The "Abuse Excuse"

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exculpate her from all liability, but would convict her, not of murder, but of some lesser crime.

Limits of justification

Let me come back to Dr. Campbell's two cases and stop there. It seems to me that in the case of the fifty-four police calls, we have a confrontation case. The woman in that case in a court today would be able to put on Dr. Campbell as an expert under the law as I think it pretty clearly exists, and that woman could raise a very strong self-defense claim on the basis of justification. In Marva's case, the shooting on the front stoop, that's one of the tough ones. And I don't pretend to be smart enough to know the answer to it. But let me close with the thought that I think Dr. Conte was making and that David Finkelhor made in his keynote address when this conference began: there is a real danger, it seems to me, of a very serious backlash if those of us concerned about victims take too far the notion of getting people out of trouble for acts they have committed because they have an abuse history. A backlash is very likely to occur, Dr. Finkelhor said, when our practice exceeds societal consensus. And it seems to me that society has not reached a consensus that it is justifiable to shoot a sleeping batterer in the head.

CHILD PROTECTIVE SERVICE

The Mental Health Needs of Children Entering the Child Welfare System: A Guide for Case Workers

—by Joshua Kendall, Grady Dale, and Steve Plakitsis

Introduction

A Child Protective Services worker removes a ten-year old girl, "Tonya," from her home following allegations of sexual abuse by her mother's boyfriend. Tonya's four siblings still live with her mother. In court, Tonya also alleged that her father molested her at age five or six. Whatever the actual extent of the sexual abuse by the two alleged perpetrators, Tonya has clearly had to endure a series of traumatic events. She is a fifth grader who has been receiving special education services since the third grade.

Tonya, who received a mental health screening at the Health Clinic in Baltimore in April, 1995, is typical of the abused and/or neglected children who enter the child welfare system and are eventually placed in-out-of-home care. At first glance, the case worker might be led to assume that all Tonya needs is protection from the alleged perpetrators and sufficient time to process the shock of being removed from her mother's home. This assumption, though rooted in common sense, fails to take into account the long-term impact of Tonya's traumatic childhood on her psychosocial functioning.

The empirical research accumulated over the last two decades suggests that children like Tonya tend to have complex mental health needs that go beyond the material needs of a clean and safe home environment. For example, her mental health screening revealed considerable impairment in her visual-motor and cognitive skills. Furthermore, because of her history of maltreatment, she remains at high risk for developing both serious emotional problems such as depression and serious academic problems that could block her path to a self-sustaining adulthood.

This article offers a guide for case workers to the specific mental health needs of abused and neglected children entering the child welfare system. Though they are expected to help children suffering from particularly acute and complicated clinical problems, few workers have academic backgrounds in psychology or social work.[1] Furthermore, case workers typically receive little on-the-job training in the developmental needs of traumatized children. Baltimore workers, for example, simply undergo a five-day training course. In addition, as Dugger (1992) notes in her report on the what she characterizes as New York City's "ill-trained case workers," workers are typically burdened with heavy caseloads and do not receive adequate administrative support and guidance. Faced with the challenge of repeated crisis management, it is no wonder that workers tend to lose sight of the long-term effects of traumas and losses for children.

In this article, we will present a brief synopsis of the empirical literature on the mental health status of abused and neglected children entering the child welfare system. This literature review features a recent study on children entering out-of-home care in Baltimore that describes the typical mental health problems among these at-risk children. We then raise some critical policy and service delivery issues, and highlight the implications of this discussion for case workers.

The literature on children entering the child welfare system

As a result of the society-wide blindness to child abuse and neglect, few investigators focused on children entering the child welfare system until the late 1970s. Fanshel & Shin (1978) conducted the pioneering research that first drew attention to the long-term psychosocial difficulties faced by children in foster care.

Research has since systematically demonstrated the high prevalence of cognitive and academic problems (e.g., Fox & Arcuri, 1980; Runyan & Gould, 1985a), behavioral or delinquency problems (e.g., Runyan & Gould, 1985b) as well as

[1]As Dugger (1992) reports, at present, only New Mexico and North Dakota require workers to have social work degrees, whereas in most of the country, a bachelor's degree in any field is sufficient. Dugger suggests that states do not set stricter guidelines because of the difficulty in recruiting candidates for this highly stressful line of work for which the remuneration is often inadequate. Not surprisingly, the turnover among caseworkers is high.

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The Mental Health Needs of Children

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psychosocial problems (e g , Frank, 1980) in this high-risk population. In the first comprehensive study of psychological disorders in foster children, McIntyre & Kessler (1986) found that over half of the foster care children in their sample manifested evidence of psychological disorders. They concluded that the relative risks associated with foster status were almost 2 to 32 times greater than for home- reared children.

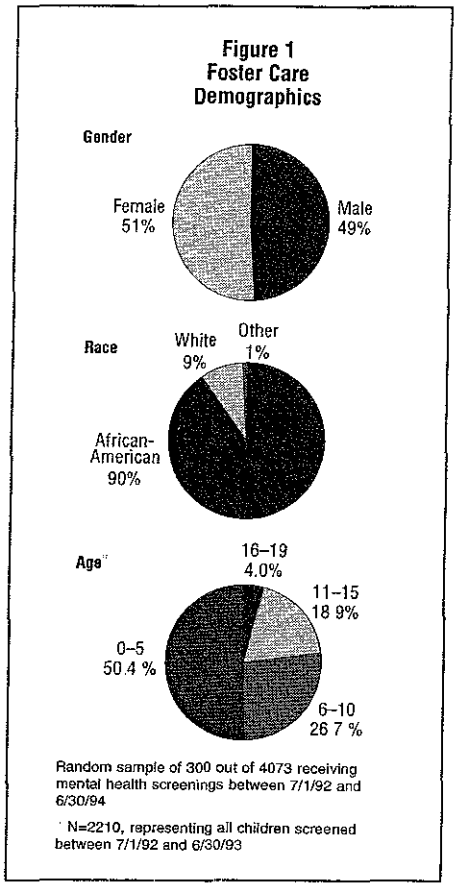

Figure 1
Foster Care Demographics

Random sample of 300 out of 4073 receiving mental health screenings between 7/1/92 and 6/30/94

N=2210, representing all children screened between 7/1/92 and 6/30/93

Finally, Hochstadt, Jaudes, Zimo & Schachter (1987) were the first to focus specifically on the mental health and medical status of children as they enter the child welfare system.

In a current study, Dale, Hayes, Cargo, Kendall, Hessenauer & Humber (1994) report on the typical cognitive and mental health problems among children entering out-of-home care. Dale et al. base their results on a random sample of 300 of the 4073 children who received mental health screenings at a centralized clinic in Baltimore over a two-year period. Their findings suggest that these at-risk children tend to have disproportionately high rates of poor cognitive and mental health functioning. Furthermore, Dale et al. (1994) suggest a direct link between the typical reasons why children enter care (e.g., abuse and neglect) and their psychological distress. The findings of Dale et al. on their Baltimore sample include the following:

- Approximately 50% of the children entering out-of-home care are age five or below. (See Figure 1 for a demographic summary of children entering foster care in Baltimore between 7/1/92 and 6/30/94.)

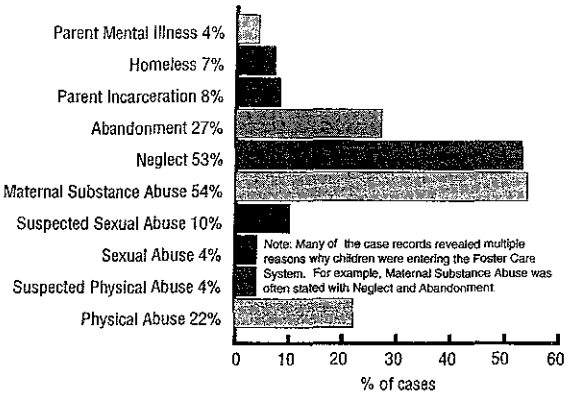

Figure 2
Reasons for Entering Care
Random Sample from 4073 children receiving mental health screenings between 7/1/92 and 6/30/94

- The most common reasons for entering foster care included maternal substance abuse (54%), neglect (53%), abandonment (27%) and physical abuse (22%). (See Figure 2.)
- On the Denver Developmental Screening Test - Version II (DDST II), 51% of children aged two months to five years were identified as "suspect for delay" compared with 10% in normative samples.
- On the Peabody Picture Vocabulary Test - Revised (PPVT-R-L), 53% of eight- to twelve-year-olds and 64% of 13- to 19-year-olds showed evidence of severe receptive language difficulties.[2]
- On the Developmental Test of Visual Motor Integration (VMI), 37% of children aged 13 to 19 showed evidence of severe deficits in visual-motor skills, compared with 10% in normative samples.
- On the Reynolds Depression Scales (RCDS and RADS), 11% of the eight- to twelve-year-old group and 30% of the 13- to 19-year-old group reported significant depressive symptomatology. (See Figure 3 on page 12.)

The above findings replicate in many respects the findings of Urquiza, Wirtz, Peterson & Singer (1994) on a similar sample of children entering the child welfare system. Though Urquiza et al. used different assessment instruments, their percentages of children deemed "at risk" in cognitive and emotional domains fell in similar ranges. In their sample, 45% (19 of 42) of infants and toddlers scored below the cutoff criteria on the Bayley Scales. The results on the Kaufman Assessment Battery (KABC) showed that 28% of the sample (N=113) were performing beneath the at-risk cutoff in academic domains. When combining the results from cognitive, academic and behavioral domains, Urquiza et al. (1994) report that 56% (94/167) were at significant risk for problems in one or more domains.

Critical service delivery and policy issues

Despite the considerable usefulness of gathering basic health information on abused and neglected children, only a small minority of children entering the child welfare system actually receive screenings. In their report on health care services for foster children in California, Halfon & Klee (1987) note that in only one of the 14 California counties they studied did children receive a mental health evaluation. Reporting on their Screening and Evaluation Project (SEP) for abused children in Sacramento, Urquiza et al. (1994) note that screenings may be essential in determining the degree to which these children's problems are situational or are rooted in developmental traumas requiring continued intervention. They issue the following policy recommendation:

> We believe...that the state has the duty, when it takes custody of these children, to identify their health and mental health problems and make reasonable efforts to alleviate them. We also believe that this would be a cost-effective secondary prevention and/or early intervention approach (Urquiza et al., 1994, p. 166).

[2]*The Health Clinic replaced the Peabody Picture Vocabulary Test with the Beery Picture Vocabulary Test as of July 1, 1995 because of its more up-to-date norms that may reduce any potential racial bias.*

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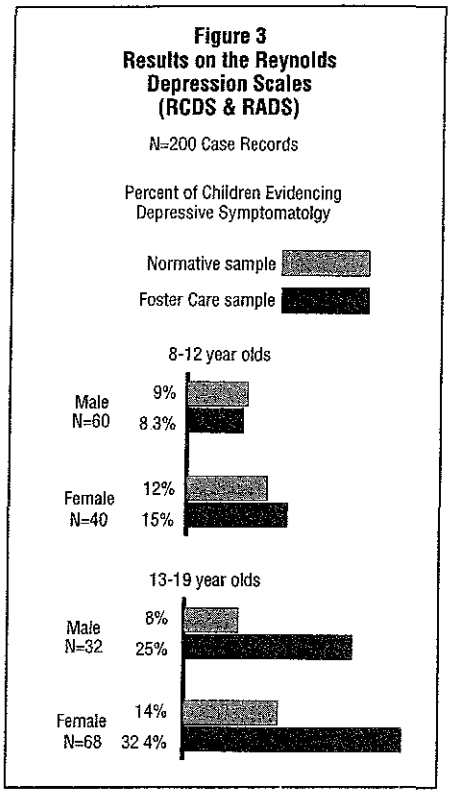
Unfortunately, few states routinely screen children entering the child welfare system. The Health Clinic in Baltimore (see Dale, Cargo, Ennis, Hayes, Hessenauer & Kendall, 1993; Dale, Hessenauer, Kendall, Lance & Holmes, 1993; Dale, Kendall & Humber, 1995) appears to be the only city-wide screening program in the nation. In most urban areas, screenings tend to be performed at sites scattered throughout the city, if at all. In rural areas, screenings are rarely performed on a routine basis.

Whereas child welfare advocates need to exert political pressure to increase the funding for these vital programs, researchers and clinicians need to address technical policy issues. For example, researchers need to develop a consensus on exactly what domains to assess and how to assess them.



Further research is needed on instruments that best assess essential characteristics of this clinical population. Eventually, psychologists and other mental health professionals could perhaps follow a standard protocol in their mental health screenings of abused and neglected children much as pediatricians engage in at present when assessing their medical condition.

Researchers must also begin to address the extent to which data obtained on children in crisis are "contaminated." One critical problem in performing developmental testing on children under age five is the lack of a parent or suitable informant at the time of screening. The child's parents are often unavailable (e.g., due to a substance abuse problem or abandonment) to provide the necessary background information, and clinicians must rely on secondary or tertiary sources, such as testimony from neighbors or case records. Researchers must also study how the timing of mental health screenings affects the results. One wonders about the reliability of diagnostic testing undertaken at a moment of crisis (i.e., right after removal from the home). A related issue is the need to monitor children after they have received the initial screening.

Tonya's case: A sample screening

Mental health screenings aim to direct children to the next level of intervention as efficiently as possible. Figure 6 presents a flow chart illustrating the mental health screening process, whereby diagnostic findings flow into clinical recommendations. The screening clinicians do not treat children, but rather issue referrals for appropriate psychosocial follow-up. Such screenings are not synonymous with full-scale psychological evaluations, which are much more comprehensive and expensive. Screenings tend to be more clinically efficient and cost- effective; in some cases, more extensive diagnostic testing may be warranted.

In the case of Tonya's mental health screening, her performance on diagnostic instruments revealed both low average visual-motor integration skills and low average receptive language skills. No further psychoeducational testing was deemed necessary at the present time, but her worker was advised to check whether she was receiving the appropriate special education services in school. Her alleged history of sexual abuse led to a referral to a local physician nationally renowned for his diagnostic evaluations of alleged abuse victims. Tonya was also referred for individual psychotherapy in which she could address issues involving her problematic relationships with her father and her mother's boyfriend. According to the screening clinician, although Tonya did not exhibit symptoms of clinical depression at the present time, outpatient therapy was needed in order to reduce the considerable risk of future episodes of depression.

Implications for case workers

As a group, children entering the child welfare system typically show evidence of difficulties in cognitive and/or emotional functioning. These difficulties may stem from the reasons for removal from the home, such as maternal substance abuse, neglect, and physical abuse, and often require long-term follow-up care.

Ideally, all children entering the child welfare system should receive a mental health screening. Given that most states do not routinely provide such services, workers may need to take it upon themselves to refer acutely distressed children for psychological services. For example, workers should be alert to symptoms of clinical depression faced by a significant minority of these children (see Figure 4 for the rates of depression found by Dale et al., 1994). In children, clinical depression typically includes a cluster of some or many of the following symptoms:

- Persistent sad or irritable mood.
- Feelings of hopelessness and helplessness.
- Feelings of worthlessness and excessive guilt.
- Decreased interest or pleasure in most activities.
- Sleep problems (insomnia, oversleeping, early morning waking).
- Changes in eating habits(weight loss or gain).
- Decreased energy and fatigue.
- Difficulties with concentration, memory and decision- making.
- Low self-esteem.
- Recurrent thoughts of suicide with or without a plan.

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Depending on the seriousness of the symptoms, these children may be referred for a mental health screening or to an outpatient psychotherapist. In emergencies, in-patient psychiatric services may be necessary.

Conclusion

Empirical research studies over the past two decades have unequivocally demonstrated high rates of mental health problems among children entering the child welfare system. These findings warrant mental health screenings for all such children as a matter of national and state policy.

The lack of such an enlightened policy places even more responsibility on already burdened case workers. Case workers need to be aware of the signs of acute psychological distress, such as depression, so that appropriate referrals can be made.

In general, case workers should understand that the vast majority of these at-risk children may need long-term psychosocial support as they struggle to break out of an intergenerational cycle of poverty and abuse. They should familiarize themselves with local programs administering to the complex mental health needs of this at-risk population and should attempt to provide expeditious referrals for the appropriate interventions.

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CULTURAL ISSUES
Implementing Racial Diversity Initiatives in Agencies Serving Maltreated Children

—by Jessica Henderson Daniel

Professionals in the field of child maltreatment confront multiple challenges as they attempt to provide the best possible services to children and families. When professionals and clients differ along class, racial and cultural lines, the challenges if acknowledged, can be quite demanding if not overwhelming. In particular, agencies that serve clients who are racially different from the providers run the risk of offering services which may be counter to the prevailing culture of the community. In such situations, despite best intentions, children and families may not be adequately served. In an emotionally charged field such as child maltreatment, recognizing and incorporating race as an important variable can only serve to improve the quality of professional services offered.

Discourse about "diversity initiatives"—i.e., efforts to ensure that agencies are culturally competent from top administrators to entry-level providers—is current in both the public and private sectors, as some agencies begin to recognize and confront the realities of the "colorization of America." Despite consensus that services must be culturally competent, moving from discourse to implementation has been a substantial challenge. Publications, lectures and workshops which support the rationale for such initiatives have not been sufficient to mobilize agencies to move forward. Resistance to racial diversity initiatives appears to be a major obstacle to implementation. The purpose of this article is to provide guidelines for ways to conceptualize and move through the resistance in order to implement a racial diversity initiative in agencies serving maltreated children and their families.

Getting started: Logistics

A racial diversity initiative needs the support of the chief administrator of the agency. Without that support and validation, the initiative is likely to fail, since most people will avoid tackling this difficult topic if given a choice.

The chief administrator can support the process by establishing a non-threatening and non-judgmental tone. In agencies with longstanding histories of serving people of color, resistance to a diversity initiative might stem from the fear that services offered previously have been less than optimal. The reality is that people have offered services based on the instruction and training they have received in college, in professional schools, and at work, as well as their personal histories. Their

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