4-1-2008

Keeping Families Together? Exploring placement of children with severe emotional disturbances in the child welfare and juvenile justice systems

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Abstract

Introduction

Mona, a parent of five children all diagnosed with several emotional disturbances (SED), describes the moment she made the decision to place her daughter (age 16) into the juvenile justice system:

> **"…**her behaviors were so bad she was assaultive to her younger siblings…in order to protect them and to make sure that her medical needs were met, because she was eloping at the time. I had to take her to court, um, file charges against her…"

Mona's name is a pseudonym, but her story is real. In this study, parents describe the circumstances preceding their decisions to voluntarily relinquish custody of their children and place them into the child welfare or juvenile justice system. This paper introduces some of the trends and an initial socio-economic picture of this phenomenon in Michigan. Parents' perspectives on the circumstances that led them to relinquish custody are shared, as well as their suggestions for support that might have prevented them from having to make this difficult decision.

Prevalence

Mental health problems among children and youth are increasing at an alarming rate. The Surgeon General's Report on Children's Mental Health (2001) shows that in the U.S., one in ten children and adolescents suffer from severe emotional disturbance; yet, in any given year, only about one in five of these children receive mental health services. Increasingly, parents are facing extreme difficulty accessing mental health services for children who have SED (GAO, 2003; Giliberti & Schulzinger, 2000). In the absence of financial support for medical services, some families have turned to the child welfare and juvenile justice systems for help, because children are more likely to be eligible for and receive needed mental health treatment while residing in out-of-home placements (GAO, 2003; Burrell, no date).

The literature strongly supports the position that the majority of youth involved in the foster care and juvenile justice system have mental health disorders (Skowyra & Cocozza, 2006). Thirty to forty percent of foster children suffer from a diagnosable physical disabilities, mental illness, substance abuse or emotional problems (Folman & Anderson, 2004; Garland & Besinger, 1997); 65 to 70 percent of youth in the juvenile justice system meet criteria for a diagnosable mental health disorder (Skowyra & Cocozza, 2006).

U.S. government agencies reported that in 2001 that over 12,700 children from 19 states were identified as having been placed in out-of-home care in order to be provided with necessary mental health treatment (CMS, 2006; GAO, 2003). Of these children, 3,700 entered the child welfare system, and approximately 9,000 entered the juvenile justice system (GAO, 2003; Waxman & Collins, 2004). Evidence suggests that these children were not placed as a result of abuse or neglect petitions, nor were they found to have committed delinquent acts (GAO, 2003; Skowyra & Cocozza, 2006). A 2004 report issued by Congress documents the inappropriate use of detention for youth with mental health needs, citing that 33 states in 2001 reported holding youth in detention with no charges—they were simply awaiting mental health services.

In 2001, Michigan identified 400 youth in Wayne County alone who were placed in the juvenile justice system solely to obtain mental health services (GAO, 2003). However, no formal or comprehensive federal or state tracking of such placements occurs. More data must be collected to accurately document the number of children in Michigan who have been placed strictly

to gain access to mental health services (Hanley, K., MDHS, 2007, personal communication). There is little information regarding service utilization and outcomes for children in out-of-home placements, and none differentiates between placements resulting from abuse or neglect and those children and youth voluntarily placed by their families to access necessary mental health services.

Economic context and consequences

Health care financing may be an important reason why this phenomenon may be more widespread than previously realized. Middle-class families who cannot secure adequate private health insurance may be affected. For poor families, there is no option besides coverage through public financing (e.g., Medicaid and SCHIP). African American, Latino, and American Indian children are more likely than White children to be uninsured and without access to mental health care (Michigan's Children, 2006); consequently, children of color are disproportionately affected by these kinds of placement decisions (MDHS, 2006; Russell & Jones, 2005). Funding for the MI Child program, which provides health insurance to children in low-income working families in Michigan, dropped 19 percent from 2006 to 2007, while monthly family premiums doubled (Michigan's Children, 2006), leaving gaps for state child welfare and juvenile justice systems to fill.

Current child welfare policies and practices favor out-of-home placements—which are very costly to taxpayers, with Michigan spending $200 million annually on foster care and $48.5 million annually on juvenile justice placements—rather than prevention services such as in-home supports. These interventions are not necessarily more effective than home and community-based care. In fact, the recidivism rates for juveniles receiving in-home and community-based interventions are equivalent if not better than those for high risk juveniles placed in expensive, restrictive residential programs (Burrell, no date). When the mental health needs of these children are not addressed in an integrated way, the return on the investment is poor, especially for children who are sent away from their homes and communities and for the system and the public that must pay for expensive out-of-home placements. Funding for preventive services has been severely cut in Michigan, reduced from $25 million to less than $10 million between 2000 and 2006 (Michigan's Children, 2006). With reduced resources for prevention, the child welfare and juvenile justice systems may increasingly bear responsibility for mental health care for children living with severe emotional disturbances.

Options for health care coverage are circumscribed by family income and economic circumstances, but the service gaps in coverage for children with SED affect both middle and low-income families. Many employer-paid, private insurance plans and public S-CHIP plans offer only limited coverage for traditional or clinical treatments such as psychotherapy, and do not cover residential treatment placements (GAO, 2003). Youth in states with S-CHIP plans, like Michigan, often have very limited mental health benefits because they are taken from a benchmark private health plan. Typical private plans limit outpatient visits to 20 or fewer and inpatient stays to 30 or fewer (Brazelon Center for Mental Health Law, 2005).

Changes in Medicaid rules may significantly affect placement rates. Low Medicaid reimbursement rates often restrict mental health providers' participation; and children placed in foster care or juvenile detention receive preference, particularly when services are court ordered (Giliberti & Schulzinger, 2000). For example, a study examining mental health service use in California found that children in foster care accounted for 41 percent of all public service users, while representing only 4 percent of eligible children (Garland & Besinger, 1997). These policies appear to be in direct conflict with other federal and state child welfare policies that emphasize family preservation.

There is little information regarding service utilization and outcomes for children and youth who are placed in the child welfare and juvenile justice system, and much of the information that is available does not differentiate between youth who have been placed as a result of an abuse or neglect petition and those who have been voluntarily placed by their families as a result of needing mental health services. A better understanding is needed of the impact placement has on the families of youth who are placed in the foster care or juvenile justice systems solely to obtain mental health care services.

This qualitative study attempts to better understand the ramifications of such placements on families in both urban and rural areas of Michigan from the perspective of parents who have had to voluntarily make this difficult decision. Parents also offered recommendations for future policy and practice.

Methods

Data was drawn from two studies of families with children living with severe physical or mental disabilities: the Pulling It All Together (PIAT) Project and the Keeping Families Together (KFT) Project. PIAT, or "Pulling it all together: Medicaid participation, work and income packaging for families living with chronic illness and disability" is a mixed-methods study that compares the economic and social strategies that low-income families use to make ends meet using various sources of cash and in-kind benefits. Interpretive data from focus groups are combined with administrative and survey data to examine trends in the use of cash, participation in social programs like Medicaid and Temporary Assistance for Needy Families (TANF), and social networks to increase social capital and achieve economic self-sufficiency. The focus groups were conducted in mid- and southeast Michigan, in rural and urban settings, respectively. Participants in the PIAT study were recruited through agencies that serve Medicaid recipients and other individuals and families with serious health problems. The semi-structured research instrument included both quantitative demographic measures and open-ended questions focusing on the participants' descriptions of their economic and social needs (including health care); and how well these needs were met using earnings work, income from social programs, and contributions from people in their social networks. Each focus group was designed to last 1½ to 2 hours. The focus groups were audiotaped and transcribed verbatim. Data collected through the focus groups were analyzed using thematic narrative analysis techniques. For this article, data from two focus groups with parents of children with SED were analyzed—one in rural mid-Michigan and one in urban area in the southeast part of the state—in which parents introduced and discussed at length the idea that they and other parents in their situations faced the decision to relinquish custody of their children to the state so that the children could access mental health services.

The second, related study, Keeping Families Together (KFT), builds on what is being learned through the PIAT focus group data. Keeping Families Together is a qualitative study of the circumstances of the families and the parents' perspectives on decisions to relinquish their children with SED to the foster care or juvenile justice systems, and social strategies that parents use to find and maintain health care and social support for their children living with SED. Data for the KFT Study are being collected throughout the state of Michigan, through in-depth interviews and brief demographic surveys of the families. The first interview in KFT was conducted with a parent from southwest Michigan who had voluntarily placed her child in the juvenile justice system. The individual interview discussion took place for 3.5 hours. The interview was audiotaped and supplemented with the interviewer's extensive field notes. The interview protocol included open-ended questions about the parents' circumstances and those specifically surrounding the supports available to the family before, during, and after the decision to relinquish custody of the child with SED. In addition to the regular protocol, the parent in this case study also provided the researcher with extensive legal documentation of her child's history as a recipient of juvenile detention services. The data for this article were analyzed using narrative methods to explore themes that arose first in the Pulling It All Together Project focus groups and were elaborated on in the Keeping Families Together case study of a parent's experiences navigating the juvenile justice system to gain access to necessary mental health services for her child.

Findings

Preliminary findings from this study and the PIAT study indicate that Medicaid-eligible families have limited access to necessary Medicaid-covered benefits, citing this as a reason for child welfare placement or juvenile detention. Two working poor parents who participated in the Mid-Michigan focus group speak directly to the financial difficulty that led them to the decision to relinquish custody, as well as describe the consequences this decision had on their families:

> C: Ok, respite…, [the subsidy is] $1500 a year per family. Now that's not much. What, do they want *you* to pay for that? We got families that got children with really serious disabilities and several of them in one family 'cause of their heredity, and they only get $1500 a year in respite. When parents get desperate, that child ends up in the foster care system.
>
> --D: And that is why my nephew is in a treat-

ment center and will be there for another two years because he's not able to access enough services for his care in our home. *We were not able to get support to be able to keep him at home.* So now the State is having to pay for him to be in a treatment center….so he's costing the State three times more than if he was living with us."[1]

C: I had to give up custody of my son so that he could get the necessary care that he needed for his mental illness because my insurance would not cover for him to be hospitalized while he was suicidal. They would only pay 50%, yeah I got a letter that I wrote to the senators. I had a bill for $40,000-that was my portion of the hospital stay. And I couldn't qualify for Medicaid, I made a $100 too much a week or a month and they wouldn't allow me to have Medicaid.

A third parent stated that she chose to relinquish custody of her child to the juvenile justice system because her child was a danger to herself and her siblings.

M: I had to do that with my second to oldest child, because her behaviors were so bad she was assaultive to her younger siblings…in order to protect them and to make sure that her medical needs were met, because she was eloping at the time. I had to take her to court, file charges against her and also requested a temporary foster care placement and ended up having to give custody to my brother in order to be able to ensure the safety of my … of her younger siblings. … My only other choice was I had to turn her over to foster care to DHS and they would file abuse and neglect charges against me and I would be at risk of losing my other four children.

One of the parents who participated in the focus group in southeast Michigan made the following comments about how her child was involved with the juvenile justice system:

CH: Yeah, the whole 3rd precinct know who I am, I could be walking down the street, Hey, [CH]… how ya' doin'. Because that's the way we have to do it. I mean have to involve them, you know to come and do something. I call the police, not sometimes, all the time… I have the cops over my house all the time to check on me.[2]

A second parent from the same urban focus group in southeast Michigan commented,

P: …But one of the hardest thing you could do, mother calling on your own kid…Because what they have to do when you have to call them, they treat em' just like they're a regular criminal, they put handcuffs on em'. You know if they have to tackle em' they will tackle em'. You know they will … they will do all these things.

Children and youth with mental health challenges and their families have been affected by the stigma surrounding mental health and are often isolated. Police arriving at their door likely means more negative attention from the community, fear of losing control of their family's situation, and even more distrust and anger directed at the systems that have failed them.

A third parent from the urban group, traumatized by her experience of calling the police on her child, commented:

N: I don't call the police anymore, because my youngest the one that is the most impaired, um, had an accident with the police…they [the police] beat him up and they maced him and everything but he's a big boy. And they thought he was an adult… . When they grabbed him, he just went out of control, you can't put your hands on him-that's number one, I don't even do it. I guess they tried to turn him around to talk to him and they … it just went out of control… all the neighborhood took pictures and videotapes and everything. I mean I didn't sue because my son did swing on the officer, but I was angry that they maced him more than four times. You know…he's a minor.

Parents who chose not to place their children in formal out-of-home care settings may contemplate ideas that include knowingly placing their children in dangerous situations to ensure access to public health insurance. One parent described a situation where she knowingly put her child in danger to obtain needed health care resources: "… I even thought about giving up custody of my son and giving him to my husband who is an alcoholic, who is eligible for Medicaid because he isn't working." Parents believed that if they were offered services such as additional respite hours and intensive, in-home support services, these would have prevented them from placing their children out-of-home. Parents also believed that these in-home,

community based service options would be less costly than the out-of-home placements.

> "…Because rather than getting respite…mental health…and-um [the state opts for] high level foster care, which crosses out of county, across the state, so it's like quadrupled the amount of money…and either that or they are in, uh, really secured residential facilities, it's costing, you know thirty thousand dollars a month or something."
>
> --"they [parents] need the support in the home."
>
> --"…need somebody to be able to come into the home, help with the parenting skills, um, modeling,…"
>
> --…"yup, just like in school, they have one on one aides, …need a one on one aide in the home."

Discussion and Summary

Many youth end up in the foster care or juvenile justice systems for behavior brought on by or associated with their mental illness. As communicated by the parents in this study, youth with mental health needs should be diverted into effective community treatment. Families need to be in the forefront and fully involved with the treatment and rehabilitation of their children. Parents are the most reliable resources a child has through the implementation of preventive, home and community-based services. When more formal and restrictive treatments are necessary, parents should also be actively engaged with law enforcement, child protective services and the courts in the development and implementation of formal treatment plans on behalf of their children.

As shared by parents who have had police involvement with their children, it is imperative that law enforcement professionals are trained on crisis de-escalation techniques for children and youth, to understand and appropriately interact with children living with SED. Law enforcement officers are generally trained to be action oriented, aimed at solving problems quickly-a practice that is not conducive to serving children with SED. Police responses have significant implications in determining treatment plans. Upon an encounter with a youth who appears to have a mental health concern, law enforcement officials need to connect the youth with emergency mental health services or refer the youth for mental health screening and assessments.

The court process plays a significant role in referring children in foster care and juvenile detention to mental health and other services. Services may be offered or ordered for children at many different points in the court process and may range from optional or voluntary services to services required by the court as part of the treatment plan. It is of critical importance that judges have sufficient information about a youth's mental condition and treatment history to understand how a youth's mental health disorder may have contributed to their entry into the foster care or juvenile justice system. Input from families is essential. This knowledge should be at the forefront as judges make dispositional decisions.

Parents have the best information about the needs of their children. It is vital that parents attend every court proceeding and provide the attorney representing the child or youth with information about the youth's mental health history so that it can be included in reports and plans. The best outcomes for youth with SED arise when parents, other family members, and all relevant care providers (i.e. foster care workers, probation officers, therapists, etc.) develop a partnership that will ensure an appropriate and comprehensive treatment plan is created, implemented and sustained.

Essential to effective system/service delivery is the ability of families to access appropriate health care and health care coverage. Public policy alternatives do exist that can help families with the difficult choice of giving up custody to the state or seeing their child go without needed care. The federal government gives states the option to participate in the Tax Equity and Fiscal Responsibility Act or TEFRA (also known as the Katie Beckett Act), a Medicaid option that allows states to cover home and community based services for children with disabilities living at home with their families. If the child meets all eligibility criteria for TEFRA, the child receives a Medicaid card and is viewed as a family of one for the purpose of medical treatment. A child can qualify without regard to family income (Burrell, no date).

In addition to creating more public awareness about TEFRA, other legislation has been introduced at the federal level that could be supported by these findings. Of particular interest are the Keeping Families Together Act of 2007, which directly addresses out-of-home placements of children with mental

health needs; the Juvenile Justice Delinquency Prevention Act of 1974, enacted to address the over-representation of youth of color who have been detained in the juvenile justice system; and the Mental Health Parity Act of 2007. All of this legislation is under current consideration for enactment or reauthorization, and faces likely changes that will reduce or eliminate funding for programs and services for Michigan families. Concern about this issue is emerging in several states, including Michigan.

There is interest across the county in addressing the issue of placing children in out of home care solely for the obtainment of mental health care (Congressman Ramstad, [R-MN] 2006; personal communication), but additional research is needed to determine the actual scope and impact of the problem. ◎

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Endnotes

1 Emphasis added. During the interview, the parent explained that this 15 year old had a long history of suspensions and expulsions from school due to physical confrontations with peers at school. This child also has a history of assaulting adults in positions of authority.

2 This parent explained that she is the biological grandparent of her 14 year old grandson whom she took into her home after a substantiated child protective service investigation.