Mental Health Advocacy:
How to Work with Mental Health Professionals

PURPOSE: *To begin a conversation about advocating for our youth's mental health needs*

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Objectives

By the end of this chapter, I will be able to…

- ✓ Understand the role as a CASA volunteer in accessing mental health services for youth.
- ✓ Identify the main types of therapy available.
- ✓ Understand the boundaries of a CASA volunteer's access to confidential mental health information.
- ✓ Know the difference between confidentiality and privilege.
- ✓ Begin to understand basic questions surrounding psychotropic medications.

Mental health disorders are more common than people think. According to the U.S. Department of Health and Human Services, studies show that at least one in five children and adolescents have a mental health disorder. At least one in 10, or about 6 million people, have a serious emotional disturbance; [1] and for foster children, the rates are higher. Studies show that somewhere between 50 – 80% of foster children have moderate to severe mental disorders.[2]

This, of course, is not at all surprising, given the fact that children in foster care have suffered some form of serious abuse or neglect. However, this does not mean that foster children are wholesale disturbed – it merely means that the children have some issues that could benefit from the help of a qualified professional.

A. The Advocate's Role

As an advocate you will be in the position to ensure that your CASA child has timely access to appropriate mental health services. You should ask:

1) Are mental health services needed, would my CASA child benefit from provision of mental health services?

2) What should these services look like?

3) Are the services provided appropriate? Are they helping? Should something else be done?

4) Are there unacceptable delays in providing services, and if so, how do I go about ensuring that my CASA child gets the needed help in a timely way?

5) What resources are available if my child is having a mental health crisis?

B. Services

The services that the Social Services Agency can offer a child are limited. Far too often there are not enough resources to provide a family with housing, enough clothes, or even transportation. However, one of the services that can be offered is access to quality mental health services.

These services can take many different forms. There can different types of therapy, medication, special living arrangements – including therapeutic foster care, and residential treatment.

1. Therapy

Therapy can be play therapy, individual therapy, group therapy, family therapy or some other form of therapy. It may prove valuable to discuss the type of therapy that the child is receiving with the social worker and the therapist to ensure that you understand the process and can respond to any questions the child might have and report to the court as appropriate.

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[1] U.S. Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services.

[2] Neal Halfon, Alex Zepeda, Moira Inkelas, *Mental Health Services for Children in Foster Care*, UCLA Center for Healthier Children, Families and Communities (Sept. 2002).

Remember also, that it is your role to bring common sense to evaluating the situation. If a child has been sexually abused, it is not acceptable that the child wait for five months before therapy begins. Likewise, if a 4 year-old child is in talk therapy rather than play therapy, it is completely reasonable to ask if this is the best form of therapy for the child.

a. Types of Therapy.

There are many different types of therapy. Some are more geared toward children like play therapy. For older youth group therapy with peers or individual talk therapy with a professional can prove helpful. When reunification is an option, family therapy can prove beneficial.

Common types of psychotherapy include:

- **Art therapy,** also called creative art therapy, uses the creative process to help express thoughts and feelings and may include music, dance and movement, drama, drawing, painting, and poetry.
- **Behavior therapy** focuses on changing unwanted or unhealthy behaviors, typically using a system of rewards, reinforcements of positive behavior and desensitization.
- **Cognitive therapy** is designed to help you identify and change distorted thought (cognitive) patterns that can lead to feelings and behaviors that are troublesome, self-defeating or self-destructive.
- **Cognitive behavioral therapy** combines features of both cognitive and behavior therapies to help you identify unhealthy, negative beliefs and behaviors and replace them with healthy, positive ones.
- **Dialectical behavior therapy** is a type of cognitive behavioral therapy whose primary objective is to teach behavioral skills to help you tolerate stress, regulate your emotions and improve your relationships with others.
- **Family therapy** helps families or individuals within a family understand and improve the way family members interact with each other and resolve conflicts. Family therapy will most always be used to help the child and the family resolve issues and make reunification easier for everyone.
- **Group therapy** brings together a small group of people facing a similar illness or situation for discussion facilitated by a qualified leader or mental health provider. Often youth in group homes will have group therapy sessions with others in the home.
- **Play therapy,** geared mainly for young children at specific developmental levels, uses a variety of play techniques to encourage children to more easily express emotions and feelings if they're unable to do so with words.
- **Psychoanalysis** is an in-depth, Freudian-based therapy that guides you to examine memories, events and feelings from the past to understand current feelings and behavior.

- **Psychodynamic psychotherapy,** based on the theories of psychoanalysis, focuses on increasing your awareness of unconscious thoughts and behaviors, developing new insights into your motivations, and resolving conflicts to live a happier life.

b. Types of Mental Health Professionals

As with everything, there are various types of mental health professionals as well. When your child is assigned to a particular mental health professional, it is best to investigate and ensure that this match is appropriate. The Court can make specific orders for certain services if necessary – this could include a certain type of professional.

One frequent problem is that there is a lack of qualified mental health providers who work with children and accept the Medi-Cal form of payment. This can result in a process where the social worker will refer the child to a professional or organization and then the child will be placed on a wait list.

Also, a child could be seen by an intern, rather than a permanent staff member. Interns can provide quality services, however, their tenure is often limited and they can leave to return to school or another assignment. Therefore, if your child's condition would benefit from a therapist that can keep the child client long-term, then you should seek to ensure that the child receives a permanent therapist.

Lastly, it is important to note that children and youth are people too. It can take some effort and time to find a therapist that they trust and that works for them. Also, it is not unusual for children to show reluctance to going to therapy – or even show adamant refusal. As a CASA, you are in the unique position of being a caring adult who is not paid for your advice. As such, you can help guide the youth through the process of engaging therapy for their long-term benefit. For example, if a child refuses one form of therapy, perhaps they would consider talking with a pastor or other culturally appropriate faith counselor.

Types of mental health professionals include:

- **Psychiatrist** - MD - medical doctor with special training in the diagnosis and treatment of mental and emotional illnesses. Like other doctors, psychiatrists are qualified to prescribe medication.

- **Child/Adolescent Psychiatrist** - MD - medical doctor with special training in the diagnosis and treatment of emotional and behavioral problems in children. Child/Adolescent psychiatrists are qualified to prescribe medication.

- **Psychologist** - PhD - Counselor with an advanced degree from an accredited graduate program in psychology, and 2 or more years of supervised work experience. Trained to make diagnoses and provide individual and group therapy.

- **Clinical Social Worker** - LCSW - Counselor with a masters degree in social work from an accredited graduate program. Trained to make diagnoses and provide individual and group counseling.

- **Licensed Professional Counselor** - LPC - Counselor with a masters degree in psychology, counseling or a related field. Trained to diagnose and provide individual and group counseling.

- **Mental Health Counselor** - CMHC - Counselor with a masters degree and several years of supervised clinical work experience. Trained to diagnose and provide individual and group counseling.

- **Certified Alcohol and Drug Abuse Counselor** - Counselor with specific clinical training in alcohol and drug abuse. Trained to diagnose and provide individual and group counseling.

- **Nurse Psychotherapist** - A registered nurse who is trained in the practice of psychiatric and mental health nursing. Trained to diagnose and provide individual and group counseling.

- **Marital and Family Therapist -** A counselor with a masters degree, with special education and training in marital and family therapy. Trained to diagnose and provide individual and group counseling.

- **Pastoral Counselor** - Clergy with training in clinical pastoral education Trained to diagnose and provide individual and group counseling.

- **Intern** – A professional in training, usually accumulating hours for their licensure. Interns are supervised by licensed mental health professionals

2. Psychotropic Medications

Prescribing psychotropic medications for children is still very controversial. Similarly, prescribing for foster children should be just as scrutinized as with any other child. Often, however, children in foster care may not have the consistent caring adult required – that is where you come in. As a CASA volunteer, you are in a position to make a difference.

You can investigate the situation; question all recommendations to make sure that you are in agreement. You can also recommend and help arrange other service that could make medication unnecessary. For example, if a child is diagnosed with ADHD – Attention Deficit Hyperactivity Disorder – you can explore whether karate is an option. Has the school held an SST (Student Success Team) or IEP (Individual Education Plan) meeting to help the child in the classroom? Studies have shown that sorting objects, being allowed to walk around the class, or even chewing gum can affect some ADHD behaviors. Have options other than medication been investigated?

Basically, your mission, "should you choose to accept it," is to do what any caring adult would do – ensure that the child does not fall through the cracks.

a. Who Approves the Meds?

When a child is living with their parent or guardian, it is up to the caregiver to decide what psychotropic medications the child takes (subject to the oversight of the Court). However, when the child is in foster care (in out of home placement), the Court must approve any and all psychotropic medications. In order for the Court's approval to happen, the prescribing psychiatrist must fill out and submit a form to the court (the JV-220).

CASAs do not necessarily get served a copy of the JV-220. Instead, all that the physician must send to the CASA is notice that they are 1) seeking to treat the child with new or continuing medication and 2) the type of medication he or she is seeking to prescribe, and 3) that the JV-220 is pending before the court. CRC 5.640(c)(7)(B)

This does not mean that you as a CASA cannot see the JV-220 – in fact, your specific court order may allow it. However, the physician does not need to serve you with a copy (unless of course the child is not represented by an attorney and you have been appointed the CAPTA GAL)

b. What about Antidepressants?

One should take great care when a child is prescribed any antidepressant, especially any type of Selective Serotonin Reuptake Inhibitors (SSRIs) like Prozac, Zoloft, Paxil, etc.

SSRIs – Selective Serotonin Reuptake Inhibitors

SSRIs have received a lot of attention in the news lately. It seems that SSRIs can increase the rate of suicidal thoughts (and thus suicide) in children and young adults.

Therefore, it is essential that if your child is prescribed these drugs that there is:

1) A plan to monitor the child by someone with the skills to assess lethality and make an appropriate intervention.
2) A mental health professional involved who has made a contract with the young person regarding suicide?
3) A plan if you are worried about a crisis? Do you know what resources are available to you should you be concerned that your youth is suicidal?
4) Consistent follow up by a mental health professional. The foster parents, you, everyone should be watching closely (especially in the first few months) to ensure that the child is safe.

These antidepressant SSRIs include:

- **citalopram** (Celexa, Cipramil, Dalsan, Recital, Emocal, Sepram, Seropram, Citox)
- **dapoxetine** (no trade name yet; not yet approved by the FDA)
- **escitalopram** (Lexapro, Cipralex, Esertia)
- **fluoxetine** (Prozac, Fontex, Seromex, Seronil, Sarafem, Fluctin (EUR), Fluox (NZ), Depress (UZB), Lovan (AUS))

- **fluvoxamine** (Luvox, Fevarin, Faverin, Dumyrox, Favoxil, Movox)
- **paroxetine** (Paxil, Seroxat, Sereupin, Aropax, Deroxat, Rexetin, Xetanor, Paroxat)
- **sertraline** (Zoloft, Lustral, Serlain)
- **zimelidine** (Zelmid, Normud)

c. Starting and Stopping Medication

Foster youth are at great risk for inconsistent and inappropriate dosing of medication. It is a simple fact that if there is no consistent, caring adult in the child's life, that mistakes can happen. A child can be moved from one home to another, social workers can be transferred off of a case, and a file is no substitute for someone paying close attention.

As a CASA you are in a position to ensure that the child is receiving the proper dose, in a consistent manner. When children move from home to home, it is quite possible that their medication history can be lost in the shuffle. As such medications do not get given properly, prescriptions go unfilled, and side effects can result.

d. What Do Foster Youth Say About Mental Health Treatment

Often when foster youth express their feelings about psychotropic medication and the delivery of mental health services, they are outraged. Once foster youth grow up and look back on their experiences with mental health services, many report that they feel that they were over medicated and received inappropriate mental health services.

In 2006, foster youth testified before the Select Committee on Foster Care. There, youth reported being put on medications when they were as young as age 4 or 5; experiencing serious side effects and receiving little or no monitoring of the effectiveness of their medications, nor were efforts made to mitigate side effects. Other youth indicated that they were not provided with effective therapy that could have reduced or eliminated the need for medication. Furthermore, youth noted they were not given information about the purpose or potential side effects of their medications, and had no opportunity to participate in decisions regarding their medication and other mental health treatment.

As a CASA volunteer, you can make a difference in the way youth are treated.

3. Psychological Testing

There are several types of testing that a child can receive. The school can do an Educational Psychological Evaluation that is aimed at determining if there are any mental health issues that are interfering with the child's learning. A psychologist can do an assessment or evaluation that will contain some combination of tests aimed at diagnosing a particular mental health issue.

Children in foster care may be experiencing a completely understandable amount of grief and anger about their situation. However, if a child seems to have more serious mental health issues than is explainable, or is more than simple acting out, a psychological evaluation may be necessary to diagnose and recommend treatment.

4. Placements

If the child has severe needs and there is testing and professional opinions to back it up, a child may need a more restricting level of care. Remember, that it is the child's right to be placed in the "least restrictive" placement. However residential treatment – care at a high level group home with extensive services may be necessary. (Usually these youth require IEPs that recommend a non-public school setting as well, so that they can attend the on-site nonpublic school.) When thinking about which placement seems most appropriate – including school placement – remember that the child should be allowed to have as normal a life as possible. Residential treatment and nonpublic schools should not be accepted without serious informed deliberations that come to the conclusion that it is best option for the child.

Another option, and in many ways preferred, is a special type of foster home called an ITFC home – Intensive Therapeutic Foster Care. This is a foster home where the foster parents have undergone specialized training and are up to the challenge of a child with special needs. If you find that mental health issues are causing your child move from foster home to foster home, this is definitely something to look into.

C. Confidentiality of Mental Health Information

Mental health records are confidential. As such, the mental health professional must guard them accordingly. You, too, should be guarding the confidentiality of your CASA child's information.

A CASA volunteer does not violate a child's rights – even if it seems like it is what is best for the child. This is what sets us apart from those the child has learned to mistrust.

This area of law is often misunderstood and argued about. So don't be surprised if you encounter resistance when trying to talk to a mental health professional or get access to mental health information – professionals are only doing what they think is right. The mental health professional may not realize that they need to share information with you. Likewise, some professionals (including attorneys) erroneously think that this information is privileged, or they feel that it should be. Regardless, the following is the current state of the law (and has been for almost a decade). All things being the same, the general rule is this:

If you have a court order authorizing access to mental health records a CASA can receive information from the mental health professional that discloses 1) ***the child's participation and progress in therapy***, and 2) ***if there are any further orders or services that might be necessary for the child.***[3] Note, however, that the therapist/professional must not tell the confidential details of the therapy.

Here are some things to think about:

1. Do you need the information?

Before you seek any mental health records ask yourself, "Do I need this information? Or am I just being curious?" If you need the information, then you must be careful how you access it – and you should only access the information that is absolutely necessary to do your duty.

[3] The case authority is *In re Kristine W.* (2001) 94 Cal.App.4th 521, and *In re Pedro M.* (2000) 81 Cal.App.4th 550.

A perfect example is the actual written psychological evaluation (psych-eval). A "psych-eval" is going to be filled with personal information, and describe the tests administered, etc. Do you really need to read the actual psych-eval when what you really want to know is – *what services could the child benefit from*?

You probably do not need to see the entire psych-eval to make that assessment – and others would not have to either.

2. Forget the Diagnosis

Caution should be used when associating a child and a diagnosis. It is too easy and too damaging to use labels as a crutch for what a child is going through. As many child psychiatrists will tell you, diagnoses can be misleading to nonprofessionals.

Diagnoses are an attempt to take an individual's symptoms and categorize them according to the "Diagnostic and Statistical Manual of Mental Disorders – also known as the DSM-IV. The DSM-IV is a manual that is published by the American Psychiatric Association and is a tool that has its limitations.

Why should we forget the diagnosis?

First, mental health care is an imprecise practice. That deserves repeating: MENTAL HEALTH CARE IS IMPRECISE. This means that different mental health care providers can (and will) give different diagnoses to the same child – using the same information. Also, individuals change, grow, and experience life – and thus the diagnoses change.

Second, a "diagnosis" is required for Medi-Cal mental health providers to get paid for their services. So, (while not always the case) a diagnosis might not really apply to the child – or may not apply the way one might assume. The diagnosis could be used merely as a placeholder, or be merely a working diagnosis.

Third, the child's diagnosis is privileged information, and unless the child authorized the release of that information, the child's rights are most likely being violated.

And lastly, CASA volunteers can play an important role in ensuring that our youth are not labeled, not pigeon-holed into something that limits their potential. Address the symptoms of the child's experience, and try to avoid the easy-to-do labeling that can unfairly prejudice the child.

3. Delegation of Court Authority and Evidentiary Privilege

As a CASA, you probably have a specific court order allowing access to confidential records, and section 107 of the Welf. & Inst. Code allows the judge to grant you that access.

However, since you are an *officer of the court*, your ability to access these records should be seen as a *delegation of the court's authority*. We must be mindful that there are rules that limit what evidence the court can have. When the court does not have the authority to see certain records,

then the court cannot make an order allowing you (the court-appointed CASA) to see the records either. Simply put, if the judge can't see it, then neither can the CASA.

Let's look at how the law breaks down:

Section 107 of the Welf. & Inst. Code states:

> Upon presentation of the order of his or her appointment by the CASA, and upon specific court order and consistent with the rules of evidence, any agency, hospital, school, organization, division or department of the state, physician and surgeon, nurse, other health care provider, psychologist, psychiatrist, police department, or mental health clinic shall permit the CASA to inspect and copy any records relating to the child involved in the case of appointment without the consent of the child or parents. *(emphasis added)*

a. "…and upon specific court order"

As a CASA, you are usually given broad access to confidential records – but it is the ***"order"*** that triggers this access. Make sure your order allows you to have the information you are requesting.

While the general practice in every county is to have the court give CASAs access to the full body of records, the judge can give you as much or as little as he or she wishes (within the bounds of the law). You serve at the judge's discretion, and he or she decides what duties you are to perform.

This usually means that in court, the judge will protect the CASA's ability to fulfill their role – as an independent investigation requires access to all confidential information. The practice in California is to have a pre-written order of appointment that states that you as the CASA can access records as described in section 107 of the Welfare and Institutions Code.

b. "…consistent with the rules of evidence"

The term "consistent with the rules of evidence" refers to the rules that limit the court's ability to see certain mental health information – we are referring specifically to the ***psychotherapists-patient privilege***.[4]

What is a "privilege"?

Confidentiality and privilege are not the same thing. Think of privilege as a deadbolt lock on the front door of your house – it is an additional layer of protection aside from the fact that the door is shut and has a lock built into the knob.

For our purposes, you should know that the court has access to a great deal of *confidential* information – but can be stopped from accessing *privileged* information. In this context, a "privilege" or "evidentiary privilege" is the right to stop certain confidential information from coming into evidence – meaning that the judge cannot see or consider the information when

[4] The psychotherapist-patient privilege is found in California Evidence Code §§ 1010 – 1027.

making his or her decision. "Privilege" also works to stop others from communicating that confidential information.

Think of some privileges you might have heard of before, like attorney-client privilege, clergyman-penitent privilege, and the physician-patient privilege, and the psychotherapist-patient privilege. A child in dependency court has the right to assert all of these privileges.

The purpose of the psychotherapist-patient privilege is to protect the privacy of a patient's confidential communications to his or her psychotherapist.

Who Can Claim the Psychotherapist-Patient Privilege?

Child and/or the Child's Attorney

In a dependency case, who can claim privilege depends on the age and maturity of the child. The court must make a finding that the child is or is not of sufficient age and maturity to claim a privilege.

While the court always needs to make a finding, it will be presumed by the court (subject to rebuttal) that a child has sufficient age and maturity to claim a privilege if he or she is over 12 years old. If the child is 12 years old or younger, or not mature enough, the court will make a finding that the child cannot exercise the privilege – and then the minor's attorney will hold the privilege.

The Mental Health Provider

A mental health professional must always "claim" privilege and not give out information unless there is a waiver from the child (or the one who holds the child's privilege).

Who Can Waive the Psychotherapist-Patient Privilege?

A privilege can be waived – both on purpose and by accident. For our purposes, it is important to note that if the child is of sufficient age and maturity, the child can waive privilege even if their attorney has claimed privilege. Therefore, if you feel it is essential to get access to privileged information, talk to the child, and have them talk to their attorney – basically you can ask the child for his or her permission. If they want you to see the records, they can sign a waiver.

What, if anything falls outside of the Psychotherapist-Patient Privilege?

Privilege only applies to certain information that is told in confidence. Therefore, there can be a debate about what is, or isn't, privileged information.

Relevant to child welfare, no privilege exists when:

1. The therapist has reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous to himself or to the person or property of another and that disclosure of the communication is necessary to prevent the threatened danger.

2. The patient is a child under the age of 16 AND the therapist has reasonable cause to believe that the patient has been the victim of a crime and that disclosure of the communication is in the best interest of the child.

3. The psych-eval is conducted under a direct order of a court per section 730 of the Evidence Code. (That's correct; privilege does not apply if the court makes an order for a psych-eval and wants to know the information. Note: This is not the same thing as having a psych-eval be part of the court-approved case plan – if it is just part of the case plan, then privilege still applies. To get around privilege, the court must make a specific order for appointment of a therapist or evaluation under section 1017 of the Evidence Code.)

4. ***The child's participation and progress in therapy*** and ***if there are any further orders or services that might be necessary for the child.***[5] (Note, however, that the therapist/professional must not tell the confidential details of the therapy, including any diagnosis)

Who Can Have Access to Privileged Information?

Social Worker (or *Probation Officer*, or *any other person who is legally authorized to have custody or care of the child*)[6]

Again, if (and only if) the provider of mental health care determines that the disclosure is reasonably necessary for the purpose of assisting in coordinating the treatment and care of the minor, that provider may disclose that <u>limited bit</u> of information.

However, the social worker (or other person) must not further disclose the information unless the disclosure is for the purpose of coordinating mental health services and treatment of the minor and the disclosure is authorized by law. *This means that the information should not find its way into the court report (or be communicated to the CASA or anyone else) unless it is absolutely necessary to provide the identified services to the child.*[7]

Minor's Attorney

The minor's attorney is given access to virtually any piece of information concerning the child's case. This includes mental health records Welfare and Institution's code §317(f) states that the attorney for the child shall have access to all of the child's records kept by any physician and surgeon, psychiatrist, psychologist (and registered assistant), family and child counselor (and trainee and unlicensed intern), clinical social worker, etc.[8]

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[5] The case authority is *In re Kristine W.* (2001) 94 Cal.App.4th 521, and *In re Pedro M.* (2000) 81 Cal.App.4th 550.
[6] See Cal. Civ. Code 56.103, 56.104.
[7] The interplay between the laws that require a social worker to report relevant information to the court and the inclusion of otherwise privileged information in court report is unclear. However, California CASA believes that CASAs should always err on the side of protecting the rights of the child. If a question ever arises, it is best to present the information to the court "under seal" (meaning in a sealed envelope), inform the court as to the nature of the information, and whether its disclosure is absolutely necessary of not, and let the judge make the decision as to whether the information is privileged or not.
[8] See Welf. & Inst. Code § 317(f) that references Penal Code 1545, and the 2000 version of Penal Code §§ 11165.7 and 11165.8; Bus. & Prof. Code § 6146 and § 500 et. seq.

4. Are the Child's Rights Being Protected?

If there has not been a valid waiver of privilege, and the social worker or other person is passing around the child's psych-eval, then this may be a violation of the child's rights. Be aware when this happens and talk to the child's attorney.

D. Working Well with the Mental Health Professional

As a CASA volunteer, you will be called upon to investigate every aspect of the child's life – provision of mental health services is certainly no exception. Therefore, you will need to call and discuss the case with the social worker, attorney, Doctors, and even the therapist and/or psychiatrist.

Working with mental health professionals can be among the most challenging relationships. This is because the law concerning confidentiality and privilege is so confusing and it is often misunderstood and misapplied.

Many mental health professionals might assume that the social worker is the one who can give the ok to release information – which is simply not true. Others will not release information without a subpoena or other high level court action – also unfortunate. Others still, will tell you anything and everything you want to know – which might intrude upon the privacy rights of the child.

Therefore, you must approach a mental health professional with a few thoughts in mind:

1) If they resist releasing records, it is not personal. They are just trying to safeguard their client's privacy – and that's a good thing;
2) They are professionals, and as such are used to doing their job with a great degree of skill and care. Your questioning their decisions is not going to sit well all the time;
3) "What do I know, I'm only a doctor." Many professionals feel slighted that their judgment is being questioned. Explain with kind insistence that you are an appointed by the court, and that it is your role to do an independent investigation – and this means that you must ask the questions again – just to make sure that everything is in order. At the same time, you can reinforce your appreciation for their taking the time to work with this child you care about;
4) Explain to them your role and purpose, and that you have been appointed by the court to investigate the child's situation and provide your own recommendations – and you need their input to formulate them. While some may have worked with CASAs before, it is possible that you are their first opportunity to work with a CASA. You cannot assume that they know your role in the system;
5) Often it is helpful to become their partners. For example, if you feel that therapy is valuable, but the child is resistant, let the therapist know that you are working with the child to encourage participation;

6) Honestly ask yourself what you truly need to know – reading the actual psych eval does not really give any further insight into the child's needs. Often, the recommendations are all that are needed;

7) If problems arise, do not escalate the situation – call for reinforcements, like your program supervisor;

8) If all else fails, take a step back, and try to get the information from the social worker;

9) Ask the child for permission to see the information – and if they say yes, get a waiver. As long as you don't try to pressure or trick them, this can be a very useful approach. You are always encouraged to make sure that the child talks about it with their attorney first – that way you know that they can make an informed decision and it won't make the attorney feel blindsided.

10) Ask the judge. If the judge says that he or she does not want you to have the information, then be fine with it. The judge has the last word.

ACTIVITY A

Juana is a 15 year old girl who has been living in a group home in town for the past month. Prior to that she was living in a different group home about 20 miles away. She had gotten into an altercation with one of the staff members and hurt her back – as a result, the group home asked her to leave. Prior to living in that group home Juana was living with her "Tia Wilma." You have discerned that Wilma is not really an Aunt, but is a second cousin who is somewhat estranged from the family. Now Juana is in a new school, and is not happy.

Juana has been prescribed fluoxetine (aka Prozac). When she takes them there is a marked improvement in her behavior – she can sit through class, is not aggressive, and can be quite charming. However, when she is off of her medication, Juana can become very angry, aggressive, and can seem scary. Juana has not been on the Prozac for about six months, and no one is certain how long she took the medication before.

Juana wants more than anything to move back with her Tia Wilma. She has asked you to ask the judge when she can move back.

5. Assume that Juana has just enrolled in the new school. What questions should you be asking about the educational situation?
6. You know that Juana just had a medication evaluation and the psychiatrist prescribed 80 mg of Prozac per day. What, if anything should you do?
7. You talk with Tia Wilma and she says that as long as Juana takes her medication she can come back to live with her. What are your next steps?
8. Assume that you're reading the IEP from the last school Juana attended. It is 1.5 years old and does not mention her medication. What should you do?
9. You call the therapist and discuss Juana's situation. The therapist says that she did not know Juana wanted to live with Wilma, in fact, she thought that Juana wanted to live with Uncle Joe. What should you do?
10. Wilma confides in you that caring for Juana can be rough – and they've had their arguments. She loves her, insists that she takes her meds, but is also worried and says, "Well, we'll see." What types of therapy should be considered for Juana and Wilma?

RESOURCE MATERIALS

1. Article, Rick Nauert, Ph.D. *Senior News Editor*, Reviewed by John M. Grohol, Psy.D. (August 4, 2008) *Psychotropic Medications Overused Among Foster Children*, University of Maryland.
   Found on 2/1/2009 at: http://psychcentral.com/news/2008/08/04/psychotropic-medications-overused-among-foster-children/2688.html
2. Usual Doses of Psychotropic Medications
3. Neal Halfon, Alex Zepeda, Moira Inkelas, *Mental Health Services for Children in Foster Care*, UCLA Center for Healthier Children, Families and Communities (Sept. 2002).