

SYSTEMS-BASED PRACTICE THE CHILD WELFARE SYSTEM Revised March 2020

SYSTEMS-BASED PRACTICE CHILD WELFARE SYSTEM OBJECTIVES*

Knowledge

The resident will demonstrate an adequate knowledge of the following:

- 1) Identify the following basic elements of the child welfare system: core mandates, definitions of child abuse and neglect, and information about frequency of abuse and neglect.
- 2) Identify 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.
- 3) Describe the following value-based practices within child welfare, in particular: family centered practices, cultural competence, and multi-system collaboration among stakeholders.
- 4) Discuss specific parameters of childhood trauma, including the following: the definition of trauma; the prevalence and the impact of trauma on children and adolescents; trauma screening; and the management of trauma, including provision of trauma informed care and trauma-specific treatment.
- 5) Identify 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.
- 6) Describe 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; serving as an advocate for evidence-based trauma-specific treatment when clinically indicated, and serving as a provider or supervisor of such treatment, when feasible; 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.

Skills

The resident will demonstrate the ability to:

- 1) Demonstrate the ability to 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.
- 2) Demonstrate the ability to 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.
- 3) Describe the nature and purpose of a service plan for a child who is involved with child welfare.

****Appendix 1 describes the systems-based practice competency in the RRC Program Requirements**

- 4) Demonstrate the ability to 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.”
- 5) Demonstrate the ability to obtain a trauma history and to describe the range of consequences and symptoms that may follow severe, chronic maltreatment and other childhood trauma.
- 6) Demonstrate the ability to participate collaboratively in a child and family team involving a child or adolescent in child welfare, his/her family, and involved system representatives, and other involved stakeholders identified by the family.
- 7) Demonstrate the ability to advocate effectively for quality services for children and adolescents in child welfare and their families, at the individual, agency and systems levels.

Attitudes

The resident will demonstrate the commitment to:

- 1) Maintain a commitment to 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.
- 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.
- 3) Maintain a commitment to 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.
- 4) Appreciate that positive change does occur through the unified efforts of participants within a well-organized child and family team.
- 5) Maintain a commitment to 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.
- 6) Maintain a commitment to support the work of child welfare professionals, offering feedback, when indicated, with respect and tact.

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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 that 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. The CAP needs to be familiar with the basics of trauma, including its prevalence and manifestations, and the role of trauma-informed care and trauma-specific treatment in addressing it. The responsibilities of those in child welfare and mental health overlap, and there is much that the two systems can learn from one other.

This module can be seen as consisting of three parts. The first part creates a context to enable the CAP to understand the workings of the child welfare system and those who enter this system. The context is delineated as follows:

- Introduction: Provides definitions of the child welfare system and the different types of child abuse.
- History and applicable federal legislation: Provides a chronology of the national focus on child abuse, from its origins up to the present, with particular attention to federal mandates and federal legislation.
- Understanding childhood trauma: Offers a definition and overview of childhood trauma, its impact on children and adolescents, trauma screening, and the benefits of trauma informed care and of trauma-specific treatment.

The second part of the module can be regarded as involving the nuts-and-bolts of the child welfare system. Topics addressed here involve the following:

- Roles, services and responsibilities of the child welfare system: The CAP cannot collaborate with child welfare unless this and the succeeding topics are understood.
- The service plan: The child welfare service plan addresses the specific needs of child and family in relation to the specific mandates of the child welfare system.

- Family-centered practice: This is the emerging value system within child welfare that prioritizes family participation in care and helps enable the child to remain in the family and community, consistent with child safety.
- Psychotropic medication prescribing: The focus here is on the special needs and challenges associated with prescribing psychotropic medication for youth in child welfare, an issue of high priority to the federal government and to the states.

The third and final part of the child welfare module addresses broader issues of relevance both to CAPs and society at large. These topics involve:

- Prevention of child abuse: CAPs, among others, are mandated reporters, but the challenge is to prevent child abuse, not just to report its suspicion.
- Potential pitfalls in child welfare: Given the complexity of the child welfare system and the number of involved stakeholders, there are many potential pitfalls, which can be avoided more easily once understood.
- Roles for CAPs: There are many satisfying ways that CAPs can serve both the child welfare system and the youth and families involved in it.
- Conclusions: Highlighting of key issues.

In making use of this module, the trainer will need to help the resident appreciate that mastering the specific information and concepts offered below is worthwhile and important. With the basics at hand, the child and adolescent psychiatrist becomes better able to forge the connections necessary for genuine collaboration.

INTRODUCTION

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 (known as kinship care).

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. In addition, although this is not consistent with the intent of the child welfare system, some children become involved with child welfare when they have severe mental health issues and existing family resources do not enable the child to be managed within the family.

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.”²

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 involves concern that it is the children of poor, minority parents who are disproportionately removed from their families and placed in foster care.

Although states may define the term “caretaker” differently, there are national statistics on the various perpetrators of child abuse and neglect³:

- Parents – including birth parents, adoptive parents, and step-parents – accounted for 78.5% of child abuse and neglect in 2004.
- Other relatives accounted for 6.5% of the abuse and neglect.
- Day care providers accounted for 0.7%.
- Residential staff accounted for 0.2%.
- Foster parents accounted for 0.4%.
- Unmarried partners of parents accounted for 4.1%.
- By gender distribution, in 2004, 57.8% of child abuse and neglect perpetrators were female, while 42.2% were male.

There are four types of child abuse – specifically, “neglect,” “physical abuse,” “sexual abuse,” and “emotional abuse:”

- 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; inadequate clothing and inappropriately dressed for the weather; presence of unattended medical problems; child states no one is home to provide care; child or caretaker abuses drugs or alcohol; caretaker failure to provide supervision of child; failure to educate child; failure to protect from exposure to domestic violence; and abandonment of the child.

- 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.

- 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.

- 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.

HISTORY AND APPLICABLE FEDERAL LEGISLATION

Child abuse and neglect was first recognized in the United States in New York in 1874 with the case of Mary Ellen, a child grossly abused and neglected by her stepmother. With nowhere to turn, a neighbor reported the abuse to the New York Society for the Prevention of Cruelty to Animals. The Society argued the case in court and the child was removed from the home and later adopted by the neighbor. As the police reporter covering the story presciently noted, "I knew I was where the first chapter of the children's rights was begin written." Within a year, the Society for the Prevention of Cruelty to Children had been founded.

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

Prior to the early 1960s, the problems of abused or neglected children had, for the most part, not been a concern of physicians, whose mission was to heal the sick, not deal with social problems. A landmark article, "The Battered Child Syndrome," published in 1962 in the *Journal of the American Medical Association* and coauthored by a pediatrician, a radiologist and a psychiatrist, caused a national outcry and prompted the first reporting laws in the nation. It was now the legal obligation of physicians and other health professional to report suspected cases of abuse or neglect. The article's lead author, Dr. C. Henry Kempe, had founded one of the first child protection teams in the nation in Colorado. He and others would later prove instrumental in developing individual therapy programs for abusive parents, as well as publish the highly esteemed, *The Battered Child*.

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.

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 the child welfare system without either a return to their biological family or adoption by another family. It is concern about this type of negative outcome that has driven much of recent federal legislation.

The Child Abuse Prevention and Treatment Act (CAPTA, Public Law 108-36)² initially passed in 1974 and then renewed in subsequent years, 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:

- The 2003 re-authorized version of CAPTA is referred to as the Keeping Children and Families Safe Act of 2003.
- 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.

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:

- Prevention of unnecessary separation of children from their families, with services and supports to the family, as needed.
- 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.
- Promotion of the return of children to their families.
- Improvement of the quality of care and services.
- Promotion of adoption, when in the child's best interests.

The Adoption and Safe Families Act of 1997 (ASFA, Public Law 105-89, US Dept of HHS; 1997)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:

- ASFA mandates that children gain permanency, either with their biological family or through some other means.
- 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.
- Time frames for birth parent rehabilitation, leading to family reunification, are made shorter and stricter.
- 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.”

- The 5 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.

The John H. Chafee Foster Care Independence Program, Title I of 1999 (Public Law 106-169, US Dept of HHS; 1999)⁷:

- 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.
- 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 18th birthday.

The Fostering Connections to Success and Increasing Adoptions Act of 2008 (Public Law 110-351)⁸:

- An extremely comprehensive law intended to promote adoption and kinship care for youth in or at risk of entering foster care, and to improve outcomes for youth in foster care.
- States have the option of providing kinship guardianship payments to grandparents and other relatives who have assumed legal guardianship of children for whom they commit to care for on a permanent basis.
- Enables child welfare agencies and experienced private nonprofit organizations to receive matching grants from the federal government, to help children in or at risk of entering foster care to reconnect with family members via a family reconnect program.
- Provides for the promotion of adoption of all children with special needs, regardless of birth family or adoptive family income.
- Requires each state child welfare services plan to develop a plan for the ongoing oversight and coordination of health care services for any child in a foster care placement. Such oversight and coordination applies to mental health services, including provision of psychotropic medication.

The Child and Family Services Improvement and Innovation Act (Public Law 112-34, 2011)⁹:

- Extends the Stephanie Tubbs Jones Child Welfare Services program (CWS, Title IV-B, Part 1 from fiscal year 2012 through 2016, and expands on the Fostering Connections to Success and Increasing Adoption Act of 2008, by adding the following requirements to the child welfare state plan:
- Monitoring of a child's emotional trauma associated with child maltreatment and removal from home.
- Tracking of psychotropic medication and the identification of protocols for the appropriate use and monitoring of psychotropic medication are now explicit provisions of health oversight.
- Addressing the developmental needs of children under five years of age, and reducing the length of time these infants and toddlers are without a permanent family placement.

- Need to describe how the state identifies populations at greatest risk of maltreatment and targets these populations. Acceptable family support services are amended to include peer mentoring and support groups for parents and primary caregivers.

The Family First Prevention Services Act of 2018 (FFPSA, Public Law 115-123):

- In a significant federal effort to prevent the need for foster care placement, the FFPSA makes it permissible for the first time for states to use IV-E dollars for prevention and treatment services in support of children at risk of foster placement (referred to as foster care “candidates”). Services may address mental health and/or substance abuse and involve both child and family, for up to 12 months. Services may be promising, supported, and well-supported, and must be trauma-informed. Federal matching for prevention services, at a rate of 50% of cost, can continue until 2026.
- In a significant effort to decrease out-of-home child placements that are not in family foster homes – e.g., use of congregate, residential, and group care settings – the FFPSA creates financial disincentives (discontinuation of federal maintenance payments after two weeks) for non-foster home placements. Exceptions to the above may include when a child is placed in a permissible “specified setting” (referred to as a Qualified Residential Treatment Program, QRTP) that follows a trauma-informed care model, when a formal assessment within 30 days of placement establishes the child’s continued need for such placement, and when the Court approves the placement within 60 days of its initiation. An acceptable QRTP must also facilitate and document family involvement and outreach.

UNDERSTANDING CHILDHOOD TRAUMA

CAPs need to be familiar with the basics of childhood trauma and how it is addressed, in order to effectively work with children and adolescents in the child welfare system and others who have been subjected to trauma.

The centrality of trauma as a national concern is reflected in the identification by the Substance Abuse and Mental Health Administration (SAMHSA) of “violence and trauma” as priority #2 within SAMHSA’s Ten Strategic Initiatives (2010).¹⁰

CAPs need to understand what constitutes *trauma*, the various *types* of trauma, the *frequency* and *impact* of trauma, and the concept of *post-traumatic stress disorder* (PTSD):

- According to Griffin,¹¹ there are three necessary conditions for an event to be regarded as involving *trauma*:
 - an *event*, which involves an objective occurrence or set of circumstances involving harm or threat of harm to the individual,
 - an *experience*, which involves a subjective response involving fear and distress by an individual to the event; and
 - an *effect*, which involves long-term, adverse impacts on the individual’s functioning and development.
- *Types* of trauma can be divided into those that involve maltreatment within a family (e.g., neglect, abuse, witnessing of domestic violence), and those that do not involve maltreatment. Among the latter are natural disasters, war and terrorism, and refugee

trauma. Another less-recognized form of trauma in this category involves system-induced trauma, which occurs when an individual is traumatized by their experiences in the mental health or other human service system. It is important that professionals in human services, education, and the legal system work to prevent system-induced trauma.

- Trauma can also be classified according to the frequency and duration of the event. Type I trauma refers to single-incident trauma. Type II trauma refers to repeated or prolonged trauma.
- *Post-traumatic stress disorder* (PTSD) is the most significant trauma-related diagnosis. PTSD may present differently in children and adolescents, based on their age and developmental level. DSM V operationally defines PTSD according to seven criteria, all of which need to be met:
 - Criterion A: *Exposure* to an event that involved death or threatened death, actual or threatened serious injury, or threatened sexual violation. The individual need not have been the victim of the event, if exposed in other ways. Note that, in DSM V, the requirement that the traumatic event cause fear, helplessness or horror is removed.
 - Criterion B: At least one *intrusive* symptom, from among those listed.
 - Criterion C: At least one symptom involving *avoidance* of traumatic reminders.

- Criterion D: At least three symptoms related to *negative changes in thoughts and mood*.
- Criterion E: At least three symptoms related to a *change in arousal*.
- Criterion F: The identified symptoms last for *more than one month*.
- Criterion G: The symptoms create considerable *distress or interfere* greatly with a number of areas in the person's life.

The prevalence of childhood trauma in American society is extremely high. Significant trauma affects 80% or more of high-risk youth and those living in urban settings and in poverty, and many of these youth have multiple exposures.^{12,13} Youth at high risk include those in public systems – child welfare, juvenile justice, drug and alcohol, mental health – and those who are homeless.

The determinants of an individual's response to trauma, and the outcomes, involve three key parameters:

- The nature of the traumatic event(s) – e.g., Type I or Type II trauma; the frequency and severity; the identity of the perpetrator.
- The characteristics of the individual – e.g., age of child; prior exposure to trauma; cognitive level; maturity level.
- The characteristics and the response of the environment – e.g., accepting and responsive to child vs. rejecting; resumption of structure and routines vs. significant disruption of the family or community.

Severe and repeated trauma can distort the child's psychosocial development, and impair daily functioning.¹⁴ Trauma affects the child's neurobiology, in particular the hypothalamic-pituitary axis and the release of epinephrine and cortisol. Trauma also may result in the underdevelopment of key parts of the brain, including the frontal lobes.¹⁵ In addition, as demonstrated in the longitudinally-based, Adverse Childhood Experiences (ACE) study,¹⁶ the effects of trauma are cumulative. The greater the number of types of trauma and other adversities experienced during childhood, the more severe the impact on the individual's mental and physical health over time.

A trauma history can be obtained through comprehensive history-taking, and through the use of specific trauma screens. Use of trauma screening enables those in need of trauma-specific treatment or immediate psychiatric services to be identified and referred.

- Trauma screening of youth is important for many reasons:
 - The vast majority of children and adolescents in the United States have experienced trauma, often maltreatment, and this information is not readily disclosed by them or their families.
 - Symptoms of trauma may mimic more common mental health disorders, or may exacerbate the severity of the latter. Making such important diagnostic distinctions becomes easier when the trauma history is known.
 - Trauma screening can help identify which children and adolescents in child welfare or in other systems need immediate psychiatric attention.

- Trauma screening can help identify which youth might benefit from an evidence-based, trauma-specific treatment, and which youth are not in need of such specialized treatment.
- Trauma screening helps identify those children and adolescents who may still be experiencing maltreatment or other trauma in the present.
- In addition, trauma screening can often identify other mental health needs that may not be specific manifestations of trauma exposure.
- There are a number of acceptable trauma screening tools, which the CAP should be familiar with. These include the UCLA PTSD Index for DSM-IV,¹⁷ and, more recently, the Child Welfare Trauma Referral Tool.¹⁸ The latter tool, created by the National Child Traumatic Stress Network (NCTSN) specifically for use in the child welfare system, is comprehensive and of potential benefit in many settings.

The management of trauma includes two potential components: *trauma-informed care*, applicable to everyone, and *trauma-specific treatment*, which is appropriate for those individuals experiencing severe, ongoing trauma-related symptoms and behaviors, which impair daily functioning.

Trauma-informed care (TIC) is a public health concept, intended to ameliorate the impact of past trauma, prevent-re-traumatization, and prevent initial traumatization, whenever possible:

- TIC is not a clinical treatment but rather involves recognition of the pervasiveness and long-term impact of trauma, combined with a humanistic approach to individuals guided by trauma informed principles.
- Trauma informed principles are intended to guide the responses of professionals and others with the individual, in order to promote a sense of mastery and help the individual overcome the effects of past negative experiences.
- According to Falot,¹⁹ there are five core trauma informed principles: 1) safety, 2) trustworthiness, 3) choice, 4) collaboration, and 5) empowerment. This formulation has recently been expanded by SAMHSA.
- Consistent with the above, TIC involves a commitment to avoid coercive practices such as seclusion and restraint in institutional care, and also attempts to gain “compliance” through intimidation.
- Trauma informed principles are applicable to professionals, agencies, and systems working with youth, families, and others affected by trauma.
- Respect and kindness, inherent in TIC, should be evident in every interaction with child or adolescent and family by professionals:
 - While some children and adolescents subjected to trauma respond primarily with internalizing symptoms (withdrawal, passivity, flattened or depressed affect, retreat into fantasy, and more extreme dissociative behaviors), others respond primarily with externalizing behaviors or a combination of both.
 - Those who externalize, in addition to being guarded and slow to trust, are quick to anger and may also be oppositional, defiant, and aggressive.
 - This latter presentation 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. Being trauma informed involves viewing the whole person

and understanding the dynamics that may be giving rise to inappropriate behavior.

- TIC is not only for those served by child-serving systems. It also needs to be provided to professionals within various agencies and systems. In the absence of provision of TIC for staff, TIC for children and adolescents and families becomes unlikely.

Trauma-specific treatment involves clinically interventions for those individuals with a history of severe, recurrent trauma, who continue to have high levels of symptomatology and functional impairment:

- There are many evidence-based trauma treatments, and these are identified on the SAMHSA website and that of the National Child Traumatic Stress Network (NCTSN).
- Two well-known, trauma-specific treatments that are evidence-based involve trauma-focused cognitive-behavior therapy and child-parent psychotherapy. Another evidence-based approach that is not trauma-specific per se but that has been shown to decrease the frequency of reported child abuse, involves parent-child interaction therapy (PCIT).²⁰
- In general, the combination of trauma informed care and trauma-specific treatment, when needed, implemented as part of a strengths-based individualized approach, can promote the resiliency and recovery of children and adolescents who experience trauma and greatly improve their outcomes.

ROLES, SERVICES, AND RESPONSIBILITIES OF CHILD WELFARE SYSTEM

Roles of child welfare workers include:

- Responding to and investigating reports of child abuse or neglect.
- Determining whether or not the child abuse or neglect allegations are substantiated or not.
- 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.
- 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. The child welfare system is also referred to in this context as the child protection system or Child Protection:
 - 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 maintains legal court custody.
 - At other times, the child protection workers or the court determines that the family can maintain legal and physical custody.
 - In highly unsafe situations, the court determines that Child Protection needs to assume both legal and physical custody of the child, and the child is placed out of the family home.
- 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.
- 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.
- Collaborating with involved professionals from other child-serving systems.

- It should be noted that, in some states, child protection functions are separated from casework functions.

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:

- Responding to, investigating, and taking appropriate action in response to suspected child abuse or neglect.
- Service planning, when child protection concerns are documented.
- Provision of in-home services to families, in support of the child or youth being able to remain safely in the family home.
- Provision of out of home placements for the child:
 - Emergency shelter.
 - Emergency foster care placement.
 - Foster home.
 - Treatment foster care (a more intense, therapeutic type of foster home).
 - Kinship care (placement with extended family).
 - Residential placement.
 - Pre-adoptive placement and adoption.
 - Group home placement.
 - Supervised independent living for youth.
- Based on identified psychiatric need, a child may be temporarily placed in an inpatient psychiatric hospital for treatment.
- Provision of prevention services for the family.
- Post-adoption services for families that adopt a child.
- 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.

Child protection-related court processes and applicable time lines:

- *The preliminary (or emergency) protection order*: Child Protection 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.
- *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.
- *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.
- *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):
 - 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.

- In some cases, the dispositional hearing occurs at the same time as the adjudicatory hearing.
- If the court determines the child needs to be removed from the home, it will also mandate Child Protection 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).
- *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.

- *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:
 - If the child remains in foster care longer than 12 months, then a permanency hearing must be held at least every 12 months thereafter.
 - 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.
- *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:
 - Once parental rights are terminated, the biological parents can no longer make decisions about the child.
 - The child is then legally free to be adopted by another family.
 - 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.
 - 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, and the parent is making progress but needs more time.
- Representation for the parents and the child at hearings:
 - 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.

- 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 states, a Court Appointed Special Advocate (CASA), a trained volunteer who usually is not a lawyer, represents the best interests of the child.

THE SERVICE PLAN

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).

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

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

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.

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

FAMILY-CENTERED PRACTICE: THE EMERGING VALUE SYSTEM WITHIN CHILD WELFARE

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.

Family-centered practice within child welfare is based on two core values:

- The best place for children to grow up is in families.
- The most effective way to ensure children's safety, permanency, and well-being involves providing services that engage, involve, strengthen, and support families.

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.

Family-centered practice is a concept applicable across systems, and is congruent with both CASSP Principles and system of care principles.

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, see below), can be as family-driven as an effectively implemented wraparound process.

Key components of family centered practice include the following:

- 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.
- Helping to stabilize families in crisis.
- Building upon strengths during service planning and service implementation, with the family an active participant throughout the process.
- Providing individualized, flexible, culturally responsive services.
- 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.
- Advocating for, and with, families.
- Connecting families to resources that address identified needs.
- 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.
- Ensuring that professionals learn about the family's culture and provide services that are culturally competent.
- Promoting multi-system collaboration among diverse child-serving professionals and their respective systems.
- Making use of evidence based and promising practices, as with family group decision-making and treatment foster care (see below).

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:

- 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.
- FGDM 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.
- 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.
- During the actual family group conference, following the first 2 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.

- 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.
- 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.
- 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.
- FGDM has a developing evidence base.

Treatment foster care (TFC, also known as multidimensional foster care) is an evidence-based approach to delinquent male youth developed by Chamberlain (Oregon Social Learning Center)²¹:

- TFC involves intensive work with the youth, the treatment foster parents, and the youth's parents/guardians.
- 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.
- 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.
- 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.
- TFC staff works with the youth's family during the placement period and for a 12-month after-care period as well.
- 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.
- 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.

PSYCHOTROPIC MEDICATION PRESCRIBING

Recent federal legislation and initiatives by the Administration for Children and Families in the US Department of Health and Human Services clearly indicate that psychotropic medication prescribing practices are under national scrutiny. In addition, it has become the mandated responsibility of state child welfare agencies to identify mechanisms for the appropriate use and monitoring of such medication:

- This mandate involves psychotropic prescribing by all eligible prescribers, including pediatricians and other primary care providers, not just psychiatrists.

- Moreover, state child welfare agencies are responsible for the overall health and wellbeing of children and adolescents in child welfare, including the oversight and coordination of health care services for youth in foster care.
- National data has clearly established that children and adolescents in foster care receive greater amounts of psychotropic medication and more frequent use of antipsychotic medication than those in the general population and also those receiving Medical Assistance who are not in foster care.
- While the greater use of psychotropic medication for children and adolescents in foster care may be clinically indicated in some cases, this is not necessarily the case. For example, regional prescribing differences within the same state suggest that psychotropic medication decisions are not solely made on the basis of the severity of clinical need.
- CAPs need to ensure that their prescribing patterns are congruent with existing evidence-based practices and with available consensus guidelines, including those developed by AACAP.
- When recommending or prescribing psychotropic medication, CAPs need to educate children and adolescents, parents, legal guardians and other caregivers, child welfare workers, and other involved human service professionals on the indications and rationale, potential side effects, and mechanisms for monitoring such medication.
- CAPs need to ensure that parents and legal guardians and youth when appropriate, receive sufficient information to enable them to provide *informed consent* for psychotropic medication. For youth not able to consent due to age or developmental limitation, the CAP should endeavor to obtain *informed assent*.
- In some states, the right of informed consent belongs to the child welfare system or the courts and not to the parents, legal guardians and youth. Even when this is the case, it is essential that the latter individuals be engaged and educated in relation to any psychotropic medication being used.
- Given the limited evidence-base at present regarding the use of psychotropic medication to treat trauma, the CAP should follow the literature to learn when more definitive evidence for the use of psychotropic medication with this population emerges.

The need for appropriate psychotropic medication prescribing and appropriate prescribing oversight applies to all children and adolescents, whether or not they are involved with child welfare and in foster care. In like manner, appropriate psychotropic prescribing is important for all psychiatric disorders, not just those related to trauma:

- Therefore, CAPs should embrace the federal mandate for state oversight of psychotropic medication prescribing, since this process can improve that overall quality of prescribing and support the recovery of children and adolescents with psychiatric challenges.
- CAPs can take an active role in helping agencies and states develop appropriate prescribing standards and oversight mechanisms.
- CAPs can act in many ways, including as individual practitioners and through regional and statewide child psychiatric societies, university medical centers, and managed care organizations.

- CAPs can also promote improved prescribing through collaboration with non-psychiatric prescribers, including pediatricians and other primary care providers. This can occur via formal and informal arrangements with medical homes, and through statewide programs that provide technical assistance to primary care physicians by child and adolescent psychiatrists.

CAPs can also promote the health and wellbeing of children and adolescents in foster care by advocating for the use of effective psychosocial treatments in conjunction with, and at times as an alternative to, psychotropic medication:

- Most of the time, psychotropic medication should not constitute a stand-alone intervention but rather be used along with specific psychosocial interventions. This is especially the case for children and adolescents in child welfare.
- The absence of effective psychosocial treatments for youth in child welfare sometimes necessitates the use of psychotropic medication as a default response during emergencies, in order to try to preserve safety or prevent a restrictive placement. Such situations create difficult choices for the CAP and are not in the best interest of the child or adolescent.
- CAPs need to be familiar with, and promote the use of, evidence-based psychosocial interventions, whether for trauma or more common psychiatric disorders. At times, the CAP may be able to provide, or supervise the provision of, evidence-based treatments directly.
- CAPs should also promote the use of trauma screening in those settings and systems where it does not occur.

PREVENTION OF CHILD ABUSE

Research has shown that 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.

Prevention of child abuse is a responsibility that extends beyond just the child welfare system:

- Pediatricians, 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 office may also be contacted.
- 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.

- 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.

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. These services vary in quality in different communities, and also in their respective evidence base. Preventive services include:

- Parent education.
- Parent support groups.
- An array of in-home services.
- Respite care.
- Other forms of family support.
- Linkage and referral to other services and to natural supports in the community.

Other child serving systems also have opportunities for prevention, beyond reporting suspected child abuse or neglect:

- 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.
- Day care settings can provide information to parents about their child, and promote the child's development.
- Schools can also provide information to parents about their child, and promote the child's development.
- Faith groups can help prevent child abuse and neglect in a variety of ways.

POTENTIAL PITFALLS FOR CHILD WELFARE STAFF AND OTHER PROVIDERS, INCLUDING THE CHILD AND ADOLESCENT PSYCHIATRIST

Pitfalls in relation to the child or youth:

- Not learning about and recognizing the child's trauma and maltreatment history.
- Not understanding how child maltreatment and other trauma affect the child's neurobiology, brain morphology and functioning, and the overall psychosocial process.
- 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.
- Viewing the child or youth solely in terms of problematic behaviors, without seeking to understand the underlying basis of the behaviors.
- Personalizing the child's behaviors as intentional and labeling them as "manipulative" and "attention seeking."
- Trying to convince a child that loyalty toward biological parents is inappropriate.
- Overlooking the possibility that the child might still be experiencing trauma in his/her current residential setting or placement.
- Overlooking the strengths of the child in designing a comprehensive treatment plan.

Pitfalls in relation to the biological family:

- Assuming that the parents do not care about the child, and are incapable of changing.

- Blaming and shaming of parents for their abuse or neglect of the child, even when an abuse allegation is found to be substantiated. Despite their unfortunate behavior, parents still need to be treated with respect.
- Overlooking the strengths of the family in designing a comprehensive treatment plan.
- Mandated reporting of possible neglect and abuse can create tension in the professional's relationship with the family. Nevertheless, mandated reporting must occur, when indicated.

Pitfalls in relation to the foster family (or pre-adoptive family):

- Assuming that the foster family understands the dynamics of child trauma and maltreatment.
- Assuming that the foster family is only in it “for the money.”
- Assuming that the foster family understands the use of psychotropic medication.

Pitfalls in relation to the child welfare system:

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

ROLES FOR CHILD AND ADOLESCENT PSYCHIATRISTS

CAP as an advocate for trauma informed care:

- Unfortunately, identification of, and provision of appropriate interventions for, childhood maltreatment do not reliably occur within mental health and other human services.
- The CAP can play an instrumental role in promoting trauma informed care within mental health and other involved child serving systems.
- Trauma informed care creates a respectful, empowering content in which specific interventions can be provided and are more likely to be effective.
- The CAP can serve as an advocate for trauma informed care by modeling the trauma informed practices while performing the following functions: conducting psychiatric evaluations; serving as member of a child and family team; prescribing and monitoring psychotropic medication; consulting to a child welfare agency; completing court-requested evaluations; and reporting suspected abuse or neglect when indicated.

CAP as clinician providing psychiatric evaluation of the child:

- Review all available information about the child, and talk with referring child welfare worker and others for collateral information.
- Include the current caregivers of the child in the evaluation process, whenever possible.

- Include the biological parents of the child, whenever possible, especially when family reunification is imminent or planned.
- Present yourself as welcoming and non-intimidating with child and family, and engage them.
- Ask about, and identify, individual and family strengths. These are essential.
- Seek to understand the situation from the point of view of the child and family.
- Obtain a thorough trauma history and developmental history, and be alert for posttraumatic signs and symptoms.
- 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.
- Expect that many families will appear guarded due to prior, negative experiences with professionals. When this occurs, work even harder at engagement.
- Write a comprehensive, respectful evaluation report that is free of jargon, which addresses the consultation question and provides direction to the team:
 - Include information about the child's maltreatment and trauma within the "History" section of the report.
 - Discuss the impact of the trauma on the child in the "Formulation" or "Discussion" section.
 - 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.

CAP as an advocate of evidence-based, trauma specific treatment:

- The CAP can advocate, at multiple levels, for the availability and use of trauma-specific treatments for those children and adolescents in child welfare in need of such specialized interventions, as determined by history, screening, assessment, and clinical evaluation.
- At the child-specific level, the CAP can identify the need for the child to receive an evidence-based treatment when the child has not responded to more supportive interventions and continues to have active and severe trauma-related symptoms and behaviors. Because trauma-specific treatments generally are more effective when a parent or responsible adult participates, the CAP can help identify the most appropriate individual(s), when necessary.
- At the provider level, the CAP can encourage agencies in both mental health and child welfare to develop a workforce that can provide trauma-specific treatments that are evidence-based. Also needed is the infrastructure to provide supervision and ensure fidelity of the treatments offered.
- At higher levels, involving county and state mental health and child welfare systems, the CAP can also advocate for the availability of evidence-based treatments for children.

CAP as a provider and/or supervisor evidence-based, trauma specific treatment:

- Increasingly, CAPs receive training in the provision of evidence-based treatments. CAPs with such expertise may be able to provide such treatment for children and adolescents in need of trauma treatment, or supervise such treatment.
- The provision and supervision of specific treatments represents another way for the CAP to develop a role that extends beyond that of evaluator and medication prescriber.

CAP as member of the child and family team:

- 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.
- If the child is living with the biological family, then the family will be encouraged to identify and expand its network of support.
- 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.
- Specific recommended practices:
 - Learn the names and roles of each team member.
 - 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.
 - Promote a strengths based perspective.
 - Offer your ideas without taking over.
 - Support the process and encourage the team. Gently refocus the team, when indicated.
 - If it becomes necessary to disagree with a team member and/or offer corrective feedback, do so tactfully and respectfully.

CAP prescribing and monitoring psychotropic medication:

- Ensure that you have a complete psychotropic medication history before prescribing medication.
- Remember that, in prescribing psychotropic medication as in all of mental health, empowering children and adolescents and their families is an essential responsibility.
- 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.”

- Identify how team members can assist you in monitoring the effects of medication.
- Remain available for questions and concerns between appointments.
- Remember that psychotropic medication should not be the sole or primary intervention for children and adolescents in foster care, and advocate as necessary for effective, evidence-based psychosocial treatments as part of your role as prescriber.

CAP as consultant to child welfare:

- Roles, and frequency of contact, may vary.
- CAP can provide training to staff, or meet informally with staff on a regular basis.
- CAP can provide psychiatric consultations, on request.
- CAP can consult directly to agency director re ways to improve coordination and care.
- CAP can assist the agency director in the development of criteria for oversight of psychotropic medication prescribing patterns.
- CAP can highlight and reinforce the need for effective psychosocial interventions and evidence-based practices for youth in child welfare.
- CAP can promote the use of a Wraparound team planning process for youth and families involved with child welfare, and provide information of this process.

Court-requested evaluations:

- These may involve an evaluation of the child, a parent, or both parents.
- At issue may be custody, termination of parental rights, or the clinical needs of the child.
- Address the identified question, and generally limit report to this.
- Usually, providing evaluations for the court is not compatible with maintaining a direct care role.

CAP as a mandated reporter:

- While specific statutes may vary from state-to-state, the CAP is a mandated reporter of child abuse or neglect, and as such is legally obligated to report suspected abuse to the appropriate child welfare authority.
- When this becomes necessary, best practice often involves the CAP informing the parents directly and remaining non-judgmental, while 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.

CONCLUSION

There is a great deal of information that the CAP needs to learn about the child welfare system 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.

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.

Children and adolescents who have experienced significant trauma can be supported in achieving resilience and working towards recovery, when CAPs and all involved professionals understand trauma and commit themselves and their systems to the provision of trauma-informed care, trauma-specific treatment when indicated, and individualized, strengths-based responses. The

appropriate use of psychotropic medication and the systematic monitoring of prescribing patterns also contribute to quality outcomes.

In order to promote family-centered practice and the health and wellbeing of children and adolescents in foster care and their families, the CAP needs to acquire specific knowledge and skills and adopt certain values related to children and adolescents, families, the child welfare system, cultural competence, and multi-system collaboration.

Potential roles and opportunities for the CAP need to be understood, and CAPs are encouraged to become involved in some way with the child welfare system within 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:

IV.B.1.f) Systems-based Practice. Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. (Core)

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

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Child Welfare System – Discussion Vignette I – Trainee Version

Jean Roberts is an 8-year-old Caucasian female who lives in a trailer with her mother and father and her 6 year old sister. Jean is in 2nd grade in a regular classroom in the local elementary school. Child Welfare 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 2 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 that 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 Child Protection worker 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 child psychiatrist, would like to ask the Child Protection worker 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?

Child Welfare System – Discussion Vignette II – Trainee Version

Angel Rivera is a 17-year-old Latina who has recently been admitted to a transitional mental health residential treatment center. 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 2 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 6 months, but with only limited impact. There was no follow-up mental health treatment afterwards.

Approximately 1 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.

Angel has had contact with her mother, who continues to be fearful of Angel, and with her 11-year-old half-sister, since her admission to the residential facility. Angel has had intermittent contact over the years with her biological father who lives in the area. For the first 2 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 the role of psychiatrist in her treatment team.

Child Welfare System – Discussion Vignette III – Trainee Version

Mark Taylor is a 13 year old African American male, who is now in his third successive foster home since his maternal grandmother, Ms. Yolanda Rogers, died unexpectedly approximately 6 months ago. Although Ms. Rogers was in her seventy's, she had appeared to be in relatively good health prior to her fatal heart attack.

Since there were no other kinship care resources for Mark, he was placed in foster care. The first two foster care placements were both discontinued by the foster families, due to Mark's disruptive behavior in the homes and his refusal to accept limits. Following these two failed foster care placements, Mark was placed in a therapeutic foster home with Ms. Regina Jones, age 67, who has reportedly been successful with other challenging foster children in the past. Ms. Jones' own children are now grown and out of the house, and she and Mark are the only ones in the home.

Mark is an athletic child, who has especially enjoyed playing basketball and football informally in the community. He attended church with his grandmother, not always with great enthusiasm. Mark likes music, especially hip hop, and has expressed interest in someday being an entertainer. While living with his grandmother, Mark was able to pass in school, but was not considered a good student. He sometimes got into conflicts with authority figures there, but they were usually able to de-escalate him. Mark generally got along well with peers except during school sports, when his competitiveness at times led to peer conflict and physical altercations. Ms. Rogers, his late grandmother, had been concerned about Mark's temper and impulsivity, although he rarely got angry with her and generally did what she asked.

Mark's history is incomplete, but it is believed that he was taken in at about age two years by Ms. Rogers, and he then lived with her until her recent death. The parental rights of Mark's biological parents were terminated many years ago. Over the years, Mark has seen his biological mother intermittently in the community, usually on drugs. He never met his biological father. Mark apparently experienced emotional and physical neglect and physical abuse during his first two years. At one point, he was put in emergency placement and then returned to his mother.

Ms. Rogers took in Mark at about age 2 years, after his mother brought him to the emergency room with bruises over his body and what was identified as a concussion. Child welfare was contacted, and Mark was then placed in kinship care with Ms. Rogers. It is not clear if Mark received mental health services when he was younger, but he was not in treatment and not on psychotropic medication, at the time of his grandmother's death.

Recent behaviors by Mark at the therapeutic foster home, have included the following:

- Being argumentative and oppositional, and defying Ms. Jones.
- Leaving home without permission, and at times not coming home until 11 PM.
- Poor academic performance and conflicts with teachers at his new school.
- Presenting at times with a "gangsta" persona.
- Impulsive behavior at school and in the therapeutic foster home.

- At times, sudden rage attacks at home, the precipitants of which are unclear to Ms. Jones. At other times, unexplained panic attacks take place.

The challenges presented by Mark are exacerbated by the following:

- The therapeutic foster parent, Ms. Jones, is very angry at Mark, because she sees him acting negatively towards her on purpose and not appreciating what she is trying to do for him.
- The child welfare worker, Ms. Beverly Ryan, is also angry with Mark, since she sees Mark as sabotaging her efforts.
- Ms. Ryan has also told Ms. Jones that she is disappointed in the foster parent's inability to work with Mark.
- Ms. Jones, in turn, is angry with Ms. Ryan, feeling that she was not given enough information about Mark prior to his entry into her home.

1. Identify at least 10 possible reasons for Mark's challenging behaviors and poor adaption in the therapeutic foster home.

2. How is the concept of trauma informed care relevant to the above situation?

3. Identify 5 core trauma informed care principles.

4. For which individuals in the above vignette is trauma informed care relevant? Identify these individuals, and explain the relevance of trauma informed care for each.