried: if Dishon was removed from school, then the family would lose their placement. The caseworker took Dishon and his mother to CMC's Behavioral Health Center, where the psychiatrist gave Dishon's mother a mixture of Depakote and Risperidol to give him daily. Sometimes his mother forgot to give him his medicine, or sometimes she handed it to him as he was getting on the bus, once in a glass of chocolate milk. When he did have his meds, he was a "zombie—worse than a zombie—he just slept the whole day."

At the end of the school year, as children were being placed in Kindergarten settings most appropriate for their needs and strengths, the teacher tried to find a supportive environment for Dishon. He was placed in a classroom for autistic children, even though he had not received a diagnosis of autism.

Steven's Story

Steven's story was told by his mother, an LCSW experienced in working with young children and their families.

Steven was born at about 4 lbs., 9 oz., lbs., his size was the result of intrauterine growth restriction (IUGR), and low amniotic fluid. A level two ultrasound ruled out spina bifida.

However, he was born with a sacral dimple, and many other earmarks of cerebral palsy. “The doctors dismissed this diagnosis, and we went on our way. At about 2 months, however, I began to notice his low tone on top and tightness in his legs, which I watched closely. We were referred to Cranial Technologies at about 4 months for cranial banding to correct his plagiocephaly. At about 6 months, we sought physical therapy, private-pay, because the doctors had ruled out any problems, so insurance wouldn’t reimburse. At 7 months, we got the diagnosis of CP from a neurologist.”

The doctors were responsive to the urgency with which Steven’s mother requested an MRI. Steven was experiencing feeding issues, spasticity, and low tone. The MRI revealed blocked cerebral spinal fluid, and at age 1, Steven underwent brain surgery. Three months later, he began to exhibit seizure-like activity (eye movement irregularity, tremors, rigidity). The doctors could not reach a diagnosis, and so recommended nothing. The family continued with the private pay physical therapy.

Just shy of his third birthday, Steven’s mother decided to try another tack; the doctors were not able to help secure services. She took Steven to the CDSA, where she had worked in the 1990s. This comprehensive evaluation verified what Steven’s mother was seeing, which the physicians were not. It also made Steven eligible for a sliding fee scale—the family was inundated with medical bills, as the older sibling was diagnosed with a Chiari malformation and required brain surgery as well.

The experience with the CDSA convinced Steven’s parents that a third opinion was in order (the family had traveled to Duke for a second, and ultimately unhelpful, opinion). They traveled to NYC for an assessment at the Chiari Institute, revealing spina bifida and an unresolved Chiari malformation. In January, 2008, at the age of four, Steven underwent another brain surgery. This time, the surgery attacked what had been at the root of Steven’s problems.

However, there were consequences to a four-year backlog of unresolved medical problems. Steven’s motor planning abilities lagged behind his cognitive abilities, and he experienced frustration and agitation when trying to execute many tasks. An evaluation at CMS did not reflect an accurate picture of Steven’s needs, and so the family, now all too aware that diagnostic instruments are sometimes not reliable, sought a second opinion, at Child and Family Development, Inc. (a multidisciplinary, private outpatient treatment group in Charlotte). Based on the results of this assessment, the family engaged (again, private pay) occupational and speech therapists. Steven’s “CLEF” score from the CMS assessment was 6.5; the independent assessment team rated him at 4.2.

As a Kindergartener in 2008-09, Steven experienced many frustrations in the task-dense environment. He began to exhibit signs of social immaturity, poor peer relations, and problems in following directions. “He looks like an oppositional kid in this setting,” said his mother, “which is directly tied to the frustration he has in not being able to enact what his brain is telling him to do.” At the discretion of CMS, he received 30 minutes of special education services four days per week.

Now, Steven sees a child psychiatrist specifically trained in working with children 0-7. She sees traits similar to Asperger’s syndrome, and continued developmental issues—all secondarily stemming from physical causes (Chiari, spina bifida). Steven experiences

nightmares, and occasional bedwetting --again residual artifacts of neurochemical and developmental issues. The family seeks private pay occupational and speech therapy because he does not qualify for services under the CMS requirements. The family's next step is to take Steven to the Center for Development in Chapel Hill for a full assessment of what his learning profile will be as he advances through school; he will repeat Kindergarten.

CDSA Stories

The following two stories were submitted by Lisa Cloninger, MSW, an Administrative Supervisor at the CDSA.

Ayla

Ayla was referred for early intervention services (CDSA) by Youth and Family Services after a substantiation of neglect and dependency when she was two years, two months old. Ayla was referred previously but Ayla's mother declined services while she still had custody of her children. Ayla was one of three children in the family and the family had a child protective services history dating back five years. Ayla's mother had a history of substance abuse and these issues along with domestic violence in the home were what led to Ayla and her siblings being removed from the home. Ayla was placed with her siblings in a sibling home that was a group home setting and they resided there until were reunited with their mother after seven months in foster care. Ayla was placed in full time childcare when she went into foster care and she had regular visits with her mother.

Ayla was evaluated and determined eligible for early intervention. Ayla's service coordinator, Susan, developed an Individualized Family Service Plan and then made a visit to the child's foster care placement. Susan became very concerned about Ayla's placement, the mental health services she was receiving and the medication that was prescribed to manage her behavior. At two years old, Ayla was diagnosed with ADHD and ODD by a local psychiatrist and was prescribed an anti-seizure medication to treat her symptoms. Ayla was also seeing a therapist in the community who starting treating her older sibling and took Ayla on as a client. Ayla's foster care placement was a renovated group home that was not set up for young children. There were no toys available at her foster home and she was cared for by caregivers that rotated on a shift schedule. Ayla's SC spoke with the caregivers at the foster home and they were open to suggestions but admitted they were trained to work with older children and didn't know how to care for Ayla and her siblings.

At this point, Susan advocated for Ayla in each setting where she spent time. Ayla's service coordinator knew that consistency in caregivers, appropriate mental health care, a developmentally stimulating environment and consistent communication with all of the people in Ayla's life was crucial to her success. Ayla received speech therapy at her child care placement and her child care providers gave consistent care. Susan provided support to the foster care placement by giving them information about developmentally appropriate care for her and made suggestions about changes to her living space that made her more comfortable.

Susan also advocated that Ayla needed to receive mental health services from a provider that specialized in working with young children. Ayla was referred to an infant mental health therapist who immediately began providing support to Ayla, her siblings and to the foster home staff. Much of her work centered around transition, and helping to re-establish relationship with her mother as she went back home. The therapist also worked to teach behavior management skills to the mother, talked with doctor about getting the child off medication, consulted with the child care provider about consistency with child across settings. The child really didn't have any atypical mental health needs outside of what would have been expected for a child with her history, living in a foster home with no consistent caregiver and typical transition needs when it was time to go home.

The team was also instrumental in supporting Ayla's family when the children went back home to live with their mother. Both the service coordinator and the therapist were able to provide services to the child and follow her once she went back home. They both participated in a Team Decision Making meeting at Youth and Family Services and their recommendations were incorporated into the reunification plan for Ayla and her siblings. These recommendations were based on the needs of not only Ayla but they were also able to assist the team in making decisions that were appropriate for young child since all three children were under the age of five. Ayla received early intervention services until she aged out of the program at three years old. Ayla transitioned to school system services to address her speech needs and she continued to work with her therapist after she left the infant toddler program.

Evan

Evan was referred to early intervention (CDSA) by his social worker at Youth and Family Services due to a substantiation of neglect. There were also developmental concerns related to Evan's speech as well as his behavior at home. Evan's mother used alcohol and smoked heavily during the pregnancy. She developed an addiction to cocaine after Evan was born and had untreated mental health issues. Evan lived with his mother and his mother's boyfriend, Max. Max was present in Evan's life before Evan was born and was a father figure to him. Evan's mother was hospitalized related to her drug use and after that, Max moved out. Evan began to have split residence with his mother and Max. After Evan's mother refused to list Max on the birth certificate and that relationship ended, Evan moved for the second time to go live with his mother and grandparents. Evan was separated from his mother again for several days during this transition when she was arrested for assaulting Max during the ending of their relationship. Evan was enrolled in childcare after his move so his mother could go to school and he was having behavior problems at home.

Early intervention services began and Evan was introduced to a speech therapist and a private sector clinical social worker who provided therapy for him. The therapist worked on parent-child interactions, consistency in setting limits, learning to read Evan's cues and developing a consistent schedule to reduce Evan's anxiety. She worked with Evan's parents, grandparents and the childcare providers on these goals. From the beginning of the relationship, the clinical social worker communicated with the YFS worker and service coordinator about Evan's progress and made suggestions about how to proceed with his transition. During the course of his multiple moves she was able to provide support and treatment to Evan in the midst of all of his transitions.

Over the course of the next few months, Evan had many more transitions. He changed childcare three more times and was placed in foster care when his mother was hospitalized again for a drug overdose. His speech therapist also changed because he moved to a different part of town.

After Evan's mother went to (substance abuse) residential treatment, plans were made to reunify Evan with his mother. The social worker met with Evan's mother for several weeks before the transition was to occur and engaged the family in parent-child therapy while Evan was visiting his mother at the treatment facility. She also continued to work with Evan's grandparents because he was moved back into their home in preparation for his transition back to his mother.

A Team Decision Making meeting was scheduled to plan for Evan's return to his mother. At this point, the service coordinator and social worker advocated again for Evan with regards to the way transition had occurred for him in the last few months. Evan made 4 moves, had 4 different caregivers, 4 different childcare providers and 2 different speech therapists in 8 months. The consistency Evan had during all of this transition was his service coordinator and his clinical social worker who were diligent about keeping consistent support services in place for him.

Evan is scheduled to return to his mother while she remains in residential treatment. Evan's mother has a good relationship with the service coordinator and the clinical social worker and feels ready to take on this challenge. Once Evan moves in with his mother, he will change childcare centers again to be close to where his mother lives.

This case example was submitted by a Developmental Disabilities Specialist at the CDSA.

“Last week, I had an IFSP (Intensive Family Service Plan) review held at the daycare. Josh and his baby brother came into DSS custody six months ago and (they) live with a foster family who is in the process of adopting his older biological brother who came to their home a few years ago. The DSS plan continues to be reunification for Josh and his baby brother. The situation with having the biological mom (becoming) involved again with this foster family is causing some friction.

Josh has been receiving speech and IMH since being placed in foster care. An IFSP review last week included the daycare director and teacher, foster parents, DSS worker, Elon Homes worker (who transports Josh to his visits with the biological family) as well as the IMH therapist. The speech therapist could not come but information from her and the speech team decision was that he met all speech goals and no longer needs therapy.

Josh, now two years old, was placed in DSS custody due to his mother physically hurting him as a form of discipline. They were also living in a homeless shelter. Josh began receiving IMH due to attachment issues (including indiscriminate attachment to unfamiliar adults). Things were going well at the foster home but he had been having mild behavioral difficulties at daycare up until a few weeks

ago when he became aggressive, irritable and had frequent tantrums. Through everyone's input at the IFSP review, it was discovered that visits with his mother changed from a weekend day to a week daytime. He was being picked up, taken to his mother and brought back to daycare with no preparation or acknowledgement from an adult about what was happening to him. His foster parents did not prepare him as they do not want to talk about his mother in the home due to Josh's brother that they are in the process of adopting. Daycare had not had anyone discuss with them the visitation process and just knew that he was being picked up to see his mother.

To make a long story short, the team really worked together to make things improve for this little boy. Foster parents are going to come up with a calendar or similar (visual) product as a way to prepare Josh for visits. Daycare staff will also prepare Josh on the days he will visit his mom. Elon Homes case manager will talk with the DSS staff that supervises the visit to get specific information as to what occurred (i.e., mom read book to Josh, Josh cried throughout visit, Josh had a snack with mom, etc.). IMH therapist will change (the scheduled) therapy time to be with Josh when he returns from visit and will talk with the Elon Homes case manager to get more information about the visit. IMH therapist will then have some private time with Josh to talk about his visit and let him "come down" from whatever emotions he may be experiencing. In other words, the adults in Josh's life are now going to be acknowledging how impactful these visits are to him. I expect that we will see a positive improvement in his behavior once this process is implemented. I really feel that DSS worker also felt how important it is to communicate changes so that everyone can work together when there is a transition occurring.”

The following case examples were shared by Kristin Tenney-Blackwell, the IMH Specialist. Each case represents an example of her work in each YFS service area.

Service Area: Investigation

Case Example One:

Chelsea, a two-year-old girl, recently moved into a shelter with her mother and two older siblings (8 and 5 years). Chelsea and her siblings allegedly witnessed an incident where their mother, Sarah, was beaten by her boyfriend. The boyfriend, Harry, was taken to jail and Sarah stated she was scared Harry would return to the house once released.

The YFS Caseworker observed and interviewed Sarah and her two older children. The Caseworker observed and attempted to interview Chelsea. It was noted that Chelsea tried to verbally communicate; however, many of her verbal communication attempts were unintelligible. It was also noted in the report that this was not the first occurrence of abuse and Sarah currently has a restraining order against Harry. The YFS Caseworker discussed compliance of the order with Sarah and stated she needs to carry the paperwork with her at all times. Apparently, Harry had come over to Sarah's house to discuss

getting the order dropped and efforts to reunify.

The YFS Caseworker provided the mother, Sarah, information with regard to how domestic violence affects children (prepared by Mecklenburg County Community Support Services – Women’s Commission), as well as additional reading material. The two older children were referred to the H.E.R.O. Program while Sarah received individual counseling services within the shelter. Harry agreed to enlist services through NOVA. Research and verification of the restraining order were completed and the Caseworker prepared for case closure.

The Infant Mental Health Specialist became aware of the case during closing. Consultation efforts focused on the following:

1. Review of the handout, *“Some Effects of Domestic Violence on Children”* contains possible responses and behaviors displayed by children based on ages (newborns, toddlers and preschoolers, school-age, and preadolescent and adolescent). Discussions with the YFS Caseworker resulted in agreement that while the information is helpful and nicely categorized by age group, many of the terms used may be difficult for parents to understand. For example, the document contains terms such as “PTSD,” “Intensified startle response,” “psychosomatic complaints,” and “frozen watchfulness.” The IMH Specialist was able to create and provide handouts utilizing parent friendly and easy-to-understand terms.
2. Future cases can involve the IMH Specialist, along with the YFS Caseworker, supporting the initial home visit(s) and observation of young children birth to five. Also discussed were ways to try to engage and interact with children who display limited verbal language skills due to age, experiences, developmental limitations or struggles, etc.
3. The IMH Specialist can help support investigation cases through social and emotional screening, observation and consultation with the primary caregiver(s) to help better understand a young child’s experiences and outline suggested needs and support services.

Case Example Two:

A YFS Caseworker requested consultation for a 3-week old child, Teisha. At birth, Teisha tested positive for cocaine. It was reported that Kara, the birth mother, has a history of mental health issues and drug abuse. Research notes four previous neglect referrals to DSS. Kevin, the biological father, has a criminal history noting possession and selling of drugs. Kevin states he does not use drugs, however. Kevin’s research records reflect one past neglect referral to DSS. Teisha is being cared for by Kevin’s sister and husband (Temporary Emergency Custody). Both parents were referred to the McLeod Center and recommended for random drug screens. Kara was also referred to the Behavioral Health Center for an evaluation.

The IMH Specialist attended a home visit with the Investigation Caseworker in which the

aunt and uncle caring for Teisha were present. Teisha was sleeping while being held by her aunt. The current recommendation is that Teisha continue to be cared for by her aunt and uncle while the biological parents complete steps outlined in a case plan which will be developed as the case is being transferred to the Family Intervention service area. Supervised visitation will be honored and supported by the paternal aunt and uncle.

Consultation efforts were as follows:

1. IMH Specialist discussed current behaviors displayed by Teisha when interacting with caregivers, and effects of drug exposure and behaviors to look for.
2. Paternal aunt works third shift and we discussed their daily schedule and caregiving routines. It was noted that Teisha was at times placed in her swing while in front of the television (within the same room where aunt was sleeping) when the aunt needed to rest during the daytime and before the uncle could get home from work. The IMH Specialist recommended caregiving outside of the home during the day when the aunt needs to sleep. Information for Child Care Resources was provided to support the search for a quality setting. The IMH Specialist also spoke about effects of television during a child's early years. Research information regarding the effects of television was provided to the YFS Caseworker.
3. The IMH Specialist also recommended a developmental screening. The YFS Caseworker noted she will make a referral to the local CDSA (Watkins Center). The IMH Specialist also offered to administer a social and emotional screening using the Devereux Early Childhood Assessment. The YFS Caseworker and paternal aunt and uncle agreed.

The case was moved to the Family Intervention service area. The IMH Specialist had an opportunity to meet with the appropriate Family Intervention supervisor and obtained contact information for the assigned YFS FI Caseworker. Upon receipt of the case assignment, the YFS Caseworker met with the aunt and uncle caring for Teisha. The Caseworker contacted the biological parents, as well, and was informed they do not have plans to care for their daughter and agree to leave Teisha in her current care situation. The YFS Caseworker recommended closing the case as the paternal aunt and uncle plan to obtain full custody of Teisha and the biological parents are not active in her life. The IMH Specialist was unable to connect with the YFS Caseworker prior to case closing.

Service Area: Family Intervention

Case Example One:

The IMH Specialist was contacted for consultation regarding a case involving two young boys, ages 3 and 4. This case was received in Family Intervention with a high risk rating on December 31, 2008.

The YFS FI Caseworker requested the IMH Specialist observe both children, Michael (3 years) and Zed (4 years). Currently, both Michael and Zed are in childcare as their biological mother, Mary, works third shift. Zed also attends an early childhood program within Starmount Elementary School. Maternal grandmother, Ann, and her husband, Pete, also help care for Michael and Zed. Ann uses American Sign Language to communicate and notes additional health problems. She is concerned because she also works and states that with everything combined, she is often very tired. The IMH Specialist had an opportunity to observe Michael while spending time in the childcare setting (center-based care). Zed was interviewed and observed during school at Startmount Elementary School.

The IMH Specialist attended a Family-Centered Team Meeting in January 2009 as a case plan was being developed with Mary to address housing instability, domestic violence, parenting and developmental concerns for both of her children. Mary has two previous neglect referrals with DSS. Mary is seeking a first or second shift schedule. During the Family-Centered Team Meeting, the YFS FI Caseworker notes both children have demonstrated an inability to express what is going on in their environment. She has concerns of domestic violence and the possibility that both children have witnessed and been exposed to this. Unstable housing is also a concern as Mary has lived in many places since the children were born – maternal grandmother’s home, friends, hotel, and her car. The Caseworker also notes concerns with both children’s speech and language development. A referral for a domestic violence assessment and parenting education was made to Creative Counseling. The IMH Specialist also requested the opportunity to accompany the Caseworker during a home visit and additional opportunities to observe Michael and Zed. Both the Caseworker and Mary agreed.

Additional consultation efforts were as follows:

1. The IMH Specialist met with Mary during a home visit scheduled by the YFS FI Caseworker. During this home visit, the IMH Specialist had an opportunity to speak with the YFS Caseworker and Mary further about the initial observations and what she saw and heard. Mary discussed her hopes and fears for her children, as well as the challenges to caring for them emotionally. Together we discussed strategies and ways to help address some of these delicate challenges. Mary completed a social and emotional assessment (the Devereux Early Childhood Assessment) tool for both Michael and Zed. Authorization was obtained to request the same assessment be completed by Michael’s primary caregiver at the center and Zed’s teacher.
2. The YFS Caseworker and IMH Specialist had opportunities to consult with the School Psychologist and teacher within Starmount Elementary School. The School Psychologist shared observations and information supporting Zed’s behaviors and efforts within her social skills groups. The teacher shared specific interactions she has had with Zed and discussed his strengths and areas of need. After the third consultation session, both the teacher and School Psychologist extended their pleasure and thankfulness for the steps taken. The School Psychologist noted, “...thank you for coming back...rarely does anyone come

back to let us know the results of an assessment or what is going on.” It was agreed that the IMH Specialist would create resources and activities similar to those shared within Zed’s social skills groups to provide to Mary to support the home environment. The School Psychologist stated she would make sure specific information is extended within his transition materials.

3. During review of the Devereux Early Childhood Assessment results with Mary, it was decided that the YFS Caseworker would support her in finding mental health therapy services directly involving her two sons. The IMH Specialist was asked to support this goal and took steps to consult with the ZFive Mentor to determine which Mentee (therapist) would be the best fit for this family. The IMH Specialist spoke with three of the ZFive Mentees and shared this information with the YFS Caseworker. The YFS Caseworker extended the referral for in-home play therapy services.
4. The IMH Specialist contacted ZFive member, Trish Tanger, the CMS Program Manager for Preschool Programs, to obtain contact information for an educational assessment referral made. Both the YFS Caseworker and Mary indicated struggles with paperwork submission and next steps to move forward on this referral. Contact was made with the appropriate individual supporting intake and Michael was accepted and scheduled for an evaluation.

Service Area: Permanency Planning

Case Example One:

A consultation referral was extended by a YFS Permanency Planning Caseworker for a 15-month-old girl, Lia. The presenting concerns were noted as “aggressive” behaviors and tendencies.

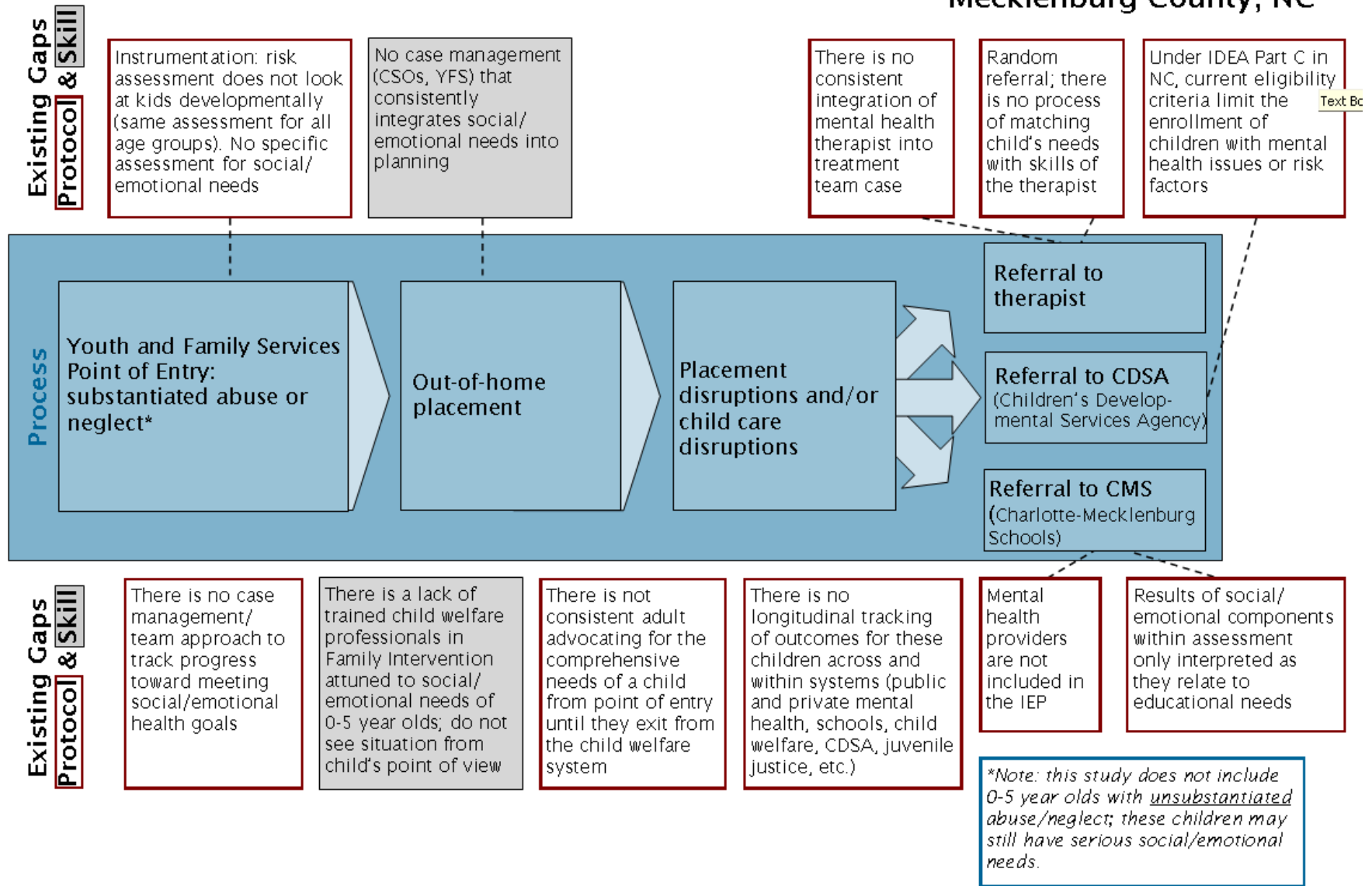
Lia had been placed into foster care approximately 3 weeks prior to the referral. During a home visit, the IMH Specialist observed the fixed gaze Mia had on her foster mother’s, Destiny’s, eyes and she was batting at her face. Destiny asked questions about Mia’s behaviors and stated she was not sure if this was normal behavior and that Mia was just “independent” or if she was trying to be “mean” to her. Destiny stated the “swatting” hurts her. In fact, Destiny had bruises on her arms and some scratch marks on her cheeks and stated these marks were the result of some of Mia’s behaviors.

The initial consultation surrounded discussions on self-preservation and soothing care. The IMH Specialist was able to share ways the foster parents could talk with Mia in simple words and with exaggerated facial cues while demonstrating on a doll that they would not hurt her. Together, discussions surrounding traumatized children and reasons that certain behaviors are sometimes amplified took place. Also discussed were the foster parents’ possible barriers to notice and interpret her cues and emotions. Following, the IMH Specialist supported the YFS Caseworker in navigating an infant mental health referral. Emphasized was the need to improve her attachments and her resultant sense of

safety. The YFS Caseworker had previous experience with an infant mental health therapist and made the decision to contact this individual for support. The IMH Specialist had an opportunity to consult with both the referred therapist and YFS Caseworker when considering the case and “goodness of fit.”

APPENDIX B

What Happens When a Child Is Removed from the Home in Mecklenburg County, NC



APPENDIX C

Elements within System Building Theory of Change (modified from Walker et al, 2008)

Clarity and Ownership

Recognition of Need: A consensus of recognition of the ineffectiveness or “brokenness” of current system and consequences thereof on child outcomes.

Shared Vision: An overall vision with attendant details for what an ideal service delivery system would operate. Go beyond the “United Agenda for Children” and hammer out the logistics.

Leadership: Multiple levels (local, state, federal) of coordinated leadership needed; a “champion” to rally leaders.

Actions and Infrastructure

Capacity and competence: Accountability and oversight, professional credentialing, expertise, and thoroughly communicated feedback loops must be up and running for service delivery improvement.

One step at a time: Actions can be taken on discrete elements as windows of opportunities are opened and can be leveraged to increase momentum of overall system improvement. Strategic interventions must be closely measured to assure efficacy before expansion (e.g., a “pilot phase”) and to engender credibility.

Political Will

Public awareness and support: Needed to sustain expansion.

Political mobilization/advocacy: Maintaining relationships coalesced around the issues.

Alignment and readiness: Having a well-stocked supply of compelling and readily delivered solutions based on the above points facilitate the system building across multiple institutions, organizations, and government entities.

APPENDIX D

AMH DATA

From 2008 data retrieved from the DHHS website, it appears that those served tend to be between the ages of 24- 54, white (60%), single (60%), and experiencing problems with substance abuse or major depression (about 2/3). In Mecklenburg County, 38,559 people were served.

INTERVIEWS CONDUCTED

CMS: Barb Pellin (Assistant Superintendent for Pre-K – 12 Support Service); Julie Babb (Director for Pre-K Programs); Trish Tanger (Exceptional Children Preschool Program Specialist); Carolyn Gaither (Director of Prevention and Intervention Services)

AMH: Grayce Crockett (Director)

CDSA: John Ellis (Director); Lisa Cloninger (Administrative Supervisor)

Thompson Child and Family Focus: Danyelle Bergeron-Rumfelt (Vice President of Early Childhood Services)

Infant Mental Health Therapists: Laverne Fesperman, LCSW; Libby Rains, LCSW

Mecklenburg County Youth and Family Services: Richard Buchanan (Senior Social Services Manager)

Bibliography

Administration for Children and Families, Office of Planning, Research and Evaluation. (2004). Children ages 3 to 5 in the child welfare system. NSCAW Research Brief No. 5. Washington, DC: Author.

McCrae, J. & Barth, R.D. (2008). Using cumulative risk to screen for mental health problems in child welfare. *Research on Social Work Practice*, 18(2), 144-159.

De Bellis, M., & Thomas, L. (2003). Biologic findings of post-traumatic stress disorder and child maltreatment. *Current Psychiatry Reports*, 5, 108-117.

Dube, S. R., Anda, R. F., Felitti, V. J., Chapman, D., Williamson, D. F., & Giles, W. H. (2001). Childhood abuse, household dysfunction and the risk of attempted suicide throughout the life span: Findings from the Adverse Childhood Experiences Study. *Journal of the American Medical Association*, 286, 3089-3096.

Dubowitz, H., Papas, M. A., Black, M. M., & Starr, R. H., Jr. (2002). Child neglect: Outcomes in high-risk urban preschoolers. *Pediatrics*, 109, 1100-1107.

Duncan, D.F., Kum, H.C., Flair, K.A., Stewart, C.J., and Weigensberg, E.C. (2009). NC Child Welfare Program. Retrieved [March 3, 2009], from University of North Carolina at Chapel Hill Jordan Institute for Families website. URL: <http://ssw.unc.edu/cw/>

English, D. J. & the LONGSCAN Investigators (1997). Modified Maltreatment Classification System (MMCS). For more information visit the LONGSCAN website at <http://www.iprc.unc.edu/longscan/>

English, D. J., Widom, C. S., & Brandford, C. (2004). Another look at the effects of child abuse. *National Institute of Justice Journal*, 251, 23-24.

Everson, M.D., Smith, J.B., Hussey, J.M., English, D., Litrownik, A.L., Dubowitz, H., Thompson, R., Knight, E.D., Runyan, D.K. (2008). Concordance between adolescent reports of childhood abuse and child protective service determinations in an at-risk sample of young adolescents. *Child Maltreatment*, 13(1), 14-26.

Flaherty, E. G., Thompson, R., Litrownik, A.L., Theodore, A., English, D.J., Black, M.M., Wike, T., Whipper, L., Runyan, D.K., Dubowitz, H. (2006). Effect of early childhood adversity on health. *Archives of Pediatrics and Adolescent Medicine*, 160, 1232-1238.

Fraser, M. W., & Terzian, M. A. (2005). Risk and resilience in child development: principles and strategies of practice. In G. P. Mallon & P. M. Hess (Eds.), *Child welfare for the 21st century: A handbook of practices, policies, and programs* (pp. 55-71). New York, NY: Columbia University Press.

Johnson, R., Rew, L., & Sternglanz, R. W. (2006). The relationship between childhood sexual abuse and sexual health practices of homeless adolescents. *Adolescence*, 41(162), 221-234.

Kelley, B. T., Thornberry, T. P., & Smith, C. A. (1997). In the wake of childhood maltreatment. Washington, DC: National Institute of Justice. Retrieved April 27, 2006, from www.ncjrs.gov/pdffiles1/165257.pdf (PDF - 221 KB)

LeBuffe, P.A. & Naglieri, J.A. (1999). *The Devereux Early Childhood Assessment*. Lewisville, NC: Kaplan Press Publishing.

National Institute of Neurological Disorders and Stroke. (2007). Shaken baby syndrome. Retrieved March 24, 2009, from www.ninds.nih.gov/disorders/shakenbaby/shakenbaby.htm

North Carolina Department of Health and Human Services: <http://www.ncdhhs.gov/mhddsas/statspublications/reports/statisticalreports/report-admissions08.pdf>

Pecora, P. J., Kessler, R.C., O'Brien, K., White, C.R., Williams, J., Hiripi, E., English, D., White, J., and Herrick, M.A. (2006). Educational and employment outcomes of adults formerly placed in foster care: Results from the Northwest foster care alumni study. *Children and Youth Services Review*, 28(12), 1459–1481.

Prevent Child Abuse America. (2001). *Total estimated cost of child abuse and neglect in the United States*. Retrieved April 2, 2009, from http://member.preventchildabuse.org/site/DocServer/cost_analysis.pdf?docID=144 (PDF - 44 KB) - NOTE: must register to view document

Prevent Child Abuse New York. (2003). *The costs of child abuse and the urgent need for prevention*. Retrieved April 2, 2009, from <http://pca-ny.org/pdf/cancost.pdf> (PDF - 146 KB)

Rosenberg, S. A., Smith, E.G., and Levinson, A. (2007). Identifying young maltreated children with developmental delays. In Ron Haskins, Fred Wulczyn, and Mary Bruce Webb (eds.), *Child Protection: Using Research to Improve Policy and Practice*, Washington, D.C.: Brookings Institution Press, pp. 34–43.

Schore, A. N. (2003). Early relational trauma, disorganized attachment, and the development of a predisposition to violence. In M. F. Solomon & D. J. Siegel (Eds.), *Healing trauma: Attachment, mind, body, and brain*. New York, NY: Norton.

Silverman, A. B., Reinherz, H. Z., & Giaconia, R. M. (1996). The long-term sequelae of child and adolescent abuse: A longitudinal community study. *Child Abuse and Neglect*, 20(8), 709-723.

Springer, K. W., Sheridan, J., Kuo, D., & Carnes, M. (2007). Long-term physical and mental health consequences of childhood physical abuse: Results from a large population-based sample of men and women. *Child Abuse & Neglect*, 31, 517-530.

Swan, N. (1998). Exploring the role of child abuse on later drug abuse: Researchers face broad gaps in information. *NIDA Notes*, 13(2). Retrieved April 7, 2009, from the National Institute on Drug Abuse website: www.nida.nih.gov/NIDA_Notes/NNVol13N2/exploring.html

Teicher, M. D. (2000). Wounds that time won't heal: The neurobiology of child abuse. *Cerebrum: The Dana Forum on brain science*, 2(4), 50-67.

U.S. Department of Health and Human Services. (2003). National Survey of Child and Adolescent Well-Being: One year in foster care wave 1 data analysis report. Retrieved April 27, 2009, from www.acf.hhs.gov/programs/opre/abuse_neglect/nscaw/reports/nscaw_oyfc/oyfc_title.htm

U.S. Department of Health and Human Services. (2008). Child maltreatment 2006. Washington, DC: Government Printing Office. Retrieved April 1, 2009, from www.acf.hhs.gov/programs/cb/pubs/cm06/index.htm

Watts-English, T., Fortson, B. L., Gibler, N., Hooper, S. R., & De Bellis, M. (2006). The psychobiology of maltreatment in childhood. *Journal of Social Sciences* 62(4) 717-736.

Widom, C.S., DuMont, K. & Czaja, S.J.(2007). A prospective investigation of major depressive disorder and comorbidity in abused and neglected children grown up. *Archives of General Psychiatry*. 64(1):49-56. Retrieved February 28, 2009, from <http://www.sciencedaily.com/releases/2007/01/070102092229.htm>

Zolotor, A., Kotch, J., Dufort, V., Winsor, J., Catellier, D., & Bou-Saada I. (1999). School performance in a longitudinal cohort of children at risk of maltreatment. *Maternal and Child Health*, 3(1), 19-27.