

# Chapter 4

4



**TEXASCASA**  
Court Appointed Special Advocates  
FOR CHILDREN



**We must protect families, we must protect children, who have inalienable rights and should be loved, should be taken care of physically and mentally, and should not be brought into the world only to suffer.”**

*– Indira Gandhi*

# Chapter 4: Mental Health, Poverty and Confidentiality

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## PRE-WORK INSTRUCTIONS

1. Read pages 152-171, “Mental Illness in Families” through “Initial Case Notes for the Greene Case.”
2. Complete the “Examining Poverty vs. Neglect Scenarios” activity.
3. Play the online game Spent to learn more about the challenges of poverty. Find the link at [www.playspent.org](http://www.playspent.org).

## Mental Illness in Children and Families

According to the National Alliance on Mental Illness (NAMI), “A mental illness is a condition that impacts a person’s thinking, feeling or mood and may affect his or her ability to relate to others and function on a daily basis. Each person will have different experiences, even people with the same diagnosis.”

Definitions of mental illness have changed over time, across cultures, and across national—and even state—boundaries. Mental illness is diagnosed based on the nature and severity of an individual’s symptoms according to definitions published in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), currently in its fifth edition. Serving as the American Psychiatric Association’s (APA) classification and diagnostic tool, the DSM serves as a universal authority for psychiatric diagnosis in the United States. The term “dual diagnosis” indicates that an individual has both a psychiatric disorder and a substance abuse problem.

A mental health condition usually has its origins in multiple, overlapping causes, which may include genetics, biology, environment and life stressors. Mental illness is not caused by personal weakness or a character defect.

No single model or perspective accounts for all instances of mental illness. Some disorders have a predominantly biological or neurological basis; others seem to be related to life experiences, trauma or difficulties in communication. The most helpful stance for you to take in your CASA/GAL volunteer work is to accept that mental illness can affect a person mentally, physically, psychologically, socially, emotionally and spiritually. Mental illness is a condition and, at times, a disability, which we do not judge a person for having. A mental illness that is treated and managed is different from an untreated mental illness. Likewise, there are varying levels of severity, as with all other illnesses.

### IMPACT OF PARENTAL MENTAL ILLNESS ON CHILDREN

A parent’s mental illness can significantly affect a child, potentially leading to social, emotional, or behavioral problems. According to Healthy Place, children of a parent with mental illness may experience the following impacts:

- Inappropriate levels of responsibility (also known as “parentification”)
- Self-blame for their parents’ problems
- Anger, anxiety or guilt
- Embarrassment, shame or isolation
- Increased risk of school-related problems, drug use and poor social relationships
- Risk of mood disorders, alcoholism and personality disorders

However, parental mental illness doesn’t automatically mean a life of problems. Approximately one in five adults in the U.S.—43.8 million, or 18.5 percent—experiences mental illness in a given year, according to the National Alliance on Mental Illness. Whether a child can thrive despite these challenges depends on the strengths and protective factors present in the family, as well as the child’s level of resilience. As a CASA/GAL volunteer, you can recommend services that build on a family’s strengths and help them overcome the challenges they face.

## **Untreated Mental Illness**

The biggest obstacle facing those suffering from mental illness is the lack of appropriate, effective treatment. This lack may result from misunderstanding the need for treatment or being afraid to seek it due to the stigma associated with mental illness. It may also result from a lack of access to treatment and affordable medical care. There may not be treatment available in a person’s community, or the person may not be able to pay for it.

Untreated mental illness can lead to isolation and despair for individuals and families. Some parents may be so incapacitated by anxiety or depression that they are unable to care for their children, or may hallucinate or have delusions which make them a danger to themselves or their children. It is critical for you as a CASA/GAL volunteer to focus less on a parent’s diagnosis and more on their ability to provide a safe home for the child. The degree to which a parent’s ability to function is impaired will vary from mild to severe. It is important to note that with medication and/or therapy, most people can function normally.

## **Mental Illness and Child Welfare**

According to Mental Health America, “A higher proportion of parents with serious mental illness lose custody of their children than parents without mental illness. There are many reasons why parents with a mental illness risk losing custody, including the stresses their families undergo, the impact on their ability to parent, economic hardship and the attitudes of mental health providers, social workers and the child protective system.

“Supporting a family where mental illness is present takes extra resources that may not be available or may not be offered. Also, a few state laws cite mental illness as a condition that can lead to loss of custody or parental rights. One unfortunate result is that parents with mental illness might avoid seeking mental health services for fear of losing custody of their children.”

To understand the impact of mental illness in a family, it is critical to examine if a parent’s level of functioning is sufficient to keep a child safe and whether another competent adult is present in the home. A person’s level of functioning is the result of many factors; not all are related to mental illness. It is important to distinguish between mental illness and other kinds of limitations. For example, many adults have limited intellectual abilities or specific learning disabilities. By looking beyond the diagnosis to level of functionality, you can make recommendations to remedy the problems that caused family involvement in the child protective services system.

### **Assessment**

It is not your task to diagnose mental illness. However, it is important to be aware of warning signs or indicators that may affect the health or safety of the child so that you can alert the child protective services caseworker about your concerns. The following are some indicators that may point to the need for professional assessment:

- Social withdrawal: “Sitting and doing nothing”; friendlessness (including abnormal self-centeredness or preoccupation with self); dropping out of activities; decline in academic, vocational or athletic performance

- Depression: Loss of interest in once pleasurable activities; expressions of hopelessness or apathy; excessive fatigue and sleepiness or inability to sleep; changes in appetite and motivation; pessimism; thinking or talking about suicide; a growing inability to cope with problems and daily activities
- Thought disorders: Confused thinking; strange or grandiose ideas; an inability to concentrate or cope with minor problems; irrational statements; peculiar use of words; excessive fears or suspicions
- Expression of feeling disproportionate to circumstances: Indifference even in important situations; inability to cry or excessive crying; inability to express joy; inappropriate laughter; anger and hostility out of proportion to the precipitating event
- Behavior changes: Hyperactivity, inactivity, or alternating between the two; deterioration in personal hygiene; noticeable and rapid weight loss; changes in personality; drug or alcohol abuse; forgetfulness and loss of valuable possessions; bizarre behavior (such as skipping, staring, or strange posturing); increased absenteeism from work or school

Availability of mental health treatment varies, and its effectiveness depends on a variety of factors. Treatment options can include medication, counseling or therapy, social support and education.

## **PERCEPTIONS OF MENTAL HEALTH**

Different communities may have varying views on mental health conditions. Background factors can influence whether individuals seek help, the types of support they choose, their coping strategies, what treatments are most effective, and any barriers they might face in receiving care. It's important for professionals to consider these factors when assessing mental health and offering treatment options.

## WHAT A CASA/GAL VOLUNTEER CAN DO

- When you're concerned that a mental illness has gone undiagnosed, you can recommend a mental health assessment of a parent or a child.
- You may request consultations with a parent's or child's mental health care provider. Although a parent's mental health care providers are ethically and legally required to maintain their client's confidentiality, they may be willing—with their client's permission—to talk to you about their perspective on the situation and any concerns you may have. Your supervisor will be able to answer your questions about gaining access to this confidential information.
- When you encounter resistance to a label, diagnosis or treatment, you can become aware of considerations unique to the family and their community.
- When appropriate, you can ensure that children are provided age-appropriate explanations of their own or their parent's mental illness diagnosis by a qualified individual.
- When appropriate, you can advocate for holistic treatment that considers all aspects of an individual, including mental, spiritual, emotional and physical, as opposed to one-dimensional treatment.
- You can create documentation of a parent's or child's mental health issues by reviewing history and case files, and listing all diagnoses, noting the year diagnosed and the medication prescribed, and recording the prescribing provider's name.



## Treatments for Mental Health and Children in Care

Medications can help children and teens in foster care, but they can also further impair them, derail them and sabotage them. Without a clear understanding of their mental health issues, misdiagnoses can be made, and incorrect medications can be prescribed. If there is no reliable caregiver who can describe the child's struggles, information collected can be biased and incomplete. If emotional trauma underlies the presenting symptoms and is not addressed, medications can have no effect or increase problems. If medications are prescribed but other therapies are not provided and supervision of the medication is inadequate, healing and stabilization supporting healthy growth will not occur.

Finally, if caregivers are not adequately trained and educated in caring for a child with significant emotional and psychological needs, medications can often be given to the child to "manage their behaviors" rather than to truly treat the child's illness.

To adequately and successfully represent and speak for a child or teen in foster care, the child's advocate must be able to communicate with the child and discuss the child's experiences. Does the child manage their acting-out behaviors and emotions, use positive social skills, think clearly and track the ongoing events in their lives?

Depression or suicidal thinking must be addressed. Self-abusive behaviors must be contained and risk-taking behaviors reduced. Medications can be part of a successful intervention and treatment plan when appropriate. Working with children and teens in foster care requires a solid understanding of the positive and negative aspects of medication use for the youth that we are serving.

Managing and treating mental health issues and the symptoms experienced by children and adolescents involves many modalities. A key aspect is that the child trust the provider.

- Medication treatment, or psychopharmacology, can alleviate or lessen the symptoms that accompany many mental health disorders. Proper medication support can provide behavioral stability and support with emotional regulation that a child or teen may need to readily engage in other forms of therapy.

## *Treatments for Mental Health and Children in Care*

- Behavioral therapy can help increase positive behaviors and decrease negative acting out.
- Trauma-Focused Cognitive Behavioral Therapy can help correct a pattern of negative thoughts that interfere with the ability to relate to others.
- Eye Movement and Desensitization and Reprocessing (EMDR) uses a structured eight-phase approach to address the past, present and future aspects of traumatic or distressing memories, and end their influence on the present.
- Play therapy and art therapy can help heal past trauma and facilitate a child's return to normal functioning.
- Child-parent psychotherapy involves working directly with the parent and child together and can help the child learn healthy ways of interacting and functioning. Parents can be coached to become more reflective and develop a deeper understanding of their child's needs and their role in their child's life. They also learn how to interact with their child to promote a healthy, secure attachment and to support healthy growth and development.
- Dialectical behavioral therapy (DBT) can provide important skills, such as distress tolerance and emotional regulation, in struggling adolescents and help them integrate new coping skills into their daily interactions.

These treatments can help manage symptoms, facilitate healing and return children to optimal functioning.

## **Questions Advocates Should Ask a Prescribing Doctor**

Children and teens have little, if any, power over their lives when they enter care. They generally lack the knowledge to understand what they need medically, regardless of the type of treatment needed.

Asking the following questions will help identify their needs and determine which recommended treatments are in their best interests.

## *Questions Advocates Should Ask a Prescribing Doctor*

- What therapies or counseling has the child received?
- Does the child already have a relationship with a certain counselor or therapist?
- What is the medication the child is on needed for?
- Were you able to obtain an accurate medical, behavioral and psychological history from parents and past providers?
- What else has been tried?
- What other modes of treatment or intervention will also be provided?
- Who will monitor the ongoing use of this medication?
- How often will this child be seen?
- What are the possible side effects of this medication, and how will they be handled?
- What evidence supports the use of this medication with children?
- Will this child be able to comply with the prescribed medication?
- Does the child agree with taking this medication?
- Who has given permission to begin this child on medication?
- What other medications is this child on? Can this medication be safely combined with the current medication(s)?
- How will this medication help improve this child's functioning?
- What are the risks vs. benefits of using this medication? What are the risks vs. benefits of not using the medication?
- Is a second opinion warranted in this case?

Adapted from "Psychotropic Medication and Children in Foster Care: Tips for Advocates and Judges," by JoAnne Solchany, ABA Center on Children and the Law, October 2011.

## Understanding the Higher Rate of Poverty in the System

### WHY ARE CHILDREN WHO ARE IMPOVERISHED MORE LIKELY TO BE IN THE SYSTEM?

Many of the children you will encounter as a CASA/GAL volunteer will be living at or below the poverty level. Developing a better understanding of the realities of poverty will assist you in being a better advocate. Keep in mind, knowing people's socioeconomic status—like knowing other aspects of their life circumstances and background—does not necessarily mean you can predict their attitudes or behavior, or their fitness as a parent long term. However, knowing their socioeconomic status does help you better understand their life experience, specifically some of the hardships they face.

While abuse and neglect occur in families at all socioeconomic levels, children who are impoverished are more likely to come to the attention of the child protection system. This happens for a variety of reasons. One reason is that middle- and upper-income families have access to many more resources within their families than people who are impoverished do. Even though family crisis, including abuse, happens at all income levels, it is people living in poverty who often have to turn to the system for support. For people living in poverty, initial contact with “the system” is usually for reasons other than abuse. The contact may be about accessing medical care, food stamps or housing. Once this contact is initiated, these families are communicating with many “mandated reporters,” increasing the likelihood that issues of child abuse and neglect will be investigated.

Poverty causes great stress in families. Because of this stress, poverty itself is a major risk factor of abuse, which increases the likelihood of both immediate and lasting negative effects on children. Children who live in poverty are far more likely to have reports of abuse and neglect, and substantiated incidents of abuse and neglect in their lives. However, poverty is not a causal agent of abuse. Most parents living in poverty do not abuse their children.

Children living in families in poverty are more likely:

- To have difficulty in school
- To become teen parents
- To earn less and be unemployed more as adults

Poverty in the first years of life can have critical consequences. Research in brain development shows the importance of the first years of life for a person's overall emotional and intellectual well-being. Poor children face a greater risk of impaired brain development due to their increased exposure to several other risk factors. These risk factors include:

- Inadequate nutrition
- Parental substance abuse
- Maternal depression
- Exposure to environmental toxins (because of where they are forced to live)
- Low-quality day care

## **RELATIONAL POVERTY**

When we speak of poverty, we are generally thinking of economic poverty, the lack of funds and resources that is historically rooted and related to social imbalances of access and power. However, we can expand our thinking about this term to include relationships. A child may be in a home that is middle- or upper-class, and be in an emotional desert. They may be neglected or in isolation from important primary relationships. And, when a child is removed from their home, they may be stripped of all the relational sources and supports they did have. This is relational poverty.

Because a strong sense of belonging and connection are central to healthy development and resilience, it's key that we also advocate for a child's relational needs as well as their basic physical needs. When children are removed from their family due to concerns about abuse or neglect, they are at risk of experiencing relational poverty.

## *Understanding the Higher Rate of Poverty in the System*

Instead of expressing these feelings of abandonment and isolation, however, youth often act out in ways that may jeopardize the sustainability of their placements and lead to further isolation through multiple disrupted placements. Family engagement efforts can help stabilize a placement by providing important relationships and empowering the youth to maintain a sense of connection and relational permanence.

### **Activity: Examining Poverty vs. Neglect**

Consider the circumstances in which each of the following scenarios would and would not constitute a child safety issue. Complete the sentence for both “Yes, if . . .” and “No, if . . .”

#### **A family does not have a refrigerator. Is this a child safety issue?**

Yes, if . . . \_\_\_\_\_

No, if . . . \_\_\_\_\_

#### **A family lives in a rental unit with holes in the floor. Is this a child safety issue?**

Yes, if . . . \_\_\_\_\_

No, if . . . \_\_\_\_\_

#### **A family lives in a car. Is this a child safety issue?**

Yes, if . . . \_\_\_\_\_

No, if . . . \_\_\_\_\_

#### **A family does not have electricity. Is this a child safety issue?**

Yes, if . . . \_\_\_\_\_

No, if . . . \_\_\_\_\_

**A family does not have beds for their children. Is this a child safety issue?**

Yes, if ... \_\_\_\_\_

No, if ... \_\_\_\_\_

**A family does not have money to buy the mother's antidepressant medication. Is this a child safety issue?**

Yes, if ... \_\_\_\_\_

No, if ... \_\_\_\_\_

**A family does not have a crib for their infant. Is this a child safety issue?**

Yes, if ... \_\_\_\_\_

No, if ... \_\_\_\_\_

**A family has one parent who uses drugs. Is this a child safety issue?**

Yes, if ... \_\_\_\_\_

No, if ... \_\_\_\_\_

## Obtaining Confidential Case-Related Records

Your status as a CASA/GAL volunteer will advise information keepers that you are allowed access to records—even records that would otherwise be confidential—pertaining to the child in your case. The court order appointing you as the child’s advocate provides fairly wide latitude. Present photo identification and copies of your legal appointment when you visit an agency to seek information, or if any source from whom you seek information asks for them. Always remember that you have enormous responsibilities with handling and protecting confidential information.

### WHAT IS CONFIDENTIAL?

The legal definition of “confidential” varies from state to state. Some laws are quite clear and others vague. The facilitator will share with you the definitions and rules in your region. You must regard as confidential any information that the source deems confidential. It is especially important that the name of any person who has made a report of suspected child abuse and neglect not be revealed.

There are legal privileges that protect attorney/client, doctor/patient, clergyperson/congregation member, psychologist/patient and caseworker/client communications. Such communication, whether verbal or written, is all confidential and must remain so unless a court order specifically states otherwise. You are not allowed to share information with anyone other than the child, CASA program staff and attorney(s), the caseworker and the court unless a local or state order allows for a broader sharing of information.

You need not treat conversations with neighbors and friends who voluntarily give information as legally confidential. Also, if you speak with a teacher who is not providing confidential school records but rather sharing impressions, these impressions would not be confidential unless the teacher requested that they be kept as such. This information, although not legally confidential, is still private and should not be shared except on a “need-to-know” basis, and then only with those people who need the information to better serve the child.



## **PROCESSES FOR OBTAINING INFORMATION FROM AGENCIES**

The process for obtaining information from agencies and schools differs from program to program. For example, information may be obtained by lawyers through a process called “discovery,” or it may be up to the volunteer to obtain those records. Follow the direction of your program on how best to access child protective services documents, school records, and other information.

Parents’ records are often more difficult to obtain. They or their attorneys may resist your efforts to access certain records if the information might damage the parents’ credibility and their chance to have their child returned home. There are some caregiver records that you will not be able to access due to law. This is most likely to occur with drug information, doctor and hospital records, and mental health records.

The best way to ensure your ability to obtain confidential records for a parent or other adult party to a case is to submit a release of information signed by the parent to the agency from which you request records. A release of information is a signed statement by a client authorizing a third party (in this case, you) with access to the client’s confidential information. Many agencies require that you use their form, so look into downloading or getting it before you visit.

Many child welfare agencies, hospitals and schools do not honor walk-in records requests. Plan to call ahead, and request that records be pulled for you to read at a certain date and time. Some hospitals and agencies will allow you to make copies on their machines; others will ask you to mark the requested pages and will send the copies to you. Your local program will advise you on how to access medical records. They may post hospital names and contact information on their website or provide a handout with that information. If you are denied access to records, contact your supervisor for support.

## **CONFIDENTIALITY AND YOUR RESPONSIBILITIES**

The CASA/GAL volunteer may not release confidential information except to the child, CASA program staff, the attorney(s) on the case, the caseworker, the court, and others as instructed by law or local court rule.

## ***Obtaining Confidential Case-Related Records***

There will be times when it will be tempting to share information with others—for example, when a person has just finished sharing information with you or when you believe doing so might help your assigned child. However, your role is to be an information gatherer for the court, not a transmitter of information to others. If certain information needs to be shared, consult with your supervisor to determine how you might facilitate communication among others without violating confidentiality yourself. Mistakes in handling confidential information can be detrimental to the children involved and can bring criminal action against the people who misuse the information. When in doubt, discuss any confidentiality concerns with your supervisor!

## **WHAT ABOUT SHARING INFORMATION WITH THE CHILD?**

You develop a meaningful relationship with the child in order to make sound, thorough and objective recommendations in the child’s best interest. The volunteer also ensures that the child is appropriately informed about relevant case issues, considering both their age and developmental level. This includes impending court hearings, the issues to be presented, the recommendations of the volunteer and the resolution of those issues. If there is any question about what information should be shared with the child, ask your supervisor for guidance.

## **SHOULD YOU TELL A SOURCE THAT YOU INTEND TO SHARE THEIR INFORMATION?**

There does not appear to be any legal requirement that you disclose to a source your intent to share information. However, it is important to be respectful and honest about your intentions with regards to the use of the information. When introducing yourself as a CASA/GAL volunteer, mention that your role includes gathering information in order to make recommendations to the court. Never promise that you will not share information received.

## **SHARING INFORMATION WITH FOSTER PARENTS**

As a CASA/GAL volunteer, you are not the foster parents' source of information about the child's case, nor are you their advocate. Your job is to focus on the child's needs and keep the child informed about the case in an age-appropriate manner, gather information for the court and make recommendations. Foster parents may seek information from you about the children in their care, but their contractual relationship is with the child protective services agency or a private licensing agency.

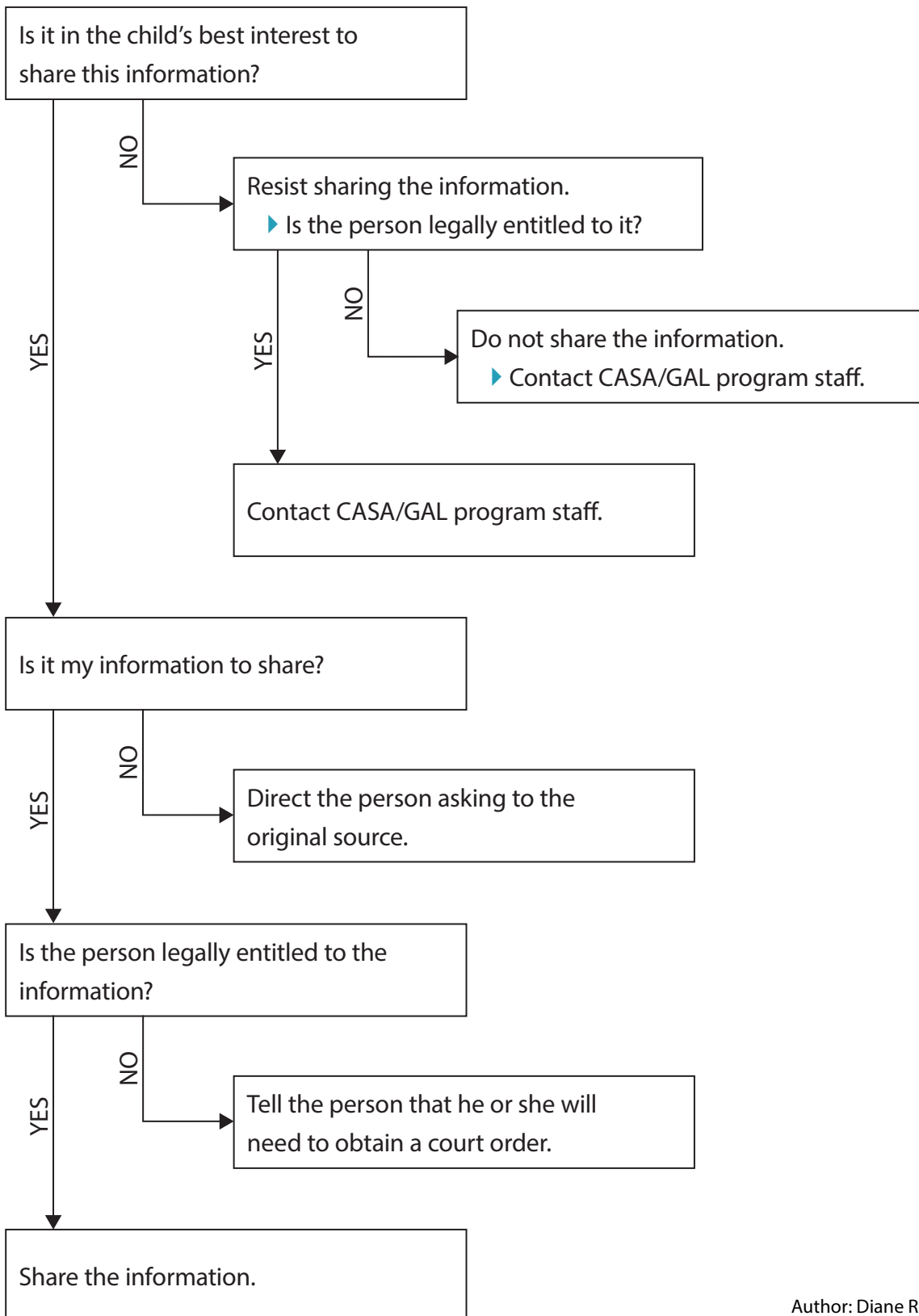
To provide adequate care, foster parents do need to know relevant information regarding the child. In fact, federal law requires that the child protective services agency provide the foster parent with the child's health and education records at the time of placement, updated periodically and each time the child is moved to another placement. These records must include, at a minimum, the following:

- Names and addresses of the child's health care provider and school
- The child's immunization record, known medical problems and medications
- The child's school record with current grade-level performance
- Other relevant health and education information (e.g., behavioral problems and/or disabilities)

There may be instances where you have information that would help a foster parent care for a child. Suppose, for instance, that you know the child has a history of sexual victimization and that they have been moved from an earlier foster home after being found in bed with a younger child. The current foster parent does not have this information, and there is another young child in the home. In such a case, it is clearly in the best interest of both the child and other children in the home that this information be shared.

After discussing the issue with your supervisor to determine the best approach, you should contact the caseworker and state a clear expectation that this critical background information be shared by the caseworker with the current foster care provider. As a CASA/GAL volunteer, you should not share this information yourself.

## SHOULD I SHARE INFORMATION WITH SOMEONE ELSE ABOUT THIS CHILD OR THIS CASE?



Author: Diane Robinson

## Time Is of the Essence in Case Communication

There is no time to waste on anyone's part in a child welfare case. The juvenile court system functions on strict timelines, which are in place so children progress toward a safe, permanent home and do not languish in out-of-home care. As an advocate, you may have to function as the timekeeper to push things along and keep everyone aware of the urgency. Please take every opportunity to respond immediately to communication, to keep the process going.

Children and parents need services put in place as quickly as possible. Timelines and deadlines intended to protect children can make successful completion of a case plan difficult for parents, especially those with drug and mental health issues. Every person on a case needs to understand where the case stands—including roadblocks, setbacks and successes. This will give the parents the best chance at reunification and the child the best chance at finding a safe, permanent home. Time is of the essence!

You will need to speak with numerous people during the life of a case, many of whom have different mandates and rules to follow. Each may have critical information that you need.

Keeping lines of communication open with all parties and professionals is essential. Be a facilitator of communication and avoid being part of a communication breakdown. Open, respectful communication among everyone involved is critical to serving the child's best interests.

## Initial Case Notes for the Greene Case

CPS Case File					
Last Name of Case: Greene			Legal Number(s): 08-5-54321-5		
Child(ren)'s Name	DOB	Age	Ethnicity	Sex	Current Location
Marky Greene	2/15	6 years	White	M	Home of bio mother & father

Current Caretaker(s)	Address	Phone
Bio Mother: Judy Greene Bio Father: Roy Greene	4810 Old Mill Rd	555-5454

Attorneys for:		
Mother	Darlene Wright	555-6000
Father	Walt Harris	555-8727
CPS	Robin Jackson	555-6552
Child	Chase Kelley	555-0311

Case History
<p>Two weeks ago:</p> <p>A call was made to the CPS hotline by the kindergarten teacher and school nurse at Parkside Elementary. The callers stated that one of their students, Marky Greene, often comes to school with poor hygiene, that much of his clothing is not his size, and that he's just come in with his third case of head lice in three months.</p> <p>This CPS social worker (SW) interviewed the child's parents, Judy and Roy Greene. The family is Caucasian; the parents are in their late twenties. Per medical records, mother was diagnosed with bipolar disorder as a senior in high school. The Greene family moved here from a few states away. They have no extended family living nearby.</p>

Case History continued

SW found conditions in the home deplorable but not dangerous. CPS decided to file a petition for neglect but to allow the child to remain at home for the time being.

Adjudication and disposition hearings were held the same day. Both parents attended. It was determined that the child’s placement will continue in their home until the three-month review hearing. Parents were ordered to cooperate with CPS treatment plan. Judge admonished them to work hard and pointed out that Marky was still under court’s jurisdiction. He ordered CPS to not hesitate to take physical custody, should conditions in the home or family deteriorate.

CASA History	Person(s)	Date Assigned	Date Terminated
Case Initially Assigned to:	You and your team	Today	N/A
Current CASA Volunteer:	You and your team	Today	
CASA Supervisor:	Jessica Clarkson		
CPS Social Worker:	Becky Howard		

Court-Ordered Services
For the Child: <ul style="list-style-type: none"> <li>• Educational needs met as appropriate</li> </ul>
For the Father: <ul style="list-style-type: none"> <li>• Psychological evaluation and treatment/counseling (if recommended)</li> </ul>
For the Mother: <ul style="list-style-type: none"> <li>• Psychological evaluation and treatment/counseling (if recommended)</li> </ul>

**END OF PRE-WORK FOR CHAPTER 4**