SYSTEMS-BASED PRACTICE
THE CHILD WELFARE SYSTEM

SYSTEMS-BASED PRACTICE: CHILD WELFARE SYSTEM OBJECTIVES*

Knowledge
The resident will demonstrate an adequate knowledge of the following:
1) The basic elements of the child welfare system: core mandates, definitions of child abuse and neglect, and information about frequency of abuse and neglect. (1,2,7,10)
2) The range of potential roles, responsibilities, and services of the child welfare system, possible outcomes for child and family, court-related processes and protections, the family service plan, and key federal legislation related to the child welfare system. (1,2,7,10)
3) Value-based practices within child welfare, in particular: family-centered practices, cultural competence, and multi-system collaboration among stakeholders. (1,11)
4) Common pitfalls for professionals working with children and youth, biological families, and foster families, and for mental health providers, including child and adolescent psychiatrists, working with child welfare workers. (1,11)
5) Potential roles for the child and adolescent psychiatrist in working with children and families involved with child welfare, which include the following: serving as an advocate for trauma informed care and identifying childhood trauma; performing psychiatric evaluations; prescribing and monitoring psychotropic medication, when indicated; participation in child and family teams; specific work with the child welfare system and the courts; and, at times, being a mandated reporter. (1,12)

Skills
The resident will demonstrate the ability to:
1) Have an empathetic understanding of the needs of children and adolescents in child welfare and the needs of biological families, foster families, child welfare workers, adoptive families, and others. (1,4,5,7)
2) Form relationships and partner with the child’s family and caregivers – biological family, foster family, and adoptive family – consistent with family-centered and family-driven practices, including the provision of services that are culturally competent. (1,4,5,7,9,11)
3) Describe the nature and purpose of a service plan for a child who is involved with child welfare. (1-12)
4) Evaluate a child or youth involved with child welfare, regardless of where the child is living or placed. The evaluation report should include information regarding maltreatment/trauma as part of the “History,” discuss its impact in the “Formulation” or “Discussion” section, and suggest interventions in “Recommendations.” (1-11)
5) Obtain a trauma history and to describe the range of consequences and symptoms that may follow severe, chronic maltreatment and other childhood trauma. (1,2,5,7,10)
6) Participate collaboratively in a child and family team involving a child or adolescent in child welfare, his/her family, involved system representatives, and other involved stakeholders identified by the family. (1-12)

* Parentheses refer to systems-based practice competencies in the RRC Program Requirements. 1 See Appendix 1 for complete list of competencies.
Attitude
The resident will demonstrate the commitment to:
1) Promote the safety, permanency, and well-being of the child, with the goal of the child remaining in, or returning to, the biological family whenever possible. (1-11)
2) Appreciate that childhood maltreatment and other childhood trauma can disrupt a child’s psychosocial development, manner of coping and behavior, necessitating the need to advocate for trauma informed care for children and adolescents. (1,2,4,5,7-11)
3) Identify and build on the strengths of the child, and not be organized solely by the child’s behaviors and/or the family’s initial response to professionals. (1,2,4,5,7-12)
4) Appreciate that positive change does occur through the unified efforts of participants within a well-organized child and family team. (1,2,4,5,7-11)
5) Remain non-judgmental and non-blaming regarding abuse or neglect allegations or findings, in order to form a positive relationship with the child’s parents. (4,5,9-11)
6) Support the work of child welfare professionals, offering feedback, when indicated, with respect and tact. (1-12)
OVERVIEW

Child and adolescent psychiatrists (CAPs) regularly work with children and adolescents involved in, and at risk of involvement in, the child welfare system. Therefore, it is important the mandates, definitions, roles, services, and responsibilities of the child welfare system be understood. It is also important that the culture and value system of child welfare be appreciated. Of particular significance is the emerging convergence of values between child welfare and mental health despite the fact that their respective mandates are different. Familiarity with evidence-based and promising practices in child welfare is also important, and there is much that the two systems can learn from one other.

It is important that the CAP understand potential pitfalls for mental health professionals in their cross-system work with children, adolescents, and families involved with child welfare, and with child welfare professionals. With recognition of these pitfalls, the CAP can be better prepared to consider a variety of meaningful roles at the interface of mental health and child welfare, and within child welfare.

The trainer will need to help the resident appreciate that mastering the specific information offered below is worthwhile and important. With the basics at hand, the CAP becomes better able to forge the connections necessary for genuine collaboration.

I. INTRODUCTION

A. The child welfare system, mandated by the federal government, involves a variety of services designed to ensure the safety, permanency, and well-being of children, and to strengthen families. The child welfare system is not a single entity and involves many organizations. Some child welfare services are provided by state and local departments of social services, while others are contracted to private child welfare agencies.

Permanency involves provision of a legally permanent, nurturing family for children. Permanent families may involve the child’s biological family, adoptive families, legal guardians (legally committed for the child until age 18 without formal adoption), and relatives who obtain legal custody or choose to become foster parents (known as kinship care).

B. The child welfare system becomes involved when there is concern that a child or adolescent (up to age 18) is being neglected or abused, or is at risk of being neglected or abused. At such time, a Child Protection Worker (CPW) becomes involved. In this module, the part of the child welfare system involved in investigating and responding to alleged or actual child abuse or neglect is referred to as Child Protective Services.

C. Child abuse and neglect, according to the Federal Child Abuse Prevention and Treatment Act (CAPTA, Public Law 108-36), involves “any recent act, or failure to act, on the part of a parent or caretaker which results in death or serious physical or emotional harm, or sexual abuse or exploitation, or presents an imminent risk of serious harm.”

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D. Child abuse and neglect are significant public health concerns in the United States. In 2004, there were 872,000 child abuse and neglect victims, according to the National Child Abuse and Neglect Data System (NCANDS) report. Child abuse most commonly takes place in the home, from a person the child knows and trusts.\(^3\)

While child abuse and neglect occur across all socioeconomic and ethnic groups, it is recognized that families living in poverty are at increased risk. A criticism of child welfare by some is the concern that children of poor, minority parents are disproportionately removed from their families and placed in foster care.

E. Although states may define the term “caretaker” differently, there are national statistics on the various perpetrators of child abuse and neglect\(^3\):

2. Other relatives accounted for 6.5% of the abuse and neglect.
3. Day care providers accounted for 0.7%.
4. Residential staff accounted for 0.2%.
5. Foster parents accounted for 0.4%.
6. Unmarried partners of parents accounted for 4.1%.
7. By gender distribution, in 2004, 57.8% of child abuse and neglect perpetrators were female, while 42.2% were male.

F. There are four types of abuse or neglect, specifically, “neglect,” “physical abuse,” “sexual abuse,” and “emotional abuse;”

1. **Neglect** involves failure by a parent or other responsible caretaker to provide for a child’s basic needs – physical, educational, medical, and emotional. Insufficient money does not constitute neglect, but rather represents a family’s need for assistance.

   *Signs and symptoms of neglect may include: child appears malnourished, or begs, steals or hoards food; poor hygiene; unattended medical problems; child states no one is home to provide care; child or caretaker abuses drugs or alcohol.*

2. **Physical abuse** involves causing injury to a child by beating, kicking, biting, burning, shaking, or other means. Physical abuse may result from injury even when the parent or caretaker did not intend to hurt the child, as when physical punishment causes injury. The parent is responsible for the child’s safety even when someone else in the home causes the injury.

   *Signs and symptoms of physical abuse include: unexplained bruises, burns, or welts, or broken bones; child unable to explain the injury, or the explanation is not consistent with nature of the injury; child is frightened of parent or caretaker, or is afraid to go home; child reports intentional injury by parent or caretaker.*

3. **Sexual abuse** involves any type of sexual activity or sexual contact by a parent or other caretaker with a child. It also includes sexual exploitation, as with promoting child prostitution or child pornography.
Signs and symptoms of sexual abuse include: age-inappropriate, sexualized play with toys, self, or others; inappropriate knowledge about sex; pain or bleeding in genital or anal area, with redness or swelling; child directly reports sexual abuse.

4. Emotional abuse involves parental or caretaker actions that can hurt a child’s emotional health, including screaming, name-calling, rejecting the child, or withholding affection.

Signs and symptoms of emotional abuse include: parent or caretaker constantly criticizing, threatening, belittling, insulting, or rejecting the child, with absence of love, support, or guidance; extremes in behavior by the child, from aggressive to passive; delay in physical, emotional, or intellectual development.

II. ROLES, SERVICES AND RESPONSIBILITIES OF THE CHILD WELFARE SYSTEM

A. Roles of Child Protective Workers include:
1. Responding to and investigating reports of child abuse or neglect.
2. Determining whether or not the child abuse or neglect allegations are substantiated or not.
3. Determining whether or not it is safe for the child to remain in the family home or is in need of immediate out-of-home placement.
4. Working in concert with the courts, leading to a determination of whether custody of the child needs to be transferred to the child welfare system.
   a) At times, the court determines that custody is divided, with the parents maintaining physical custody (e.g., the child continues to live with the family), while Child Protection Services maintains legal custody.
   b) At other times, the CPWs or the court determines that the family can maintain legal and physical custody.
   c) In highly unsafe situations, the court determines that Child Protection Services needs to assume both legal and physical custody of the child, and the child is placed out of the family home.
5. Providing, or arranging for the provision of, a variety of services for the child and family, and for alternative caretakers, when a child is placed in their care.
6. Promoting preservation of the biological family by either helping a child remain at home or preparing for family reunification when consistent with the family service plan and the determination of the court.
7. Collaborating with involved professionals from other child-serving systems.

B. Services and responsibilities of the child welfare system – all in some way related to the mandate to ensure the safety, permanency, and well-being of children under the age of 18 years – may include the following, depending on the needs of child and family, and the age of the child:
1. Responding to, investigating, and taking appropriate action in response to suspected child abuse or neglect.
2. Service planning, when child protection concerns are documented.
3. Provision of in-home services to families, in support of the child or youth being able to remain safely in the family home.

4. Provision of out of home placements for the child:
   a) Emergency shelter, often for less than 24 hours.
   b) Emergency foster care placement, which can be for up to 30 days or more, at times also becoming a long-term placement for the child.
   c) Foster home.
   d) Treatment Foster Care (a more intense, therapeutic type of foster home).
   e) Kinship care (placement with extended family).
   f) Residential placement.
   g) Pre-adoptive placement and adoption.
   h) Group home placement.
   i) Supervised independent living for youth.

5. Based on identified psychiatric need, a child may be temporarily placed in an inpatient psychiatric hospital for treatment.

6. Provision of prevention services for the family.

7. Post-adoption services for families that adopt a child.

8. Services that support a youth’s transition to adulthood, including support for independent living and a possible board extension to remain in care from age 18 to 21.

C. Child protection-related court processes and applicable time lines:

1. *The preliminary (or emergency) protection order*: The CPW petitions the court that handles juvenile or family court matters, in order to gain temporary custody of the child and place the child out of the family home, based on immediate concerns about abuse or neglect.

2. *Emergency removal hearing*: This hearing takes place a short time after the emergency protection order is granted to determine if the emergency protection order was justified and if there is a continuing need to have the child placed out of the home. It can also be referred to as a detention hearing.

3. *Adjudicatory hearing*: Recommended to occur no later than 60 days from the time of the child’s removal from home, this hearing determines if abuse or neglect in fact occurred, with the determination typically made by a judge. It can also be referred to as a jurisdictional hearing.

4. *Dispositional hearing*: The court determines who will have custody of the child and where the child will live (e.g., the disposition of the child is determined).
   a) While there is no federal timeline regarding when the dispositional hearing must occur, some guidelines recommend that it occur no more than 30 days after the adjudicatory hearing.
   b) In some cases, the dispositional hearing occurs at the same time as the adjudicatory hearing.
   c) If the court determines the child needs to be removed from the home, it will also mandate Child Protection Services to make “reasonable efforts” to help the family get the child back home, unless there are “aggravated circumstances” that override the usual process of helping the family get the child back (e.g., child abandonment, failure to improve family situation, attempt to harm or murder another child,
involuntary termination of parental rights to another child, or other circumstance as defined by specific state statute).

5. Review hearing: A review hearing, scheduled to occur at least once every 6 months while a child is in placement, reviews the service plan and the progress made by the child and the family seeking the child’s return.

   *A determination is also made as to whether or not the contracted child protection agency has made “reasonable efforts” to promote the child’s return home, consistent with the family service plan.*

The review hearing may be conducted in court or by a separate administrative panel composed of at least one member not directly responsible for the services the child and family receive.

6. Permanency hearing: This hearing determines the nature of the child’s permanent home. It is held at the latest between 12-14 months after the child is placed, assuming that the child has not already returned home.
   a) If the child remains in foster care longer than 12 months, then a permanency hearing must be held at least every 12 months thereafter.
   b) If the court decided at the dispositional hearing that “reasonable efforts” were not indicated to help the child return home, then the permanency hearing must occur within 30 days of that decision.

7. Termination hearing: This hearing, per federal law, takes place when a child has been in foster care for 15 of the most recent 22 months, and can result in the termination of rights of the biological parents.
   a) Once parental rights are terminated, the biological parents can no longer make decisions about the child.
   b) The child is then legally free to be adopted by another family.
   c) In some situations, the termination hearing occurs earlier than described above, as when parent abandons the child, makes no efforts to improve the situation that created the need, or attempts to harm or murder another child.
   d) In some situations, termination of parental rights are not pursued according to the 15/22 guideline, as when the state has not provided the family with necessary services, or the parent is making progress but needs more time.

8. Representation for the parents and the child at hearings:
   a) Parents are entitled to be represented by a lawyer. In most states, this can be obtained at no cost, if the family cannot afford their own lawyer.
   b) The child has his/her own, separate legal representation, usually provided by a guardian ad litem. The guardian ad litem, who is usually but not always a lawyer, is appointed by the court to represent the best interests of the child. In some jurisdictions, the youth may have both a guardian ad litem and a separate attorney.
   c) In some states, a Court Appointed Special Advocate, a trained volunteer who usually is not a lawyer, represents the best interests of the child.

III. THE SERVICE PLAN
A. The plan to ensure safety, permanency, and well-being for the child, which typically identifies required changes by the biological family in order to have the child remain or return home, is called the service plan (also referred to as the family service plan).

B. The service plan is a formal agreement between Child Protection Services and the parents, and is signed by the parents. The parents are given a copy of the plan to keep.

C. The service plan includes an assessment of strengths and needs, including the reason for Child Protection Services involvement, and then lists goals, objectives, and time frames.

D. It is expected that the child’s parents are given the opportunity to participate actively in the development of the service plan. If age-appropriate, the child or youth should also participate.

E. The service plan is reviewed at least every 6 months, and can be changed, as circumstances change.

IV. HISTORY AND APPLICABLE FEDERAL LEGISLATION

A. In 1909, the First White House Conference on the Care of Dependent Children upheld the importance of children growing up in families, including the need for children without families to be placed in the community with substitute families rather than in orphanages.4

B. Although there has been recognition of the importance of biological families to children, the child welfare system has, through the years, tried to balance the desirability of children remaining in – or returning to – their families with issues related to the safety of children in situations where significant safety concerns exist in the biological family.

C. The foster care system, rather than a temporary placement for children on their way to permanency, became prolonged, and many children grew up in the custody of Child Protection Services without either a return to their biological family or adoption by another family.

D. The Child Abuse Prevention and Treatment Act (CAPTA, Public Law 108-36),2 initially passed in 1974 and then renewed in 1996, 2002, and 2003, had key goals to improve child safety: increasing identification, reporting, and investigation of child maltreatment; developing uniform reporting and response across the country; and enhancing the federal government’s role in the detection, prevention, and treatment of child abuse.
   1. The 2003 re-authorized version of CAPTA is referred to as the Keeping Children and Families Safe Act of 2003.
   2. The law currently provides for: investigation of child abuse and neglect; prosecution of child abuse; child abuse prevention services and grants; and training for child protection service workers.

E. The Adoption Assistance and Child Welfare Act of 1980 (Title IV-E of the Social Security Act, Public Law 96-272)5 provides the largest federal funding stream for child welfare services. The law requires child welfare agencies to make “responsible efforts” to keep families together and to return children in foster care to their original homes.” Goals of the law included:
1. Prevention of unnecessary separation of children from their families, with services and supports to the family, as needed.
2. Reduction of both the frequency of placement of children in foster care and the duration of a child’s stay in foster care, with foster care reconceptualized as a temporary service.
3. Promotion of the return of children to their families.
4. Improvement of the quality of care and services.
5. Promotion of adoption, when in the child’s best interests.

F. The Adoption and Safe Families Act of 1997 (ASFA, Public Law 105-89)\(^6\) extended the goals of the Adoption Assistance and Child Welfare Act of 1980, and established as the primary goals of the child welfare system the safety, permanency, and well-being of children in its care:
   1. ASFA mandates that children gain permanency, either with their biological family or through some other means.
   2. ASFA requires concurrent planning for family reunification and for termination of parental rights, leading to adoption. All reasonable options for permanency need to be considered at the earliest possible point following a child’s entry into foster care.
   3. Time frames for birth parent rehabilitation, leading to family reunification, are made shorter and stricter.
   4. The law’s 15/22 rule mandates that states move for termination of parental rights when a child has been in foster care for 15 of the previous 22 months, unless there is documentation of “compelling reasons for not pursuing termination.”
   5. The five acceptable permanency arrangements identified within ASFA involve the following: reunification, adoption, legal guardianship, living with a fit and willing relative, or another planned, permanent living arrangement.

G. The John H. Chafee Foster Care Independence Program, Title I of 1999 (Public Law 106-169)\(^7\):
   1. Provides funds to states to assist youth and young adults (up to age 21) who are leaving foster care, by providing educational, vocational, practical, and emotional services and supports.
   2. Title I of the Act gives states the option to extend Medicaid coverage to youth between 18 and 21 years, who were in foster care on their 18\(^{th}\) birthday.

V. THE EMERGING VALUE SYSTEM WITHIN CHILD WELFARE – FAMILY-CENTERED PRACTICE

A. Child welfare is working to become more collaborative with birth parents, some of whom have voiced concerns about being blamed and dictated to, rather than worked with by the system.

B. Family-centered practice within child welfare is based on two core values:
   1. The best place for children to grow up is in families.
   2. The most effective way to ensure children’s safety, permanency, and well-being involves providing services that engage, involve, strengthen, and support families.
C. Family-centered practice is a way of working with families that involves collaboration, partnership, mutual respect and trust, and open communication between parents and service providers in order to enhance the family’s capacity to care for and protect its children.

  *The basic premise is that the family is central to the child’s well-being.*

D. Family-centered practice is a concept applicable across systems, and is congruent with both Child and Adolescent Service System Program (CASSP) Principles, which emerged initially from the public mental health system and uphold the need for collaboration by professionals with families, and with system of care principles, which guide many communities in the development and implementation of human services for children and their families, with families seen as equal partners with professionals.

E. Family-centered practice and family-driven care differ in that family-centered practice has emerged in part from within child welfare, while family-driven care has emerged from within mental health. While in theory family-driven care affords the family greater opportunities for empowerment, interestingly one newly emerging child welfare practice, family group decision-making (FGDM), can be as family-driven as an effectively implemented wraparound process.

F. Key components of family-centered practice include the following:

1. Engaging, partnering with, and empowering families in goal setting and decision-making. Engagement includes listening carefully to child and family, providing emotional support and being respectful at all times.
2. Helping to stabilize families in crisis.
3. Building upon strengths during service planning and service implementation, with the family an active participant throughout the process.
4. Providing individualized, flexible, culturally responsive services.
5. Working with the family unit to ensure the safety and well-being of all family members, and strengthening the family’s capacity to function effectively.
6. Advocating for, and with, families.
7. Connecting families to resources that address identified needs.
8. Offering services that promote the prevention of child abuse to benefit at-risk families and also those in which abuse or neglect has already taken place.
9. Ensuring that professionals learn about the family’s culture and provide services that are culturally competent.
10. Promoting multi-system collaboration among diverse child-serving professionals and their respective systems.
11. Making use of evidence-based and promising practices, as with family group decision-making and Treatment Foster Care.

G. Family group decision-making (FGDM) is one family-centered practice being used by some child welfare agencies. It is considered one of the most advanced family centered practices.

1. FGDM, also known as family group conferencing, is an approach to problem solving in which the family is given the opportunity to develop its own solution.
2. FGDM was developed in New Zealand, and is now being used in over 20 countries. It can be used in child welfare both to prevent out-of-home placement of the child and to promote family reunification. FGDM as a tool is also relevant to juvenile justice.

3. FGDM embraces a broad definition of family – the biological family is encouraged to assemble a network of support from the extended family and community. A child welfare facilitator helps the biological family identify and recruit the family network.

4. During the actual family group conference, following the first two stages (the Introduction and Information Sharing stages), the family is given private time to develop a practical plan to address the safety and well-being needs of the child and associated needs of the family.

   *The family is given information about necessary “bottom lines” from the child welfare worker, and is free to develop a plan of their choice, within the limits of those constraints. The goal is for the family to develop a supportive network in conjunction with identified services from involved systems.*

5. During the final stage, the Decision Stage, the plan is presented to the child welfare worker and discussed. Assuming that it is acceptable, the worker then presents the plan to the court. In some cases, the worker may be empowered to approve the plan directly.

6. If the plan is effectively implemented, the desired outcome occurs (child remains at home or child is returned home). If the family is unable to effectively implement the plan, then the court may pursue a different permanency plan.

7. FGDM is typically used only in situations where there is moderate rather than extreme risk of harm to the child, and the focus is on child safety and the safety of others also. The process is strengths-based, and involves careful attention to the family’s culture.

8. FGDM has a developing evidence base.

H. Treatment Foster Care (TFC, also known as Multidimensional Treatment Foster Care) is an evidence-based approach to delinquent male youth developed by Oregon Social Learning Center.8

1. TFC involves intensive work with the youth, the Treatment Foster parents, and the youth’s parents/guardians.

2. Males ages 12-18 years, referred by the juvenile justice system due to history of chronic delinquency, are in a 6-month Treatment Foster family placement, with an individualized management program.

3. Goals for the youth include: reduced criminal behavior and substance use; reduced association with delinquent peers; improved school attendance and grades; and improved ability to live successfully in a family setting.

4. Goals for the youth’s family include: increased level of involvement with their child; improved parenting skills, especially supervision and use of effective discipline; and helping the youth engage in pro-social activities in the community.

5. TFC staff works with the youth’s family during the placement period and for a 12-month after-care period as well.
6. TFC has an evidence base: a randomized study comparing TFC with traditional group care placement found that youth in TFC had significantly better outcomes, including: fewer arrests, less frequent institutionalization, better school adjustment, more frequent return to their family, fewer psychiatric symptoms, and greater life satisfaction.

7. This approach is being adopted in many states, and it is also being adapted for use with delinquent adolescent females who also have serious mental health problems.

VI. PREVENTION OF CHILD ABUSE

A. Research has shown parents and other caretakers who have resources and support are more likely than those without such benefits to provide safe, healthy homes for their children.

B. Prevention of child abuse is a responsibility that extends beyond just the child welfare system:
   1. Physicians, teachers, therapists, community members, and others are all responsible for being alert to, and reporting, suspected child abuse, as established by federal law. Such reporting can be done directly or anonymously, by contacting the state’s designated Child Abuse Hotline. In some cases, the county Child Protection Services office may also be contacted.
   2. CAPs and other designated professionals (social workers, health care workers, mental health professionals, school personnel, child care providers, medical examiners, police, and in some states clergy) are “mandated reporters:”

      Mandated reporters are required by law to report suspected child abuse or neglect, and are granted immunity from prosecution in doing so.

   3. Because poverty is a risk factor for child abuse and neglect, it is the responsibility of the community and society as a whole to provide services and support to families experiencing limited resources.

C. The child welfare system typically has an array of services that seek to prevent child abuse and neglect in at-risk families and to ameliorate child abuse and neglect and prevent further episodes in families where this has already occurred. Preventive services include the following:
   1. Parent education.
   2. Parent support groups.
   3. An array of in-home services.
   4. Respite care.
   5. Other forms of family support.
   6. Linkage and referral to other services and to natural supports in the community.
   7. When a child is receiving services from another system (e.g., mental health), coordination of child welfare services with these services also promotes prevention.

D. Other child-serving systems also have opportunities for prevention, beyond reporting suspected child abuse or neglect:
1. Pediatricians and other primary care physicians play a key role in providing education and anticipatory guidance, answering parent’s questions, and making referrals to other agencies, when indicated.
2. Day care settings can provide information to parents about their child, and promote the child’s development.
3. Schools can also provide information to parents about their child, and promote the child’s development.
4. Faith groups can help prevent child abuse and neglect in a variety of ways.

VII. POTENTIAL PITFALLS FOR CHILD WELFARE WORKERS AND OTHER PROVIDERS, INCLUDING THE CHILD AND ADOLESCENT PSYCHIATRIST

A. Pitfalls in relation to the child or youth:
   1. Not learning about and recognizing the child’s trauma and maltreatment history.
   2. Not understanding how child maltreatment and other trauma affect the child’s neurobiology, brain morphology and functioning, and the overall psychosocial process.
   3. Not understanding that children in foster care and other out-of-home placements experience the trauma of being removed from their home and family in addition to whatever other specific maltreatment may have occurred.
   4. Viewing the child or youth solely in terms of problematic behaviors, without seeking to understand the underlying basis of the behaviors.
   5. Personalizing the child’s behaviors as intentional and labeling them as “manipulative” and “attention seeking.”
   6. Trying to convince a child that loyalty toward biological parents is inappropriate.
   7. Overlooking the possibility that the child might still be experiencing trauma in his/her current residential setting or placement.

B. Pitfalls in relation to the biological family:
   1. Assuming that the parents do not care about the child, and are incapable of changing.
   2. Blaming the parents for their abuse or neglect of the child.
   3. Mandated reporting of possible neglect and abuse, which can create tension in the professional’s relationship with the family. Nevertheless, mandated reporting must occur, when indicated.

C. Pitfalls in relation to the foster family (or pre-adoptive family):
   1. Assuming that the foster family understands the dynamics of child trauma and maltreatment.
   2. Assuming that the foster family is only in it “for the money,” and/or underestimating the degree of desired involvement and attachment of the foster parents.
   3. Assuming that the foster family understands the use of psychotropic medication.

D. Pitfalls for CAPs in relation to the child welfare system:
   1. Not understanding how current federal legislation and the need to ensure safety, permanence, and well-being drives child welfare practices.
2. Not appreciating the CPW’s difficult tasks of determining the presence or absence of abuse, and determining the best disposition for the child.
3. The strict operational criteria for a formal abuse finding, which can at times result in an unsubstantiated finding even when the reporter believes that abuse did occur.

VIII. ROLES FOR CHILD AND ADOLESCENT PSYCHIATRISTS

A. CAP as an advocate for trauma informed care:
   1. Unfortunately, the identification of, and appropriate interventions for, childhood maltreatment do not reliably occur within mental health and other human services.
   2. The CAP can play an instrumental role in promoting trauma informed care within mental health and other involved child-serving systems.
   3. Trauma informed care involves recognition of the pervasiveness of childhood trauma, including childhood maltreatment, in the lives of children and adolescents, and the consequences of such exposure when chronic and severe, so that appropriate interventions can be developed to address the trauma and promote the child’s healthy development.
   4. At the level of the individual child, trauma informed care involves obtaining a trauma history, ensuring the safety of the child, and developing interventions that reverse or mitigate the symptoms and other consequences of the trauma.
      a. Symptoms of significant traumatic exposure can involve any or all of the 3 core symptoms of posttraumatic stress disorder (PTSD): re-experiencing, avoidance, and hyperarousal.
      b. In addition, such children and adolescents often are guarded and slow to trust, quick to anger, and vulnerable to act in an oppositional, defiant manner. The latter may lead some adults to mistakenly focus only on the behavior and not on the underlying anxiety and concerns about survival that may be driving it.
      c. Other children and adolescents respond primarily with internalizing responses, which can include withdrawal, passivity, flattened or depressed affect, retreat into fantasy, and more extreme dissociative behaviors (episodes of depersonalization, derealization, or dissociative identity disorder).
   5. Trauma informed interventions seek to avoid coercive practices and potential re-traumatization of the child, including avoidance of seclusion and restraint except as an emergency safety intervention of last resort. Trauma informed care also involves staff collaborating with the child, offering meaningful choices, and promoting the child’s self-awareness and acquisition of coping skills.
   6. The CAP can fulfill the role of advocate for trauma informed care in many ways, including the following: performing psychiatric evaluations, serving as member of a child and family team, consulting to schools, prescribing and monitoring psychotropic medication, consulting to a child welfare agency, completing court-requested evaluations, and becoming a mandated reporter, when indicated.

B. CAP as clinician providing psychiatric evaluation of the child:
   1. Review all available information about child, and talk with referring child welfare worker and others for collateral information.
2. Include the current caretakers of the child in the evaluation process, whenever possible.
3. Include the biological parents of the child, whenever possible, especially when family reunification is imminent or planned.
4. Present yourself as welcoming and non-intimidating with child and family, and engage them.
5. Ask about, and identify, individual and family strengths. These are essential.
6. Seek to understand the situation from the point of view of the child and family.
7. Obtain a thorough trauma history and developmental history, and be alert for posttraumatic signs and symptoms.
8. Identify signs and symptoms that might be a result of either trauma or other psychiatric conditions, especially when the child's behaviors have been regarded as “intentional” in nature. Children often express distress behaviorally.
9. Expect that many families will appear guarded due to prior, negative experiences with professionals. When this occurs, work even harder at engagement.
10. Write a comprehensive, respectful evaluation report that is free of jargon, which addresses the consultation question and provides direction to the team:
   a. Include information about the child’s maltreatment and trauma within the “History” section of the report.
   b. Discuss the impact of the trauma on the child in the “Formulation” or “Discussion” section.
   c. The “Recommendations” section should suggest interventions to address the trauma and promote trauma informed care, as well as offer additional recommendations to promote the psychosocial development and best interests of the child.

C. CAP as member of the child and family team:
1. The composition of the child and family team will vary, based on where the child is living and the legal status of the child and biological family. Team members, as well as others committed to the well-being of the child and family, even if not active team members, can be referred to as “stakeholders.”
2. If the child is living with the biological family, then the family will be encouraged to identify and expand its network of support.
3. If the child is living with a foster family, the child welfare system needs to address the needs of the biological family also, unless parental rights have been terminated.
4. Specific recommended practices:
   a. Learn the names and roles of each team member.
   b. Remember that you are only one of many experts. Support the contributions of child and family, and other team members. This is a team process.
   c. Promote a strengths-based perspective.
   d. Offer your ideas without taking over.
   e. Support the process and encourage the team. Gently refocus the team, when indicated.
   f. If it becomes necessary to disagree with a team member and/or offer corrective feedback, do so tactfully and respectfully.
D. CAP prescribing and monitoring psychotropic medication:
   1. Whenever possible, obtain a complete psychotropic medication history before prescribing medication. When this is not possible, obtain as much information as possible before moving forward, and maintain efforts to obtain missing information. Carefully documenting the medication history in conjunction with your own medication decisions will help the team and future providers.
   2. Be familiar with the requirements for informed consent for use of medication in your jurisdiction.
   3. Provide information about medication to child, family, child welfare worker, and other involved team members. Establish that there is a consensus in favor of medication use, or work to achieve that consensus.
      
      Help team members understand that medication is just one of many interventions.
      Help the parents understand that medication will be helpful only if the child takes it regularly. Help the child understand that medication will be helpful only if the child “works with it.”

   4. Identify how team members can assist you in monitoring the effects of medication.
   5. Maintain ongoing communication with the child’s primary care provider.
   6. Remain available for questions and concerns between appointments.

E. CAP as consultant to Child Protective Services and the child welfare system:
   1. Roles, and frequency of contact, may vary.
   2. CAP can provide training to staff, or meet informally with staff on a regular basis.
   3. CAP can provide psychiatric consultations, on request.
   4. CAP can consult directly to agency director on ways to improve coordination and care.
   5. CAP can help facilitate coordination of medical care.

F. Court-requested evaluations:
   1. These may involve an evaluation of the child, a parent, or both parents.
   2. At issue may be custody, termination of parental rights, or the clinical needs of the child.
   3. Address the identified question, and generally limit the report to this.
   4. Usually, providing evaluations for the court is not compatible with maintaining a direct care role.
   5. Determine if the court is actually seeking a forensic report or instead is trying to facilitate access to treatment and care. The functions of a forensic report and a clinical referral are quite different.

G. CAP as a mandated reporter:
   1. As with any involved professional, the CAP may at times be called upon to be a mandated reporter of child abuse or neglect.
   2. When this becomes necessary, the CAP needs to inform the parents directly and remain non-judgmental, making every effort to be supportive. The family should be
informed of the likely sequence of events, their rights as parents, and the opportunity to receive services, based on the outcome of the investigation.

IX. CONCLUSIONS

A. There is a great deal of information that the CAP needs to learn about the child welfare system and Child Protective Services in order to understand its mandates, roles, and responsibilities, the range of available services, and the possible outcomes for children and families when a child protection concern exists.

B. Family-centered practice is increasingly guiding the child welfare system. Family-centered practice involves principles of partnership and collaboration with families consistent with system of care principles. While family-centered practice may not in theory be as family empowering as family-driven care, it is positive that there is such convergence between child welfare and mental health.

C. In order to promote family-centered practice, the CAP needs to acquire specific skills and adopt certain values related to children and youth, families, the child welfare system, cultural competence, and multi-system collaboration.

D. Potential roles and opportunities for the CAP need to be understood, and CAPs are encouraged to become involved in some way in the larger system of care.
APPENDIX 1∗

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:

1) work effectively in various health care delivery settings and systems relevant to their clinical specialty;
2) coordinate patient care within the health care system relevant to their clinical specialty;
3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;
4) advocate for quality patient care and optimal patient care systems;
5) work in interprofessional teams to enhance patient safety and improve patient care quality; and,
6) participate in identifying system errors and implementing potential systems solutions.
7) know how types of medical practice and delivery systems differ from one another, including methods of controlling health care cost, assuring quality, and allocating resources;
8) practice cost-effective health care and resource allocation that does not compromise quality of mental health care for children and adolescents;
9) advocate for quality patient care and assisting patients in dealing with system complexities, including disparities in mental health care for children and adolescents;
10) work with health care managers and health care providers to assess, coordinate, and improve health care;
11) know how to advocate for the promotion of health and the prevention of disease and injury in populations; and,
12) instruct in the practice of utilization review, quality assurance and performance improvement.

REFERENCES

1. Accreditation Council for Graduate Medical Education. Program Requirements for Residency Education in Child and Adolescent Psychiatry. 


4. First White House Conference on the Care of Dependent Children. 


OTHER RESOURCES


Jean Roberts is an 8-year-old Caucasian female who lives in a trailer with her mother, father and 6 year old sister. Jean is in 2nd grade in a regular classroom in the local elementary school. Child Protective Services became involved after the school called the Child Abuse Hotline with concerns about possible neglect of Jean by her parents. Jean had been coming to school in dirty, torn clothes, and did not have good hygiene. Her school performance over the past two months has gone down, with Jean being off-task much of the time and staring out the window. When asked if anything is wrong, Jean would always smile and quietly say there is nothing wrong. Calls to the home by the teacher and guidance counselor have not been returned. The immediate circumstance that precipitated the call to the Child Abuse Hotline was when Jean’s teacher saw her trying to steal food from the school cafeteria. When asked why she had done this, Jean replied that her mother had not given her dinner the prior night or breakfast that morning, and she was hungry.

The Child Protection Worker, having made an initial visit to the home, indicates that the investigation is ongoing and that it is not necessary to remove Jean from the home on an emergency basis. The CPW has requested that you, as a school-based psychiatric consultant, proceed with an expedited psychiatric evaluation of the child, with the goals of assessing Jean’s current emotional state and recommending how to best address her needs.

1. What are some of the questions that you, as the CAP, would like to ask the CPW about Jean’s parents?

2. What is the definition of neglect? What are signs and symptoms of neglect?

3. What information would you like to have regarding Jean?

4. What type of collateral information would you like to obtain?
5. Assume that the problem involves a combination of lack of financial resources and multiple family stressors, including depression in Jean’s mother, the father working long hours to try to make ends meet, and increasing marital conflict, plus emerging signs of depression in Jean. What would be the best way to proceed?

6. What do you think your role should be, when the child and family team convenes?
Angel Rivera is a 17-year-old Latina who has recently been admitted to a transitional mental health residential treatment center (RTC). Angel, who is in 11th grade, is attending the facility’s on-grounds school. Angel has been previously diagnosed with bipolar disorder and Asperger’s disorder. There is no history of a substance use disorder. While Angel has reportedly benefited from psychotropic medication in the past, she is currently refusing medication. Angel has had problems with aggressiveness and a conflictual relationship with her mother, a single parent, for at least two years. It was approximately 1½ years ago, after Angel threatened to kill her, that Angel’s mother requested in-home psychiatric services. The family then received in-home services for approximately six months, but with only limited impact. There was no follow-up mental health treatment afterwards.

Approximately one month ago, Angel assaulted her mother and threatened to kill her. When her mother tried to have her admitted to a psychiatric hospital, Angel ran away from home. After police found Angel, she was admitted to a psychiatric hospital. At the time of discharge from the hospital, Angel’s mother was unwilling to have her return home. Hospital staff called child welfare, which took custody of Angel. Angel’s mother retained parental rights but not legal custody. Placement with a foster family was arranged, but Angel’s oppositional and defiant behaviors, along with a threat to the foster mother, led to the decision to place Angel in the current transitional residential treatment facility, which helps adolescents prepare for independent living.

Since her admission to the residential facility, Angel has had contact with her mother, who continues to be fearful of Angel, and with her 11-year-old half-sister. Angel has had intermittent contact over the years with her biological father who lives in the area. For the first two years of her life Angel lived with her mother and father, who never married. The couple separated after Angel’s mother became concerned about the aggressive behavior of Angel’s father, which included severe corporal punishment of Angel. Following the couple’s separation, Angel lived with her mother and maternal grandmother until her recent out-of-home placements. Neither Angel’s mother nor her father is regarded as an appropriate aftercare resource for Angel, and no other family members are available.

Within the RTC so far, Angel has been anxious but largely cooperative. She has not been aggressive, suicidal, or self-injuring. Angel has presented as gregarious, with elated affect. As a result of limited social skills, Angel has been socially awkward and verbally impulsive with peers, which has alienated many of them. Due to limited judgment and poor interpersonal boundaries, Angel has made inappropriate self-disclosures with peers, and has been flirtatious with many of the male residents. Thus far, staff is relieved that Angel has not been violent, but they are concerned about her elevated and inappropriate mood and her impulsivity. Staff believes that Angel would benefit from psychotropic medication.

You are Angel’s psychiatrist at the transitional RTC. Thus far, you have performed only a cursory admission assessment. You will be performing a comprehensive psychiatric evaluation and then serving in the role of psychiatrist in her treatment team.
1. Identify at least five critical tasks that the CAP should seek to accomplish while evaluating Angel.

2. Identify at least two critical tasks for the CAP in terms of working with Child Protective Services.

3. List the services and responsibilities of Child Protective Services that relate to Angel’s situation.

4. Given that Angel is an adolescent with very few resources, identify at least five presumptive goals for the team.

5. What are some possible reasons for Angel’s reluctance to use medication?

6. What are some potential service options within child welfare to support Angel’s transition to adulthood, with which the CAP should be familiar?